ABIM Foundation Forum 2015: **Summary**

By Tim Lynch

Physicians, patients, medical students, residents and other health care leaders joined together at this year's ABIM Foundation Forum to consider how culture shapes how care is delivered, and how conscious efforts to change those cultures can foster better patient experiences and outcomes. Over the course of three days, a discussion that could have lent itself to abstraction instead produced practical guidance that these leaders can apply in their institutions to promote and provide improved care.

Setting the Stage

The Forum began with a discussion between Richard Baron, MD, President and CEO of the American Board of Internal Medicine (ABIM) and the ABIM Foundation, and Holly Humphrey, MD, Chair of the ABIM Foundation, about how culture has influenced how they manage their organizations and their personal health care experiences. Dr. Baron discussed how a seemingly trivial element of a former health sector employer's culture—the CEO's donning of a Halloween costume, even in the midst of a contentious business negotiation—became ingrained in the institutional culture through successive costumed CEOs. Dr. Humphrey described how the University of Chicago Pritzker School of Medicine, where she serves as the Dean for Medical Education, addressed survey findings in which 30 percent of graduating medical students reported that they were mistreated. The medical school took a series of steps to improve its culture, including establishing a professionalism steering committee, creating peer role model awards for students and faculty, and appointing confidential ombudspersons to whom students could confidentially present concerns. While it took time and a few years of continued poor survey results, the school changed its culture and the percentage of students reporting mistreatment shrank to zero. In a comment that would be echoed by others later in the meeting, Dr. Humphrey said, "One of the keys to our success was focusing on what about our daily interactions was positive."

Although one of these cultural touchstones seems purely symbolic while the other involved a series of structural changes, both illustrate ways in which leaders sought to achieve their goals by shaping their institution's culture and creating a more positive work environment.

Three speakers followed Drs. Baron and Humphrey to share their stories in TED-style talks about culture change:

- Christopher Moriates, MD, a hospitalist at the University of California, San Francisco (UCSF), talked about his interactions with patients on rounds. Before leaving a patient's bedside, he would ask, "Do you have any questions?" while a voice in his head would chant, "Please don't." Over time, he said his patient satisfaction scores slipped and he became less satisfied with his clinical work. A colleague then taught him a modified approach, asking his patients instead, "What questions do you have?" "Those first few times, it felt like a magic trick, and my internal chant no longer applied," he said. He also began finishing visits by saying "thank you" to his patients. These changes in language "were simple but strangely powerful," he said. "They changed how patients felt and changed how I felt."
- Richard Frankel, PhD, discussed appreciative inquiry, which he and his colleague, Thomas Inui, MD, introduced as part of an intentional effort to create a new culture at the Indiana University School of Medicine. He described appreciative inquiry as the "idea that in every organization, something is going well, and if we can harness the energy of what's going right, we can change the nature of the conversation and, in doing so, change the culture." This focus on learning from "positive deviants" was extremely popular with Indiana students, who, for the last 11 years, have created booklets featuring positive student stories and included them in the pockets of arriving students' white coats.

- Maureen Bisognano, the President and CEO of the Institute for Healthcare Improvement, shared her brother Johnny's story. He was diagnosed with Hodgkin's lymphoma when he was 17, and by the time he turned 20 he knew he was dying. "I thought my job was to give him hope and encouragement," said Bisognano, who was three years older than Johnny. "But in his last year, I learned a profound lesson that has carried me through my whole career." In his last days in the hospital, the doctors, residents and medical students caring for him would frequently come to his room but would rarely talk with him. One day, however, a physician came to his room and asked Johnny what he wanted. He said that he wanted to go home; the physician then took Bisognano's jacket, put it on Johnny and carried him to her car. When they went home, Bisognano asked Johnny what he wanted, and he said that he wanted to turn 21, a milestone that was about one week away. Johnny reached that milestone and passed away the following week. "I think back to that question," Bisognano said. "What if I had known to ask him what he wanted? What would he have done and seen in the time he had left? I want to thank that doctor who helped me think about health care in a different way."

The Kimball Lecture

These stories were followed by the Kimball Lecture, the Forum keynote address that honors former ABIM and ABIM Foundation President and CEO Harry Kimball, MD. This year's address was delivered by Jo Shapiro, MD, Chief of Otolaryngology at Brigham and Women's Hospital in Boston. Dr. Shapiro discussed her drive to improve the patient safety culture at her hospital, including through the creation of the center she directs. She focused her remarks on four "personal touchstones" that shaped her work: psychological literacy, awareness, inspiration and relational intelligence.

Her first attempt to improve patient safety, which involved her analyzing and presenting data about compliance with duty hours limitations, failed to produce results. Through this experience, in which her work was criticized by leaders at the hospital, she learned the significance of *psychological literacy*, which she defined as the ability to read one's own response to challenges and master that response.

She also stressed the importance of *awareness* of one's environment and the "criticality of a failure to notice." In her own environment, Dr. Shapiro said she noticed unprofessional behaviors, poor teamwork, heartbreaking stories of burnout and a loss of joy among clinicians. At the same time, she also noticed that many national leaders chastised clinicians for failing to do the right thing without recognizing the limits they were facing. In response to her *inspiration* to help create a culture that would enable more professional behavior, she proposed creating a Center for Professionalism and Peer Support at Brigham and Women's. She persuaded the hospital's leadership that such a center could counteract the "epidemic of burnout and how it makes it impossible to provide compassionate care," and enhance relationships between physicians and patients.

The Center also allows people to confidentially bring forward concerns about unprofessional behavior, and hold all clinicians responsible for upholding agreed-upon standards of conduct. "The Center allows for difficult conversations and the ability to give critical feedback that acknowledges the offender's view of behavior but also points out the impact of that behavior on patient care," Shapiro said. "This is a patient safety issue, not just 'Kumbaya.'"

Dr. Shapiro said that the Center's work involves the development of *relational intelligence*, describing an "extraordinary amount of teamwork, building on successes and learning from failure." The Center offers skills training in conflict resolution, giving difficult feedback, teamwork and communication. It also offers peer support, to aid clinicians as they handle the feelings involved in causing harm to a patient. "If we can't be there for each other in those moments, everything else we do is window dressing," Dr. Shapiro said. Peer support is provided for the entire team involved in providing care after an adverse event, and one-on-one

counseling is also available. Support is not only made available when errors occur, but also after tragic events such as the 2013 Boston Marathon bombing or the murder of a physician at the hospital earlier this year.

During the discussion period after the lecture, Meg Gaines, JD, Director of the Center for Patient Partnerships at the University of Wisconsin Law School, praised the creation of Dr. Shapiro's center for providing crucial support for clinicians. From her perspective as a patient advocate, she said she was a strong believer that "you can't give what you don't get," and that providing this kind of support for clinicians was critical to enabling clinician-patient conversations.

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– Charles Kilo, MD

In response to questions about the transferability of her concept to other institutions, Dr. Shapiro said that she didn't think she was the most popular person at her hospital and that she has come in conflict with very powerful people as a result of her work. But she said that she is asked to speak with hospital leaders across America and in other nations about the concept, and that she tells them that the only reason not to create a center like hers is "if you're not interested in patients." She also pointed to the long experience the health care system has had in leaving clinicians alone after adverse events, and the negative consequences that have resulted, such as a suicide rate for female physicians that is 130 percent higher than the suicide rate for women generally.

Changing Cultures: Learning from Leaders

During a panel following the Kimball Lecture, other leaders shared stories about driving culture change, from raising consciousness about end-of-life options to collaborating with providers across a community on an application for Pioneer Affordable Care Organization status.

- Bernard Hammes, PhD, from Gundersen Health System, discussed his work in La Crosse, Wisconsin, to encourage community members to clarify their preferences for end-of-life care. After trying unsuccessfully through education endeavors to promote conversations between clinicians and patients about creating a care plan, Dr. Hammes conceived of including a space on patients' discharge summaries to detail such plans. "This simple process change became a complex change and the fulcrum for all our work on care plans," Dr. Hammes said. "We learned that to change culture, workflow redesign should precede training rather than attempting to use education alone. Using this principle, 96 percent of patients [in La Crosse, Wisconsin] now have care plans in place at the time of death."
- Charles Kilo, MD, discussed the implementation of Lean at Oregon Health & Science University (OHSU), where he is Chief Medical Officer. OHSU's Lean implementation has been ongoing for three years, and Dr. Kilo said that it has gone well but is fragile. He pointed to the importance of leadership and creating institutional stability that enables an organizational culture that overrides differences of supervision and style among individual departments. "I don't think of culture as elusive or intangible," he said. "I see it as a specific component of a delivery system that has to be managed as much as any other part of the system. Culture is the definition of what is acceptable behavior in an organization."
- Two speakers from the University of Arkansas for Medical Sciences (UAMS), Interprofessional Education Director Lee Wilbur, MD, and Patient- and Family-Centered Care Advisor Kathy Lease, EdD, discussed the need to overcome silos to improve care. The UAMS chancellor tasked Dr. Wilbur with "changing the culture yesterday," and he found greater success by overcoming silos and including all clinicians and patients in the change effort. For example, Dr. Lease described how she was enlisted to serve on a hospital advisory council while she was receiving treatment in the system's infusion center; she has now served on multiple committees and

instructed clinicians. Among other things, her work has led to clearer discharge instructions for patients and reductions in missed ambulatory visits by improving how patients are notified about appointments. "Culture is dependent on leadership, but leadership can come from anywhere; it's not dependent on title," Dr. Wilbur said. "It's amazing how powerful the voices of residents and medical students are, and how powerful the patient's voice is. We forget about the patient sometimes, and then when that voice comes up, it's like common sense."

- Susan Thompson, RN, described overcoming silos of a different sort, surmounting divisions between hospitals, physician groups, community mental health centers, long-term care facilities and other actors to apply for Pioneer ACO status. She was the CEO of one of the involved hospitals (Unity Point Health-Fort Dodge) at the time, and was tasked with leading the application process. "Until we took on the work of forming an ACO, we had never had conversations across the community about how to provide better care," she said. "The change in conversation has been striking; we've gone back to the simple question of why you got involved in health care to begin with."

Summarizing Day One

The Forum's first day closed with remarks from Harvey Fineberg, MD, who said he was struck by the "emotional content of much of what we discussed" and noted that hearing personal stories about how our experience was affected by culture was "a powerful message through the day." He framed his remarks around five Rs:

- **Recognition:** He said that one of the fundamental characteristics of culture is that it often goes unnoticed, or, put another way, "It's easier to detect a pebble on your neighbor's lawn than a boulder sitting on top of your own house." He suggested that we need to be mindful of the gigantic boulders impeding what needs to be done, and wondered if leaders would be better served by thinking about "aligning our values with our behaviors and reaching to the deepest values of our culture to guide the behaviors we want to express."
- **Responsibility:** He called upon leaders who recognize cultural issues to take responsibility for fixing them, enabling person-to-person relationships that go beyond hierarchy and formal roles.
- **Redesign:** He pointed to the need for the redesign of systems to enable change, and noted that the audience heard some examples of process redesign that were simple and others that were complex.
- **Reinforce:** He stressed the importance of reinforcing new cultural attitudes and changes, and suggested this was an area in which leadership was critical.
- **Replicate:** He noted that an area that needed additional attention was how cultural change can be spread and become the norm.

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Day Two: Voices

The Forum's second day opened with three additional TED-style talks, one from a patient and two from physicians who shared their perspectives on culture. Donna Cryer, JD, has lived for 30 years with a variety of conditions that she said had earned her the title "complex patient." She told a story of how a mismatch in participatory medicine styles and belief in shared decision-making, and a shift in the relative power of patients and physicians, culminated in a frustrated negotiation with her primary care physician, who insisted the only option to receive fluids when she suffered a flare-up of symptoms stemming from her Crohn's disease was to go to the ER. "To me, the ER was the option of last resort: expensive, time-consuming and risky for someone who is immunosuppressed," she said. Ultimately, she gave in to her physician's demands, but returned home without receiving

care in the ER when the process became disconnected and the ER wanted to start evaluating her from scratch. She received the fluids she needed at home, which she now does routinely. She also found a new primary care physician, and, as a patient advocate, steered her work "toward redesigning the health care system to work for patients, instead of the reverse." She now meets regularly with hospital leaders to derive workable lessons for improving care from her own experiences.

> "…if you have a continuously learning, collectively intelligent team, the team figures out the right thing to do…"
>
> *– Stuart Pollack, MD*

Lawrence Casalino, MD, PhD, related similar concerns as Ms. Cryer, from the perspective of the physician. He expressed concern that, as physicians work in larger and larger organizations, "human scale" is being lost. He contrasted larger organizations with his former practice, where he had only three medical assistants over 20 years. He stated that the mutual knowledge and respect among patients, physicians and medical assistants were a source of pleasure and comfort for all and resulted, he believes, in better care. He wondered whether the loss of such relationships "will result in areas of medicine that are hard to measure but nevertheless critical—such as timely and accurate diagnoses—being done less well, with no one even realizing that that is what has happened." He expressed hope that the question of whether and how large organizations can include human scale in medicine will receive serious attention.

Vineet Arora, MD, then spoke about her role at the University of Chicago, where she served as chair of a professionalism steering committee. She talked about a time when she witnessed a resident saying derogatory things about a patient, and how she spoke up instead of pretending not to notice, as she might have done earlier in her career. The resident then asked if she was the "professionalism police." The University of Chicago joined with two peer institutions to explore failures of professionalism and their causes, and found that although each institution had different cultures and manifestations of unprofessionalism, all three had serious need for improvement. After a series of interventions, including videos and workshops, unprofessional behavior decreased and residents reported a lower tolerance of unprofessional behavior in others.

Culture Change in Primary and Palliative Care

On the Forum's second day, participants also heard from national leaders in reinventing the culture of primary care and changing how we view palliative care.

Stuart Pollack, MD, spoke about Brigham and Women's Advanced Primary Care Associates, the Boston primary care practice he helped develop. The patient population includes many people with co-morbidities and complex psychiatric issues, and before the practice opened, few of them had relationships with primary care physicians. Dr. Pollack said he sought to follow a "form follows function" approach in designing the way care would be delivered, beginning with the services the practice would provide and then designing clinical teams that could perform them. Pharmacists, social workers, medical assistants and other professionals all were central players. The practice design was shaped by the observation that in the National Demonstration Project, success was linked not to staffing ratios but to features of "adaptive reserve" such as a consistent vision and a learning culture.

Dr. Pollack shared a few theories for why his practice has succeeded, all of which involved cultural change and the development of shared values. They included a reliance on teams, hiring at all levels for personal qualities such as simply being "nice," valuing the opinions of non-physicians, employing the "spirit of motivational interviewing," and building processes that are "managerially loose but culturally tight." He said that "if you have a continuously learning, collectively intelligent team, the team figures out the right thing to do" when protocols break down, as they often do.

He said that when he began establishing the practice, he didn't know "whether truly great primary care was even possible" but that he is now confident that it is. "If you ask what's bugging me in the moment," he said, "it's whether truly great Triple Aim-achieving primary care is scalable." He stressed the importance of such a spread, arguing that "pretty much every scenario of a happy ending for the U.S. health care system presumes we can do it."

Diane Meier, MD, then discussed the "countercultural" effort she is helping lead to make palliative care an integrated and more central part of the health care system, rather than an option available only at the end of life. She began with the story of Mr. and Mrs. B, who were labeled as "abusers" of the ER by physicians after calling 911 on multiple occasions because of extreme back pain from Mr. B's arthritis that immobilized him, leaving Mrs. B no alternative but to call 911 for help. The ER doctor, recognizing that expertise in safe and effective opioid management was necessary for a frail older adult with disabling pain, called the palliative care service for help. As a result of palliative care consultation, Mr. B received low dose opioids, a bowel regimen, and extensive caregiver education on how to safely administer these medicines. The team also arranged a house calls referral, meals-on-wheels, and a home safety evaluation through a home care agency. Social services and supports (a friendly visitor program through their church) needed to address their isolation and Mrs. B's caregiver burden were identified and implemented. As a result of these interventions, Mr. B's pain came under reasonable control, and the couple received the food, home safety equipment (such as an elevated toilet seat), transportation and human support they needed. As a result, the pattern of relying on emergency services after hours ended, with no 911 calls or hospitalizations for more than two years.

The story of Mr. and Mrs. B illustrates what Dr. Meier called the new model of palliative care. Under this model, palliative care is delivered at the same time as other care, and because it prevents and averts predictable symptom crises and caregiver exhaustion, it leads to a reduction in acute care utilization.

This requires a major cultural shift in how physicians and other professionals understand and implement palliative care, but it can deliver meaningful results. For example, Dr. Meier cited several recent studies showing that cancer patients receiving palliative care alongside usual cancer treatments lived longer than those receiving standard care alone.

Dr. Meier suggested that the major requirement for achieving this model is better training of physicians and nurses in core palliative care knowledge and skills, such as pain management, communication, and standing with patients throughout the full course of illness, whether or not curative or disease treatments are indicated. To illustrate, she told the story of Jenny, who was diagnosed with advanced cancer at age 59 and given a year to live. With expert care from her oncologist, she ultimately survived more than six years. Toward the end of her life, however, her oncologist recommended intrathecal chemotherapy for brain metastases. When Dr. Meier, who was also co-managing Jenny for her palliative care needs (pain, fatigue, worry, difficulty concentrating), asked him what he hoped to accomplish with this treatment, he conceded it would provide no benefit but said "I don't want Jenny to think I'm abandoning her."

Summarizing Day Two

Debra Ness, the President of the National Partnership for Women & Families, reflected on the discussions over the Forum's first two days. She noted both the many examples of how culture influences professionalism, and the various factors that facilitate positive change. She underscored the powerful effect of "stories" in a learning environment and their role in helping individuals develop new perspectives, and she highlighted the particular importance of positive stories and positive inquiry in the culture change process. "We can learn so much from focusing on the positive," she said, urging the solicitation of positive stories from patients as a way to learn from their experiences of care. She recognized other change facilitators such as leadership, shared values, "relationship literacy" and "teamness," and also highlighted some of the challenges—such as how to scale and replicate culture change in large organizations

and systems, and how to measure the impact of culture change efforts. She also noted how difficult it is to change how a culture responds to error, the significant implications for clinicians, patients and families, and the tendency to see more constructive response to error in cultures with higher levels of teamwork.

Most importantly, she reminded participants that the Forum's focus on culture change was ultimately intended to help us improve care for patients and families. She noted that the focus on improving the culture for clinicians is a step in that direction, but that we must strive to create a culture that fosters a different kind of relationship between clinicians and care teams and patients and families. She recalled a recurring theme from many of the stories that were shared from the Forum's stage—the importance of understanding *what matters to the patient*…the difference between asking "*what matters to you*" and "*what is the matter with you*." She urged participants to reflect on the transformational impact this reframing could have—and how it could shift our paradigm of care and create a pathway to genuine partnership with patients and families.

She recalled a recurring theme from many of the stories that were shared from the Forum's stage—the importance of understanding what matters to the patient…the difference between asking "what matters to you" and "what is the matter with you."

Ms. Ness concluded her comments with a strong call for participants to keep their eyes on the prize—better care for patients and families—and to ensure that our efforts to change health care culture lead us to genuine partnership with patients and families. Finally, she urged that we begin this journey by including patients and families as true partners in the change process itself.

Day Three: Academic Medical Centers

Cultural expectations and understandings are transmitted to medical students and residents throughout their education, making academic medical centers crucial players in any effort to create meaningful cultural change. During the Forum's final day, participants heard from four physicians involved in culture change efforts at academic medical centers and residency programs.

Hope Ricciotti, MD, Chair and Residency Program Director of the Department of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center, stressed the importance of "understanding whom you lead." Most current trainees are millennials, and their expectations regarding technology and workplace culture differ from earlier generations. In part to appeal to this generation, Dr. Ricciotti led a transformation of her department's physical space, moving to an open design with pathways through which all personnel would move. Physicians gave up their office space, and there is now far more informal social contact, including the creation of an eat-in kitchen. Dr. Ricciotti said that the redesign not only created a more collaborative workforce, but also served as a recruiting tool.

Neel Shah, MD, was recruited a few years ago to the department Dr. Ricciotti runs, and he said he was struck both by how "culture was being managed intentionally" and by how "culture was influencing how we were caring for our patients." He discussed an effort he led to reduce the number of C-sections performed at Beth Israel. He said that while standard labor and delivery can take a long time and require significant clinical attention, performing a C-section is routine and quick, providing a clear incentive for the latter. But although physicians everywhere have that same incentive to perform a C-section, the actual rate of C-sections performed varies significantly across institutions. Dr. Shah is studying the influence of management processes on a physician's decision to choose standard labor and delivery, and finding a link between the institution's capacity (number of beds, number of nurses, backup protocols) and physicians' decisions regarding childbirth.

Vivian Lee, MD, PhD, then talked about a major transformation that she has led at the University of Utah, where she has been dean of the medical school and CEO of University of Utah Health Care (UHC) since 2011. In 2008, under Dr. Lee's predecessor, the system began a major effort

to improve the patient experience. All patients received surveys that included questions about patient engagement, communication, whether they were involved in decisions about their care and whether they felt respected. The survey results were shared with the providers who treated them and the providers then received training that helped lead to consistent improvement over time. In later phases of the project, provider scores were shared with all members of their department, and then in 2012, scores and patient comments were publicly released on the system's website. This process has had a powerful effect. In 2009 and 2010, the system's provider scores were roughly average compared to national peers also using the Press Ganey system. Now, 50 percent of the Utah providers are in the top 10 percent nationally, and 26 percent are in the top 1 percent.

UHC has since taken on a second significant project: to better understand the real costs of delivering care. The system assembled a team of people with financial expertise and priced every element of delivering care, from supplies to operating room time to indirect costs. Providers then receive access to their own cost information and see how the cost of, for example, the joint replacement surgeries they perform compares with their peers. The health system also partnered with the university's business school to implement a system-wide Lean process. In orthopedics, care quality (as measured by a combination of payer-defined and provider-defined metrics) has improved while costs have declined by 32 percent over one year, and Dr. Lee said this success has been replicated across specialties. She also reported that the University HealthSystem Consortium has ranked the University of Utah in the top 10 on quality measures for academic centers for five consecutive years, and that its annual increase in costs has been held to 0.5 percent while costs at academic medical centers as a whole have risen by almost 3 percent annually.

Finally, in another example of collaboration across schools, Patrick Shea, MD, a child psychiatrist at the University of Utah, talked with participants about the Medical-Legal Partnership that he started in conjunction with the university's law school. The partnership enables collaborations between attorneys and physicians who are treating patients whose problems include issues with housing, personal safety or legal status, or other social problems with a legal element. Together, the physicians and attorneys seek to solve not only the patient's immediate medical needs but also the larger conditions that are harming their health.

Innovation Tournament

During the Forum's closing hours, all participants became innovators. Attendees were divided into 13 groups and tasked with developing an innovation that would improve the culture of caring for patients. A representative from each group presented its innovation, all participants voted for their favorites, and then the top six vote-getters refined their ideas (with contributions from new team members whose first concepts had not advanced). Many of the ideas presented involved how to enhance patients' ability to participate in their care, including reserving the first minute of a patient-clinician encounter for the patient to talk (the Patient Minute) and ensuring that patients are asked what matters to them during rounds and ambulatory visits (the First Vital Sign). Others involved coordinating community services to ensure that patients' social needs are met along with their health care needs (Community Connect), promoting physician-patient conversations about cost (*Choosing Wisely*®: The Next Generation), and using technology similar to that used by matchmaking websites to enable patients to choose physicians who are a "good fit" for them (First Date).

After the six finalists presented their ideas, participants voted again to select a winner. The champion was a concept called Help!, a proposed app that would connect patients and families that needed home services with members of the community who were interested in working as caregivers.

Conclusions

Robert Wachter, MD, closed the meeting by offering six observations about culture that he gleaned from the proceedings. His first observation concerned the intentionality of culture creation.

He told them they would be under rigorous pressure to produce satisfying, high-quality care at the lowest possible cost. At that, one of the residents raised his hand and asked, "Well, what was it that you were trying to do?"

He agreed with Dr. Kilo's statement about culture being a specific thing that needs to be managed, but also pointed out that "culture is often terribly subtle and frustratingly indirect." Dr. Wachter said that, as the interim Chairman of the Department of Medicine at UCSF, he is trying to change the culture, but that it cannot be done in one fell swoop. Instead, he said, it requires diagnosing the current culture, inspiring people to appreciate shared values, creating structures and artifacts, promoting certain behaviors, and discouraging others. "When you're done, you've created a culture," he said.

Second, he commented on the invisibility of culture, citing the analogy of a fish having no concept of water. This makes reform all the more challenging.

Third, he cited the need for a burning platform to create culture change. Nearly everyone who spoke at the Forum, he said, provided examples of organizations and individuals changing in response to profound challenges, such as the death of a loved one or a widespread belief by students that they were being mistreated.

Dr. Wachter's fourth observation was that culture is built in small acts. Here he cited Dr. Moriates' switch from "Do you have any questions?" to "What questions do you have for me?"; the minor change in the discharge forms at Gundersen Health System that led to a community-wide adoption of advance directives; or a change in physical space that led to an increase in connectedness at Beth Israel.

His fifth lesson learned was the need to create time and space for culture change, such as by enabling more time for clinician-patient conversations, staff huddles and other efforts to improve care. He noted that these kinds of changes often cost money, and that, although it is predictable that system leaders will first try for easy fixes, they must "then recognize it's probably not going to work and try a more ambitious approach."

Finally, he commented on the need for optimism. He said he was surprised by how little nostalgia he heard at the meeting for the bygone (but not terribly distant) era in which students and trainees learned nothing about culture, leadership, teamwork or cost. He shared a conversation he had with a group of residents at UCSF, in which he told them they were entering a profession that had changed profoundly in the last three decades. He told them they would be under rigorous pressure to produce satisfying, high-quality care at the lowest possible cost. At that, one of the residents raised his hand and asked, "Well, what was it that you were trying to do?"

Dr. Baron closed the Forum by asking participants to take what they had learned about culture back to their institutions and improve care.

We hope that participants learned a great deal and came to appreciate culture's significance more keenly as a result of the three days they spent at the Forum. As so many of the speakers suggested, a focus on culture can lead to improvements that make the health system work better for patients and clinicians alike. The ABIM Foundation would be very interested in learning from participants about any stories of culture change that arise in the coming year; we look forward to hearing from you.

Notes

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