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IN DEPTH

Building a Culture of Respect for People

Lynne A. Chafetz, JD, Alice M. Forsythe, MBA,
Niki Kirby, MSN, RN, C. Craig Blackmore, MD, MPH,
Gary S. Kaplan, MD

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The delivery of safe, effective, and efficient health care requires both technical ability and an enduring culture of respect within the institution. Respect for People is Virginia Mason Medical Center's comprehensive effort to foster an organizational culture of respect. This multiyear endeavor has engaged every employee through a series of workshops and ongoing communication. As part of this effort, we sought to evolve the artifacts, norms and values, and underlying beliefs that constitute our organizational culture. Implementing and sustaining Respect for People has redefined the health care environment at Virginia Mason, to the betterment of patients and staff.

A Strategic Imperative: The Criticality of a Respectful Culture

The importance of culture as a driver of safety and quality is well recognized, dating from *To Err Is Human: Building a Safer Health System*,[1] the seminal report that is widely regarded as having launched the present-day patient-safety movement.[2] Institutional culture has a direct effect on health care providers and team members. Institutions in which staff report higher levels of respect, empowerment, and fairness have better safety records.[3] Interventions to improve culture may be associated with decreases in hospital mortality and improved outcomes.[4] Teamwork is impeded in the absence of mutual respect, resulting in health care workers being less likely to follow safe practices, less likely to ask for help from other team members, and more likely to make errors.[5] In addition, institutional culture drives the patient experience, which is associated with a range of outcomes, including care processes (e.g., medication adherence, use of preventative services, and adherence to physician recommendations), resource utilization (e.g., length of stay, frequency of

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hospitalizations, and number of primary care visits), and patient outcomes (e.g., functional health status and mortality).[6]

The health care quality movement has elevated the call to achieve high reliability, recognizing that health care delivery systems, like other high-risk industries, operate in a complex environment with a risk of catastrophic errors. Such errors carry both direct economic costs as well as indirect costs related to loss of trust by patients and health care team members, low morale, and lost worker productivity.[1] A culture of respect within an organization is a critical component for achieving high reliability.[7] High-reliability organizations (HROs) exhibit an "environment of 'collective mindfulness,'" in which all workers are empowered to identify and report problems.[8] HROs also exhibit "sensitivity to operations" and foster an environment in which all personnel not only feel free to speak up with concerns, but also recognize that they have an obligation to do so.[8] HROs defer to expertise and favor listening to those who are most knowledgeable and closest to the work rather than deferring to organizational hierarchies and seniority. A culture of respect provides psychological safety for workers and supports team engagement in care delivery.[9] Accordingly, creating and sustaining an environment in which respect is the norm is not optional — it is a strategic imperative.[10,11]

> "*Institutions in which staff report higher levels of respect, empowerment, and fairness have better safety records.*"

Unfortunately, the vital need to create and foster respectful cultures in health care organizations remains largely unmet. Disrespect is common in health care environments and is experienced by patients and their families as well as by health care workers.[12] The Agency for Healthcare Research and Quality's (AHRQ) annual hospital Surveys on Patient Safety Culture continues to underscore the significant challenges that hospitals face in maintaining a culture that supports patient safety.[13] Furthermore, the stress of the ongoing Covid-19 crisis may exacerbate the effect that disrespect has on health care workers. Finally, the recent resurgence of the Black Lives Matter movement has helped to make visible the toll of disrespect on health care workers of color.[14]

Defining a Culture of Respect

Numerous definitions of "organizational culture" exist.[15] This article relies principally on Edgar Schein's definition of culture as "[t]he pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems."[16]

In this construct, organizational culture is a multilayered concept,[17] including:

1. Visible artifacts: what we see. What would a new employee or visitor notice in the organization? Artifacts include a broad range of tangible items and observable actions.[15] Examples include logos, mission and vision statements, signs, common frameworks, rubrics, and language.[18]

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2. Norms and values: what we say. What are the rules of behavior that help define how people interact and make decisions given the observable artifacts?[19]

3. Underlying assumptions: what we deeply believe and act on. "Unconscious, taken-for-granted beliefs about the organization and its work/purpose, about people, rewards and punishments."[19]

We define a culture of respect as an environment that is supportive and nurturing, in which every worker feels appreciated, experiences a sense of dignity and belonging, and has the resources and skills needed to succeed at their job.[11] In an organization with a strong culture of respect for people, leaders create a psychologically safe environment in which team members are comfortable raising concerns and admitting mistakes. Rather than seeking to assign blame for errors, such leaders focus on learning from failure, understanding the root causes of errors, asking team members to openly share ideas for improvement and mistake-proofing, and helping to translate these ideas into action. Leaders who foster a culture of respect will not tolerate disruptive behavior, regardless of an individual's level in the organizational hierarchy.

Virginia Mason's Respect for People Strategy

Virginia Mason is an integrated system that includes an acute-care hospital licensed for 336 beds and a multispecialty group practice of >470 physicians located in the greater Seattle, WA, area. In 2002, we at Virginia Mason embarked on an ambitious, systemwide strategy to change how we deliver health care in an effort to improve patient safety and quality. We did so by combining basic tenets of the Toyota Production System along with elements from the philosophies of Kaizen and Lean to create the Virginia Mason Production System (VMPS). In adopting VMPS, we sought to develop a culture that embeds, at the deepest level, the "core pillars" of VMPS: continuous improvement and respect for people.[16]

In 2009, with VMPS as a desired foundation of organizational culture, we initiated a strategic organizational goal specifically focused on increasing respect. With broad input from team members, this Respect for People strategy defined respect and dignity for the organization and created expectations, support, and accountability for behaviors that encourage and enhance open communication, teamwork, recognition, and trust. The strategic vision was embodied in two core principles: "we believe in a culture in which everyone experiences respect" and "we all have a role in sustaining a community where everyone feels valued, included, and respected."

Introducing Respect for People

Our Respect for People journey began with a review of relevant organizational data, including our culture-of-safety and staff-engagement surveys, which highlighted deficiencies in communication, teamwork, and respect. In 2010 to 2011, the Board of Directors adopted Respect for People as an organizational goal, and we developed a list of 10 "foundational behaviors of respect" (Figure 1). From the outset, we recognized the need to commit to a sustained multiyear effort with visible senior leadership and appropriate resource allocation. We sought to actively involve and receive input from all staff and to implement a series of unified and enduring tactics, such as

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communication campaigns, practical tools for leaders and teams, role modeling, and enforcement of behavioral expectations.

FIGURE 1

Chart Showing the List of the 10 Foundational Behaviors of Respect

Chart showing the list of the 10 foundational behaviors of respect at Virginia Mason.

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Our initial efforts culminated in mandatory workshops during which Respect for People was introduced into our organizational vernacular and organization-wide behavioral expectations were defined. During these workshops, an acting troupe presented vignettes demonstrating disrespectful interactions based on team members' reported experiences across a broad spectrum of job categories, positions, and experiences. We conducted these workshops at offsite performance spaces, with Virginia Mason leaders facilitating discussions following the vignettes. Over 99% of our team members, including all physicians and board members, attended a workshop.

> *"Teamwork is impeded in the absence of mutual respect, resulting in health care workers being less likely to follow safe practices, less likely to ask for help from other team members, and more likely to make errors."*

The workshops were supported with broad and deep promotion via multiple communication channels. A "playbill" listed the 10 foundational behaviors, and participants were asked to commit

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to focused personal development of two behaviors. These commitments were reinforced on work unit posters depicting team members discussing their selected behaviors. Through this communication campaign and leadership facilitation, we made our organizational expectations and values visible and explicit. These overt communication vehicles became important artifacts in our process of purposeful cultural transformation.

After the workshops, we observed improvements as illustrated by the preintervention and postintervention AHRQ Surveys on Patient Safety Culture results for the Communication Openness dimension, which addressed the following items:

- Staff speak up if they see something that may negatively affect patient care.
- Staff feel free to question the decisions or actions of those with more authority.
- Staff are afraid to ask questions when something does not seem right.
- Staff are frequently unable to express disagreement with the attending/staff physicians.

In 2011, prior to the training, our organizational performance score was 66.0 on this dimension. After the training in 2013, the score improved to 68.9 (P = .01).

Refreshing the Commitment to Respect for People

Starting in 2016, our staff-engagement and culture-of-safety survey results revealed a need to refresh and reinforce our commitment to Respect for People. Improvement in the Communication Openness dimension was not sustained at the 2013 level; the 2017 score for the system overall was 67.9, and the 2018 score was 64.5. As a result of normal turnover, many newer physicians and staff had not experienced the initial training. Although our initial effort focused principally on desired transactional encounters (e.g., “I listen to understand,” “I speak up,” and “I express gratitude”), survey comments about disrespectful work climates propelled us to extend our focus to the emotional and psychosocial impacts engendered by respectful and disrespectful interactions. We sought to deepen our team members’ sensibilities about how it feels to experience respect and disrespect.

> “*In the complex health care environment, multiple strategies are needed to positively impact and change the components of organizational culture — the artifacts, beliefs, values, rules, and basic assumptions that guide behavior.*”

We also introduced the concept of “secondhand respect” (or disrespect) to illustrate how an interaction radiates beyond the individuals directly involved, to everyone who witnesses and experiences it, and to our community. In addition, we modified the definitions of the foundational behaviors to encompass the lenses of diversity, equity, and inclusion. These concepts are

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intrinsically tied to self-identity, self-awareness, and respectful experiences, so our organizational respect behaviors needed to reflect them. Finally, we sought to broaden our approach beyond our team members to include our patients and the community. In the time period since the initial Respect for People initiative, Virginia Mason had enhanced and expanded its preexisting Patient–Family Partner program, creating a pool of volunteer patients and family members who had expressed interest in helping Virginia Mason improve its care delivery.

Design: Listening Sessions, Needs Assessment, and Update of Respect Behaviors

We began the Refresh effort with a needs analysis. Data sources included eight in-person listening sessions; provider and team member engagement surveys; stakeholder interviews; voluntary all-staff Town Halls focused on racism, sexism, workplace violence, and physical and psychological safety; an online survey about the meaning of respect; and senior leadership discussions. This discovery effort resulted in feedback from >400 team members, including physicians.

Our analysis identified gaps in leader competence and confidence to foster discussions on diversity, equity, and inclusion. Four key directions emerged: (1) redefine and reinforce the 10 foundational behaviors; (2) engage additional team members, leaders, and patient–family partners in defining the behaviors; (3) contract with a management consultancy that specializes in diversity and inclusion to help rewrite the behavior definitions; and (4) use multimodal messaging and training platforms to reach the broadest possible audience.

Team members prioritized “Listen to understand,” “Be encouraging,” “Express gratitude,” “Share information,” and “Be a team player” as the top behaviors for focus (Figure 1). Survey respondents noted that they wanted more support from their leaders and better skills in giving feedback in the face of disrespect. In the Town Hall forums, participants voiced a desire for diversity and inclusion education, resources, and tools. Senior executive leadership group discussions and stakeholder interviews highlighted the need for a training and communications strategy that addressed secondhand respect and disrespect while also integrating diversity, equity, and inclusion concepts. Our iterative design process informed the development of tools (artifacts) and leader training to reinforce values and behavioral norms. The design team included a blend of frontline staff, providers, educators, patient–family partners, and teaching artists from the acting troupe. We tested and revised the definitions and visual depictions of each respect behavior through rapid-design focus groups that included patient–family partners. Once the behaviors were finalized, we designed workshop content and gathered additional feedback in focus groups and dress rehearsals. Throughout the design process, we received input from diverse audiences comprising the executive guiding team and representative stakeholders, including physicians, nurses, and educators.

Preparing Leaders

Recognizing the critical role that leaders play in cultural change, we knew that preparatory education would be essential to advance our aims. We faced significant challenges in ensuring that the entire leadership team was fully engaged and invested in the efforts, given their conflicting priorities and levels of baseline knowledge, particularly in terms of their understanding of diversity, equity, and inclusion in the workplace.[20,21] Through targeted workshops that began 9 months

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before the all-staff training, we prepared >400 administrative and physician leaders to communicate effectively about the Respect for People concepts, values, and normative behaviors with their teams. Leaders received 16 hours of workshops on diversity, inclusion, health equity, unconscious bias in talent management, sexual harassment, and racism. We contracted with outside experts to deliver this interactive content.

Training and Communication Campaign

At the outset of the refreshed Respect for People effort, we launched a communication plan connecting respect to daily work, creating an incremental "drumbeat" prior to the systemwide implementation of the updated behaviors and required organization-wide training.

Given the success of the 2012 theatrical performance as an educational delivery method, we chose to invest in this modality again in 2018. The learning goal for the workshop was to build competency in responding to firsthand or secondhand respect or disrespect so that participants would be able to:

1. Express gratitude in the moment in response to respectful behavior.[22]

2. Share information with others proactively about the top one to three specific triggers that make them feel disrespected.

3. Share information in the moment (or as soon as possible afterward) when disrespect is felt, including: (a) sharing the emotional impact that they felt; (b) humbly inquiring about the other person's intended behavior[7]; and (c) agreeing on a way forward that helps both parties feel a sense of respect and dignity.

We collaborated with a local acting troupe to produce a 90-minute "summit," performed at various theaters in our service area for >5,400 team members (including our Board of Directors), achieving a 94% participation rate. The performance featured a series of live vignettes consisting of patient–team member or team member–team member interactions that reflected actual reported experiences at our institution (Appendix), encounters that highlighted a lack of respect and the need for greater sensitivity to power differentials, diversity, and inclusion. The performers depicted disrespectful behavior in the first enactment of each scene. Then, after large-group discussion with the audience, the actors replayed each scene using respectful behaviors. As in the 2012 training effort, we aimed to define and advance productive normative behavior at Virginia Mason. Moreover, the scenarios and large-group discussions directly addressed concepts of microaffirmations, microaggressions, unconscious bias, conscious inclusion, "upstanding" (standing up for someone who is being harassed or disrespected), and "bystanding" (observing a disrespectful interaction but not speaking up or taking action against it).

> *"We did not unilaterally declare behavioral expectations but instead engaged our frontline teams and patient–family partners to share their lived experiences."*

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An additional characteristic distinguishing the second round of training from the original effort was a focus on how to respond to patients when they are disrespectful to team members, as depicted through the videos displaying Code Blue initial enactment with disrespectful behavior and Code Blue reenactment with respectful behavior. Through facilitated discussion during the training, staff learned one technique (redirecting the conversation toward the patient's health care needs), and it became apparent that they wanted additional phrasing, tools, and support to build skills in responding effectively when patients openly exhibit disrespect toward the team. Although the

Table 1. Percentage of Responses that Were "Strongly Agree" or "Agree" in the Preintervention, Postintervention, and 6-Month Surveys

Question*	Preintervention Survey	Postintervention Survey	*P* Value**,#	6-Month Survey	*P* Value**,§
Q1. Adjust speech	84% (1,077 of 1,287)	86% (1,068 of 1,246)	.16	87% (1,127 of 1,299)	.028
Q2. Share feedback	45% (574 of 1,287)	64% (801 of 1,252)	<.001	63% (822 of 1,298)	<.001
Q3. Say thanks	79% (1,014 of 1,290)	88% (1,107 of 1,252)	<.001	90% (1,172 of 1,304)	<.001
Q4. Value contributions	66% (855 of 1,290)	72% (904 of 1,250)	.001	70% (910 of 1,298)	.037

*Q1: I adjust the way I speak and interact in order to be respectful to everyone. Q2: I know how to share feedback with others when I see or experience disrespect. Q3: I say thanks as soon as possible in response to respectful behavior. Q4: The members of my work team value and respect each other's contributions. **χ^2 test. The level of significance was $P < .05$. #Preintervention survey vs. postintervention survey. §Six-month survey vs. preintervention survey. Source: The authors.

original initiative focused almost exclusively on team member interactions, our staff now actively requested help with patient interactions. The backdrop for this request was an increasingly challenging patient-care environment requiring focused attention on workforce safety and de-escalation of some patient interactions (Table 1).

Reinforcing and Sustaining Respect for People

We adopted specific tactics to reinforce and sustain Respect for People. Before the summit, we distributed Respect for People posters (Figure 2) and a team discussion guide, enabling leaders to introduce the new respect behaviors to their teams interactively. After the summit, we launched an additional discussion guide that focused on development opportunities and behavior change. Over the next year, leaders guided team discussions regarding diversity, inclusion, speaking up, psychological safety, and the connection between respect and integrity (Figure 3). We promoted these resources and behavioral expectations with a comprehensive communications campaign.

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FIGURE 2

Respect for People Poster Depicting the 10 Foundational Behaviors

Respect for People poster depicting the 10 foundational behaviors at Virginia Mason.

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FIGURE 3

Respect for People Discussion Guide Focusing on Inclusion

Respect for People discussion guide focusing on inclusion at Virginia Mason.

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To achieve sustainability in the face of normal organizational staff turnover, we designed a new mandatory orientation training workshop to ensure that all team members would be exposed to the core organizational commitment to Respect for People at the outset of their employment. This weekly workshop also provided an opportunity to train staff who were not able to attend the summit and enabled us to attain nearly 100% participation. Continuing leader education focused on community building, connecting with others, psychological safety, and reducing power differentials. We also embedded Respect for People into medical resident and medical staff training, with a specific focus on speaking up and setting expectations when faced with disrespect by patients.

Evaluating the Success of Respect for People

We evaluated the success of the program through team member surveys designed specifically for the Respect for People intervention as well as through the standard AHRQ Surveys on Patient Safety Culture, standard patient and family/caregiver discharge surveys, and a count of adverse employee events reported to our human resources department.

Survey evaluations of all team members before and immediately after the refresh intervention as well as 6 months later assessed progress in sustaining the change in behavioral expectations. The survey items addressed the strong relationship between psychological safety and the ability to share feedback and feel respected. We asked four questions in these surveys and used a six-choice Likert-style format to assess respondent agreement with each item:

1. I adjust the way I speak and interact in order to be respectful to everyone.

2. I know how to share feedback with others when I see or experience disrespect.

3. I say thanks as soon as possible in response to respectful behavior.

4. The members of my work team value and respect each other's contributions.

For each question, statistically significant improvement was sustained at 6 months after the intervention (Table 1). The greatest effect was in sharing feedback, for which the survey responses improved by 18 percentage points (from 45% to 63%; $P < .001$).

In addition, we asked team members whether they identified increases in any of the desired respectful behaviors in their teams after the summit. Most respondents (76%; 958 of 1,258) reported improvements in at least one measure. Improvement was reported in all 10 of the foundational behaviors, most commonly "Express gratitude" (32%) and "Be a team player" (30%) and least commonly "Keep your promises" (8%) (Table 2).

In the team member surveys, respondents offered input to focus ongoing sustainability efforts. For example, team members expressed interest in having more tools for learning how to speak up to patients and families. In response, we implemented a discussion guide, poster, and communications on "Speaking Up to Disrespect." An accompanying article enumerating the "top

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Table 2. Improvement in Specific Respect for People Behaviors*

Respect for People Behavior	No. of Respondents (N = 1,258)
Express gratitude	408 (32%)
Be a team player	383 (30%)
Listen to understand	332 (26%)
Share information	315 (25%)
Speak up	312 (25%)
Be encouraging	308 (24%)
Connect with others	267 (21%)
Walk in their shoes	189 (15%)
Grow and develop	158 (13%)
Keep your promises	98 (8%)
None	350 (28%)

*As indicated on the postintervention staff survey. Respondents were able to select more than one behavior in which improvement was observed. Source: The authors.

10" ways to speak up to patients and others was one of the most read and liked articles on our intranet in 2018. This activity on speaking up has been integrated into the weekly Respect for People onboarding workshop. Related scripting is also part of the workforce safety toolkit, as are "stay safe huddles," which any team member can call whenever they need leader and team support immediately after experiencing extreme disrespect from a patient or family member.

Patient response to the Respect for People efforts is reflected in the "Doctors/Nurses Treat You with Respect" questions that are administered routinely as part of our inpatient postdischarge patient satisfaction surveys. Positive responses to these questions have trended upward through the course of the Respect for People work, with statistically significant improvements over baseline for nurses (Table 3). We also surveyed patients as to whether hospital staff took their preferences into account, with similar upward trends (Table 3).

These results were mirrored in the AHRQ Surveys on Patient Safety Culture that were administered to all staff. For the question regarding staff members treating each other with respect, we saw an increase in positive responses from 76.0% (3,209 of 4,223) at baseline in 2010 to 84.5% (2,824 of 3,342) in 2018 ($P < .01$). We also observed decreases in adverse events reported to human resources, with the average number of adverse reports decreasing from 27.1 per month prior to the refresh intervention in August 2018 to 19 per month after the intervention ($P = .03$).

Driving Sustained Change

In the complex health care environment, multiple strategies are needed to positively impact and change the components of organizational culture — the artifacts, beliefs, values, rules, and basic assumptions that guide behavior. Large-scale sustainable organizational culture change requires leadership alignment, commitment, and perseverance.[7,10] Virginia Mason's continuing efforts to build and enhance a culture of respect for people are multipronged, systemic, and evolving.

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Table 3. Responses on Inpatient Discharge Surveys*

	Baseline 1 (January 2011 to March 2012)	Baseline 2 (April 2012 to September 2018)	Follow-up (October 2018 to July 2019)	*P* Value**
Doctors treat with respect#,§	89.3% (2,404 of 2,692)	90.2% (13,570 of 15,050)	90.6% (1,287 of 1,421)	.20
Nurses treat with respect#,§	86.2% (2,324 of 2,696)	88.5% (13,359 of 15,093)	92.3% (1317 of 1,427)	<.001
Hospital staff took preferences into account†	NA	52.1% (7,242 of 13,910)	55.3% (767 of 1,387)	.02

*The values are given as the percentage of surveys in which the highest response was given. **The *P* values pertain to the comparison of the follow-up survey with baseline 1 survey. The level of significance was set at $P < 0.05$ (χ^2 test). #The available survey response options were "always," "usually," "sometimes," and "never." §From third-party Hospital Consumer Assessment of Healthcare Providers and Systems surveys. †The available survey response options were "strongly agree," "agree," "disagree," and "strongly disagree." Baseline 1 was not available (NA), and baseline 2 was from April 2012 to September 2018. Source: The authors.

Codesigning Visible Artifacts, Embedding Norms and Values, and Transforming Underlying Assumptions

In both of our Respect for People initiatives, we engaged hundreds of team members to define foundational behaviors of respect. We did not unilaterally declare behavioral expectations but instead engaged our frontline teams and patient–family partners to share their lived experiences. By incorporating this broad input into our expected core behaviors, we synchronized our efforts with our Lean management system principles. Those closest to the work — the frontline team members and our patients and families — are in the best position to identify both problems and solutions, and we must recognize and honor their experiences as we seek to change culture.

> *"By explicitly acknowledging the emotional impact of our behaviors (and not just the intent of the behaviors), we sought to influence and transform fundamental organizational values."*

On the basis of this broad input, we developed visible artifacts — tangible, observable actions, documents, and tools — describing our expectations. These artifacts included the participant training workbook, visible Respect for People posters, discussion guides, communication campaigns (including monthly CEO emails illustrating how respect connects to our organizational mission, vision, values, and strategic goals), the mandatory new employee training workshop, and leadership development training and tools explicitly tied to respect behaviors. These efforts visibly demonstrate leadership's commitment to a respectful workplace. Leaders and team members regularly use Respect for People visuals and concepts in presentations, documents, and Lean improvement efforts. Our Board-approved organizational goals continue to focus on our team member and patient experiences, workforce safety, and health equity, explicitly incorporating Respect for People as a focus and core principle.

An Evolved New Approach To Go Deeper and Wider: Moving from Transaction to Emotion and Secondhand Impacts

Efforts to change institutional culture cannot be manifested in a single intervention. Instead, iterative and evolving efforts are necessary to understand and support the desired cultural attributes. A distinguishing attribute of our most recent Respect for People initiative was reframing

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and deepening the concept of respect, moving from “transactions” to “feelings” and explicitly recognizing the emotional impact of respectful and disrespectful behaviors. For example, in listening sessions, we inquired about emotional experiences, such as feelings of support, confidence, and trust engendered by listening to understand. We modeled and practiced active listening, during which the recipients of information are not merely listening to respond but are acknowledging what they hear, actively asking for clarification, and being open to new ideas.[23] By explicitly acknowledging the emotional impact of our behaviors (and not just the intent of the behaviors), we sought to influence and transform fundamental organizational values.

By introducing the concept of secondhand impact, we raised awareness of the significant detrimental effect that disrespectful behavior has on team members, patients, and families who witness the behavior. We provided specific tools and training (e.g., disrupting the disrespect by calling people into a conversation; using the “Concerned, Uncomfortable, Safety Issue” tool from the AHRQ Team Strategies & Tools to Enhance Performance & Patient Safety [TeamSTEPPS] curriculum) to help team members move from bystanding to upstanding. We emphasized cross-functional learning and building relationships across work units and traditional hierarchies, an effort that included patients, families, and our community. This approach is synchronous with our Lean management focus on normalizing codesign by including patients and families in our improvement work.

Additionally, our team’s request for tools and training to de-escalate disrespectful and threatening interactions with patients and families reflects the need to address increasing occurrences of racism, sexism, and harassment.[24] Supporting and preserving a physically and psychologically safe environment for our staff and patients is critical to the delivery of safe, high-quality health care.

Challenges and Sustainability

Sustainability is a key challenge in any organizational culture change. The initial and subsequent organization-wide mandatory training sessions occurred over 4- to 8-week periods, with preparation and follow-up before and after the training sessions. By mandating multidisciplinary training, with visible CEO and senior leader endorsement and support, we sent a powerful message regarding our values and beliefs. We enhanced buy-in by intentionally involving physicians in each step of the process, including the guiding team, program design, and leadership preparation. We also included all new physicians and staff in orientation training on respect, diversity, and inclusion. A newly redesigned physician course that focuses on strengthening communication skills to build relationships and trust also incorporates Respect for People foundational behaviors. Respect for People principles are embedded in the nurse residency program and other nursing classes and workshops.

> *“Our team’s request for tools and training to de-escalate disrespectful and threatening interactions with patients and families reflects the need to address increasing occurrences of racism, sexism, and harassment.”*

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In addition, we do not view our Respect for People initiative as a stand-alone program. Rather, it is linked to myriad other organizational strategies and tactics, most critically as a pillar of the organization's Lean management method and philosophy, the VMPS. It is integrated into long-term strategic efforts focused specifically on diversity and inclusion, health equity, the patient experience, team member engagement, and workforce safety.

Assessing the impact of the program is challenging. We relied on surveys of staff members and patients, which may be subject to response bias. However, the results from presummit baseline surveys were consistent with qualitative input from the listening sessions. Furthermore, the survey questions targeted key areas in psychological safety adapted from the Team Learning and Psychological Safety Survey and other sources.[25,26] According to Harvard University professor Amy Edmondson, psychological safety creates a climate in which team members feel safe to ask for help, discuss problems, and admit errors.[26] This climate has important implications, because if team members do not feel safe psychologically to provide feedback openly, patient safety could be compromised. We are also unable to assess programmatic costs, because the work is now integrated into daily activities at our institution. Even assessing the true costs of the workshops is difficult, because we cannot balance any loss of productivity from workshop attendance with any potential gains in productivity and improvement in outcomes related to an improved work environment.

We also note that large in-person gatherings as we have described may not be appropriate in the post–Covid-19 world. Nonetheless, the basic tenets of the program as well as the interactive nature and involvement of the entire workforce can be sustained with creative use of virtual technology. Furthermore, we posit that the foundational behaviors of Respect for People are even more important in the face of a crisis.

A culture of respect is foundational to achieving remarkable patient and team member experiences, high reliability, and physical and psychological safety, all of which are attributes of an environment that leads to enhanced trust. This culture of respect, characterized by joy in the workplace, team member well-being, and respectful behaviors toward others, is achievable with systematic, sustained effort. We believe that the approach that we have described is scalable and transferrable to other organizations with commitment from the highest levels of leadership and unrelenting perseverance to effect and measure organizational cultural change.

Lynne A. Chafetz, JD
Senior Vice President and General Counsel, Virginia Mason Medical Center, Seattle, Washington, USA

Alice M. Forsythe, MBA
Senior Organizational Development Consultant, Virginia Mason Medical Center, Seattle, Washington, USA

Niki Kirby, MSN, RN
Nursing Professional Development Specialist, Virginia Mason Medical Center, Seattle, Washington, USA

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C. Craig Blackmore, MD, MPH
Director, Center for Health Care Improvement Science, Virginia Mason Medical Center, Seattle, Washington, USA

Gary S. Kaplan, MD
Chairman and CEO, Virginia Mason Medical Center, Seattle, Washington, USA

Appendix

Respect for People Training Vignettes

Disclosures: Lynne A. Chafetz, Alice M. Forsythe, Niki Kirby, C. Craig Blackmore, and Gary S. Kaplan have nothing to disclose.

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