

A Road Map for Advancing the Practice of Respect in Health Care: The Results of an Interdisciplinary Modified Delphi Consensus Study

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Background: Most health care organizations' efforts to reduce harm focus on physical harm, but other forms of harm are both prevalent and important. These "nonphysical" harms can be framed using the concepts of respect and dignity: Disrespect is an affront to dignity and can cause harm. Organizations should strive to eliminate disrespect to patients, to families, and among health care professionals.

Methods: A diverse, interdisciplinary panel of experts was convened to discuss strategies to guide health care systems to embrace an expanded definition of patient harm that includes nonphysical harm. Subsequently, using a modified Delphi process, a guide was developed for health care professionals and organizations to improve the practice of respect across the continuum of care.

Results: Five rounds of surveys were required to reach predefined metrics of consensus. Delphi participants identified a total of 25 strategies associated with six high-level recommendations: "Leaders must champion a culture of respect and dignity"; with other professionals sharing the responsibility to "Promote accountability"; "Engage and support the health care workforce"; "Partner with patients and families"; "Establish systems to learn about and improve the practice of respect"; and "Expand the research agenda and measurement tools, and disseminate what is learned."

Conclusion: Harm from disrespect is the next frontier in preventable harm. This consensus statement provides a road map for health care organizations and professionals interested in engaging in a reliable practice of respect. Further work is needed to develop the specific tactics that will lead health care organizations to prevent harm from disrespect.

Despite the fact that many health care experiences go well, patients and their families still suffer harm from interactions with the health care system. To date, organizational efforts to reduce harm have focused primarily on physical harm, but other forms of harm are both prevalent and important.^{1–5} Such "nonphysical" harms can be framed using the concepts of respect and dignity. In health care, these concepts can be defined as follows: *dignity* is the intrinsic, unconditional value of all persons; *respect* is the sum of the actions that honor or acknowledge a person's dignity.^{6,7} The specific actions that constitute respect may vary depending on the context of care. Disrespect is an affront to dignity and can cause harm. See [Table 1](#) for examples.

Disrespect has been associated with a worse patient experience, a lower likelihood of perceiving care as high quality,

and a lower likelihood of seeking care again in the same facility.^{8,9} Patients and families aren't alone in experiencing disrespect. Health care workers of all kinds experience disrespect from other health care workers; such disrespect is common,^{10–12} can inhibit communication and cooperation, and undermines morale.^{13,14} Disrespect can push patients, families, and health care professionals away from health care organizations, risking the loss of revenue from patient attrition and increased costs from medical malpractice claims and employee turnover.^{15–17} These are all nonphysical harms from disrespect. Notably, it appears there is also an association between disrespect and the risk of physical harm.^{17–22} Moreover, bias—whether overt or implicit—can be perceived as a form of disrespect and has been associated with health care disparities, which may put patients at risk for preventable physical harm.^{23,24}

Health care organizations have a moral and ethical responsibility to "do no harm" and should therefore incorporate nonphysical harms into organizational harm prevention programs and strive to eliminate disrespect in health care.²⁵ Although it may not be possible to eliminate all disrespect, setting this audacious goal promotes an aspirational standard of care that can drive improvement.

Beyond nonmaleficence, there are many other important reasons to focus on respect and dignity in health care.

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Table 1. Examples of Disrespect Experienced by Patients and Families in Health Care

An elderly inpatient admitted for pneumonia and delirium suffers a fall in the early evening, just prior to change-of-shift for the physicians and nurses. X-rays are obtained and reveal he has fractured his hip. The first notification to the patient's son to let him know about this event is more than six hours later, in the middle of the night, and it is from the orthopedic surgeon asking for consent to repair the broken hip in the operating room. The son is upset that he was not notified earlier.

A patient with limited English proficiency is scheduled for an elective procedure. The day of the procedure, the patient's family drops her off at the hospital, and it is discovered that no interpreter has been arranged. No interpreters are available on short notice, so informed consent cannot be performed, and the procedure has to be canceled. The family is angry and frustrated.

A patient had a procedure that required her to stay overnight in a semi-private room. Her doctor comes in to talk with her about how the procedure went and mentions the fact that she has HIV in his description of her condition. The doctor speaks loudly enough for the roommate to hear. The roommate yells, "I am not going to share my room with an AIDS patient!" The patient is outraged that her privacy has been violated.

A patient dies unexpectedly in the hospital and the primary care physician (PCP) is not notified. A week later, the bereaved wife calls the PCP's office with questions, which is when the PCP first learns about the death. The PCP has cared for the patient's family for many years, knows them very well, and would have wanted to proactively support them during what has been a difficult time. The PCP notes this is not the first time this has occurred; she easily remembers two other patients who died in the hospital without notification of their PCPs. The PCP and wife are distressed by the lack of communication and the missed opportunity to grieve together.

A patient comes to a doctor's appointment, is greeted, and brought to an exam room by a medical assistant. Thirty-five minutes later the patient comes out to ask about the delay in being seen. It is then discovered that her doctor is not in the clinic that day. When the patient asks how this could happen, a staff member responds by saying, "It's not my job to schedule appointments." The patient is so upset by the whole experience that she transfers her care to another doctor.

Being treated with respect and dignity has been independently and positively associated with such outcomes as a better patient experience, adherence to recommended therapies, and receipt of optimal preventive care.²⁶ Achieving patient-centered care—a core component of the quality of care—requires an organizational culture that treats patients with respect and dignity.⁶ Respect is a foundational aspect of safe, high reliability organizations,²⁷ and the American College of Healthcare Executives (ACHE) and the National Patient Safety Foundation's Lucian Leape Institute (NPSF's LLI) recently described how CEOs and other health care leaders should "Value Trust, Respect, and Inclusion."²⁸

To develop and strengthen health care's approach to these concepts, we gathered a diverse panel of experts (see author list and Collaborators) in June 2016 at a Convening titled "The Practice of Respect: The Next Frontier in Preventing Harm" held in Boston. We began with the goal of developing the principles and strategies that will lead our health care system to embrace an expanded definition of patient harm that includes both physical and nonphysical harm. The phrase "practice of respect" was chosen because we believe that respect must be seen as an integral part of professional practice and that advancements with regard to respect will rely at least in part on cycles of iterative improvement. We chose to focus on respect because it is the actionable component of "respect and dignity."⁶

The Convening began by reviewing some examples of disrespect that led to nonphysical harm, and a series of facilitated conversations followed. Although we initially focused on disrespect experienced by patients and families, many other topics were discussed, including the importance of addressing disrespect among health care professionals and ways to promote a positive culture of respect. Participants ultimately believed that we would need a broad approach to lead health care systems toward a more reliable practice of respect. After the Convening, we initiated the consensus-building process described in this manuscript with the aim of developing a practical guide for health care professionals and organizations about the practice of respect across the continuum of care.

METHODS

Selection and Qualification of Participants

The Convening occurred on June 16, 2016, and included 32 participants from a variety of backgrounds, including clinicians, researchers, bioethicists, patient and family advisors, and leaders from various organizations involved in health care delivery, research, and policy. Participants were invited because of their diverse experiences and their anticipated willingness to engage in deliberations about the concepts of respect and dignity.

After the Convening, 3 of the 32 participants [L.S.H., P.H.F., S.M.B.] formed a steering committee along with two research staff [C.L.A., S.D.R.] and another content expert who helped plan the Convening but had been unable to attend [B.S.L.]. The Convening participant who had facilitated the meeting was excluded from the Delphi invitation list [J.T.A.; see Collaborators section]. This left 28 Convening participants who were invited to participate in the modified Delphi process.

Modified Delphi Process

The Delphi process is a method for achieving a convergence of opinion among topic area experts.²⁹ Following current recommendations regarding the reporting of key methodological criteria in publications of Delphi studies,³⁰

we predefined our criteria and processes. In an initial phase, we defined consensus as $\geq 50\%$ agreement among participants, but ultimately we raised the threshold to $\geq 75\%$. Statements that did not meet this threshold were eliminated. If a statement was eliminated, but analysis of feedback indicated that a significant revision might lead to consensus, a revised statement was introduced for revoting in the next round. If two statements were similar or overlapping, a merged statement was proposed to participants. Finally, we determined that the iterative Delphi process would continue until we reached saturation (that is, no new ideas or opinions were suggested), and either each statement had achieved the predefined level of consensus or had been eliminated. See [Appendix 1](#) (available in online article) for additional details about the Delphi process.

Delphi Survey Development and Administration

A broad variety of topics were discussed during the June 2016 Convening (see [Appendix 1](#) for details), and—with participant consent—all discussions were audio recorded and transcribed. In round 1, given the time that elapsed between the Convening and the initiation of the Delphi process (December 2016), participants were first asked open-ended questions to solicit the principles and strategies they thought would lead our health care system to embrace an expanded definition of patient harm that includes both physical and nonphysical harms. Using the transcripts from the Convening, the steering committee then presented and solicited feedback on seven broad conceptual categories that encompassed 36 action items proposed by attendees during the Convening. The surveys for each round of the Delphi process can be found in [Appendix 1](#).

The round 1 survey responses were compiled, a summary of the findings and a consensus statement were drafted, and these documents were presented to the round 1 respondents who were then invited to complete the round 2 survey. Round 2 survey participants were instructed to first read through the draft consensus statement and then respond to Likert-style questions regarding the extent to which they agreed with including proposed items. Free-text feedback regarding the rationale for their votes was also solicited.

Rounds 3, 4, and 5 of the survey introduced further modifications to the draft consensus statement based on prior-round survey results. For items that achieved consensus on inclusion, participants were then asked about their agreement with the item's wording. For new items, or items that had undergone significant revision, we asked participants about their agreement with including those items in the consensus statement, and then in a subsequent round asked about agreement with the wording. Due to a drop in the number of participants after round 2, we raised the standard for consensus in subsequent rounds, defining consensus as $\geq 75\%$ of respondents agreeing with both the inclusion and the wording of an item. In rounds 2 and 3 we asked partici-

pants to rank the order in which they believed the statements should appear.

Survey Administration

All surveys were administered using REDCap (Research Electronic Data Capture), a secure Web-based application.³¹ Convening attendees who were not on the steering committee were invited to participate in the first round, but for all subsequent rounds, only those individuals who completed the previous round's survey were invited to participate. For each round, the steering committee data analyst [S.D.R.] sent an individual invitation that included a unique survey link and a copy of the draft consensus statement. Each version of the draft consensus statement included a summary of the results from the previous round, as well as the rationale for the changes, including de-identified quotations from participants. Participants were given two weeks to complete surveys, and nonresponders received up to two e-mail reminders from the data analyst who was the only member of the steering committee who could see which invitees had completed the survey.

Data Analysis and Manuscript Preparation

De-identified data were exported from REDCap and collated into a single document. Three members of the steering committee [L.S.H., C.L.A., S.D.R.] read through the results individually, came to consensus on how to incorporate participant feedback, and drafted revisions. The entire steering committee then reviewed participant feedback, the rationale for the proposed changes, and the revised draft of the consensus statement. A modified Borda count was used to identify consensus about the order in which the statements would appear.³² This study was determined to be exempt by the Institutional Review Board at Beth Israel Deaconess Medical Center.

After completion of the Delphi process, those who had participated in all rounds, and the steering committee, drafted and revised the manuscript.

RESULTS

Selection and Qualification of Participants

Of the 28 Convening participants who were invited to participate in the modified Delphi process, 1 transitioned to become a member of the steering committee prior to completing the first survey [L.F.], and 13 did not participate in all rounds. The identities and characteristics of the 14 invitees who participated in all rounds were representative of the diversity of the Convening participants and are described in [Table 2](#).

Modified Delphi Process

Five rounds of surveys were required to reach our predefined stopping point, with response rates as follows: round 1, 71.4% (20/28); round 2, 80.0% (16/20); round 3, 93.8%

Table 2. Characteristics of Delphi Participants*

Expert	Institution/Location	Role(s)/Experience(s) Relating to Respect and Dignity
Tobie Atlas, MEd	Beth Israel Deaconess Medical Center (BIDMC), Boston	<ul style="list-style-type: none"> • Co-chair, Patient/Family Advisory Council of Healthcare Associates, the Primary Care Practice at BIDMC • Member of the BIDMC Ethics Advisory Council and the Task Force on the Patient Experience • Educational consultant, former adjunct professor and teacher • Former Director of Communications for the Group Insurance Commission (GIC) of Massachusetts
Dominique D. Benoit, MD, PhD	Ghent University Hospital and Ghent University Faculty of Medicine and Health Sciences, Ghent, Belgium	<ul style="list-style-type: none"> • Head of the Intensive Care Department at the Ghent University Hospital • Professor at the Ghent University Faculty of Medicine and Health Sciences • Senior Clinical Investigator at the Belgian Research Foundation (FWO), and Principal Investigator at the Ethics Section of the European Society of Intensive Care Medicine, for the APPROPRIUS and DISPROPRICIUS studies regarding the appropriateness of ICU care and impacts of disproportionate ICU care • Member of the European Society of Intensive Care Medicine and the Belgian Society of Intensive Care Medicine • Section Editor of <i>Intensive Care Medicine</i>
Greg F. Burke, MD	Geisinger Health System, Danville, PA	<ul style="list-style-type: none"> • Chief Patient Experience Officer at Geisinger Health System • Medical Director at Geisinger HealthSouth Rehabilitation Hospital and Emmanuel Skilled Nursing Facility • Member of the Geisinger Bioethics Committee • Past member of the editorial board of <i>Linacre Quarterly</i> and <i>National Catholic Bioethics Quarterly</i>
Terri Payne Butler, BA	Beth Israel Deaconess Medical Center (BIDMC), Boston	<ul style="list-style-type: none"> • Emeritus Patient Advisor, BIDMC Patient/Family Advisory Council • 33-year history as a patient at BIDMC, including 20 surgeries • Author of <i>Side Effects</i>, a memoir chronicling her medical journey, the history of the procedures that kept her alive, and her life
Frank Federico, RPh	Institute for Healthcare Improvement (IHI), Cambridge, MA	<ul style="list-style-type: none"> • Vice President of IHI • Faculty for the Patient Safety Executive Development Program at IHI • Executive Producer of <i>First, Do No Harm, Part 2: Taking the Lead</i> • Former Program Director of the Officer Practice Evaluation Program at the Risk Management Foundation of the Harvard Affiliated Institutions • Former Director of Pharmacy at Children's Hospital, Boston
Tejal Gandhi, MD, MPH	National Patient Safety Foundation (NPSF), Boston	<ul style="list-style-type: none"> • President and CEO of NPSF, the NPSF Lucian Leape Institute, and the Certification Board for Professionals in Patient Safety • Associate Professor of Medicine at Harvard Medical School • Former Executive Director of Quality and Safety at Brigham and Women's Hospital • Former Chief Quality and Safety Officer at Partners Healthcare
Gail Geller, ScD, MHS	Johns Hopkins University Berman Institute of Bioethics and School of Medicine, Baltimore	<ul style="list-style-type: none"> • Director of Education Initiatives at the Berman Institute • Appointments in the Johns Hopkins School of Medicine and in the Bloomberg School of Public Health • Co-leader of the respect and dignity team of the Johns Hopkins Emerge/Libretto site funded by the Gordon and Betty Moore Foundation
Gerald B. Hickson, MD	Vanderbilt University Medical Center (VUMC), Nashville, TN	<ul style="list-style-type: none"> • Senior Vice President of Quality, Safety and Risk Prevention at VUMC • Joseph C. Ross Chair of Medical Education and Administration and Professor of Pediatrics at VUMC • Chair of the Certification Board for Professionals in Patient Safety (CBPPS) • Developer of the Patient Advocacy Reporting System (PARS), which uses unsolicited patient complaint data to identify and support interventions on high-risk clinicians implemented in > 150 hospitals and health systems nationwide • Co-Developer of the Coworker Observation Reporting System (CORS), which uses staff complaints to identify and intervene on high-risk clinicians implemented in 10 hospitals and health systems nationwide

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Table 2. (continued)

Expert	Institution/Location	Role(s)/Experience(s) Relating to Respect and Dignity
Cheryl Hoying, PhD, RN	Cincinnati Children’s Hospital Medical Center, Cincinnati, OH	<ul style="list-style-type: none"> • Senior Vice President for Patient Services at Cincinnati Children’s Hospital Medical Center • Fellow of the American Academy of Nursing • Member of the Joint Commission’s Nursing Advisory Committee, the American Hospital Association’s Committee on Clinical Leadership and the Political Action Committee, and the National League of Nursing’s Strategic Steering Committee
Thomas H. Lee, MD, MSc	Press Ganey Associates, Inc., Wakefield, MA	<ul style="list-style-type: none"> • Chief Medical Officer for Press Ganey Associates, Inc. • Primary care practitioner at Brigham and Women’s Hospital • Chair of the Board of Geisinger Health Plan • Part-time Professor of Medicine at Harvard Medical School and Professor of Health Policy and Management at Harvard School of Public Health • Former Network President for Partners Healthcare and CEO for Partners Community HealthCare, Inc.
Mark E. Reynolds, BA	The Risk Management Foundation (RMF) of the Harvard Medical Institutions Incorporated (CRICO), Boston	<ul style="list-style-type: none"> • President and CEO of RMF/CRICO • Former Medicaid director in Massachusetts and Tennessee • Former CEO of Neighborhood Health Plan of Rhode Island
Ronen Rozenblum, PhD, MPH	Brigham and Women’s Hospital (BWH) and Harvard Medical School, Boston	<ul style="list-style-type: none"> • Founding Director of the Unit for Innovative Healthcare Practice and Technology, Director of Business Development of the Center for Patient Safety Research and Practice, Member of the Patient Experience Strategy Committee, all at BWH • Assistant Professor at Harvard Medical School • Co-Chair of Patient-Centered Care Criteria and Member, Accreditation Steering Committee, Adult Congenital Heart Association / Adult Congenital Heart Disease Program, USA • Member of the Abstract Committee, responsible for the Patient and Family Experience, Engagement and Coproduction Sessions, International Society for Quality in Health Care (ISQua) • Member of the National Patient Experience Survey Committee, Ministry of Health, Israel • Co-editor, <i>Information Technology for Patient Empowerment in Healthcare</i> (book)
Kenneth E. Sands, MD, MPH	HCA Healthcare, Nashville, TN	<ul style="list-style-type: none"> • Chief Epidemiologist and Chief Patient Safety Officer for HCA • Former Chief Quality Officer and Senior Vice President for Health Care Quality at Beth Israel Deaconess Medical Center • Associate Professor of Population Medicine at Harvard Medical School (HMS) • Cofounder of the HMS Fellowship in Patient Safety and Quality
Kathleen Turner, RN	University of California, San Francisco (UCSF) Medical Center, San Francisco	<ul style="list-style-type: none"> • Nightshift ICU bedside and charge nurse at UCSF Medical Center • UCSF Medical Center Peer Support Program provider • Faculty for University of California Integrating Multidisciplinary Palliative Care into the ICU project (IMPACT-ICU) • Staff Liaison for the UCSF Adult Critical Care Patient & Family Advisory Council

*Delphi participants are listed in alphabetical order.

(15/16); round 4, 93.3% (14/15); round 5, 100% (14/14). Early in the process, participants identified an organizing structure for the consensus statement: a small number of high-level recommendations, under each of which would appear several strategies that would be associated with several suggested tactics. Strategies are general goals, whereas tactics are specific actions that may help achieve strategies. Given the novel nature of this work, instead of asking participants to vote on the tactics we instead solicited free-text feedback about them in rounds 4 and 5 of the survey. See [Table 3](#) for the recommendations and strategies and the percentage

agreement among Delphi participants. See [Sidebar 1](#) for the full statement, including suggested tactics. During the Delphi process, two of the original seven recommendations were merged into one, leaving a total of six final recommendations. Of the 26 strategies proposed in round 2, subsequent rounds led to the introduction of 4 new strategies, the merger of 4 into 2, and the elimination of 3, resulting in a total of 25 final strategies.

Below, we provide brief overviews of each recommendation, clarify key terms, and share themes that emerged from participant feedback during the Delphi process.

Table 3. Recommendations and Strategies to Develop the Practice of Respect		
Recommendation		Agreement (%) [*]
No.	Strategy	
Leaders Must Champion a Culture of Respect and Dignity		100
1	Engage leaders to confirm and strengthen their commitment to a culture of respect and dignity.	100
2	Leaders must model respectful behavior for all members of the health care team, patients and families, and for the organization.	94
3	Leaders must communicate that the values of respect and dignity are fundamental to the success of the organization.	94
4	Leaders must take action to promote health equity as an integral component of their organization's practice of respect.	86
5	Leaders must develop and support the people, processes, and systems that will create a culture of respect and dignity.	80
6	Leaders must set expectations for professionals about behavior as well the processes that will be used to pursue accountability when those expectations are not met.	100
Promote Accountability		94
7	When expectations about respect and dignity are not met, leaders must champion transparency, fairness, and a just culture, rejecting a culture of shame or blame.	80
8	Board members and chief executives must remain actively involved in ensuring accountability throughout their tenure.	87
Engage and Support the Health Care Workforce		100
9	Foster a healthy work environment by addressing individual and system factors that promote respect among professionals and reduce burnout.	100
10	Support health care professionals who experience disrespect from other health care professionals, patients, and/or family members.	100
11	Engage health care professionals in understanding the connections among respect, dignity, safety, quality, outcomes, and the experience of care.	87
Partner with Patients and Families		100
12	Set the expectation that patients and families have a right to always be treated with respect by health care professionals; they should likewise treat health care professionals with respect.	100
13	Organizational leaders should partner with patients and families to develop a shared vision of the practice of respect.	86
14	Since what constitutes respect may vary among patients and families, health care professionals at the point of care must partner with them to learn how best to honor their goals, values, and preferences.	94
15	As part of the practice of respect, promote health equity by engaging and partnering with individuals and communities that experience disparities.	80
Establish Systems to Learn About and Improve the Practice of Respect		94
16	Recognize, celebrate, and learn from respectful behavior and positive experiences.	100
17	Ensure that episodes of disrespect are acknowledged and addressed in a timely fashion, supporting all involved parties.	87
18	Learn from episodes of disrespect by recognizing, capturing, categorizing, and analyzing them, as is done through incident analysis.	94
19	Beyond incident analysis, develop and utilize other methods of learning about the practice of respect.	93
20	Embed organizational systems for learning about and improving the practice of respect in operational structures to ensure their success and sustainability.	94
21	Within organizations, develop methods for effectively sharing what is being learned about the practice of respect to broaden engagement and promote improvement.	94
22	Prevent future harm by designing and implementing changes based on what is learned about the practice of respect.	100
Expand the Research Agenda and Measurement Tools, and Disseminate What Is Learned		93
23	Expand the research agenda to define the nature, scope, and connections among the topics of nonphysical harm, respect, and dignity.	93
24	Further develop measures to guide improvement toward, and demonstrate success in, the reliable practice of respect.	87
25	Identify, compile, and share successful strategies at all sites, including non-health care sites.	94
*Because voting occurred over a number of rounds, and response rates varied among rounds, the number of participants voting on each statement varied from 14 to 16.		

Leaders Must Champion a Culture of Respect and Dignity

Delphi participants repeatedly emphasized the critical role of leaders in advancing the practice of respect, and 100% agreed that this recommendation should appear first. For pur-

poses of this recommendation, the term *leaders* includes those at all levels of the organization: from board members and the “C-suite,” to directors, managers, frontline health care professionals, and nonclinical employees who may not have leadership titles but nonetheless lead groups or teams.

Sidebar 1. Recommendations, Strategies, and Examples of Tactics

Leaders Must Champion a Culture of Respect and Dignity

Strategy	Tactics
Engage leaders to confirm and strengthen their commitment to a culture of respect and dignity.	<p>Share stories and data about respect and dignity with leaders.</p> <p>Coach leaders about what constitutes a culture of respect and dignity, and about how the specific actions that embody those concepts may vary between individuals.</p> <p>Help leaders appreciate the costs—financial and otherwise—of failing to address issues of respect and dignity.</p>
Leaders must model respectful behavior for all members of the health care team, patients and families, and for the organization. Leaders must communicate that the values of respect and dignity are fundamental to the success of the organization.	<p>Encourage the individuals and committees that select leaders to make their choices at least in part based on candidates’ understanding and embodiment of respect and dignity, so that once in their role they naturally model respectful behavior.</p> <p>Conduct weekly “respect rounds” and collect examples of respect to be celebrated.</p> <p>Share stories about respect and dignity during meetings—including stories about intra- and inter-professional interactions—and the impacts on care and the work environment.</p> <p>Encourage periodic public communication to reiterate the value and importance of respect and dignity to the health care organization.</p>
Leaders must take action to promote health equity as an integral component of their organization’s practice of respect.	<p>Coach leaders to recognize the existence and extent of health and health care disparities, as well as how such disparities can be perceived as disrespect.*</p> <p>Integrate the concept of equity into the organization’s strategic planning process. Charge an interdisciplinary team with crafting and sharing an organizationwide vision for achieving health equity.</p> <p>Create and disseminate an organizationwide “equity report” with data that examines differences in the care provided to patients from different racial, ethnic, language, and socioeconomic groups. Rather than blaming individuals for any disparities that are revealed, the report’s purpose is to create a sense of urgency and learn which systems may need to be changed to address those disparities.</p>
Leaders must develop and support the people, processes, and systems that will create a culture of respect and dignity.	<p>Develop recognition programs to acknowledge and commend those who champion the practice of respect.</p> <p>When making strategic, policy, or procedural decisions, consider the impact the proposed changes may have on the practice of respect.</p> <p>Consider aligning the patient safety, patient relations, and risk management functions under one leader in one department.</p> <p>Coordinate improvements with the compliance, business conduct, employee relations, and human resources functions of the organization.</p> <p>Commit the resources necessary to pursue accountability including the teams of people, the processes, and the systems for documenting, analyzing, and communicating about issues.</p> <p>Hire diverse individuals who can represent and be responsive to the diverse populations served by the organization.</p>
Leaders must set expectations for professionals [†] about behavior as well the processes that will be used to pursue accountability when those expectations are not met.	<p>When selecting health care professionals for the organization, consider their ability to be consistently respectful to others.</p> <p>In the organization’s “code of conduct” emphasize that the practice of respect is everyone’s responsibility. Ensure this responsibility is highlighted in job descriptions, onboarding, performance reviews, subsequent training, and promotions.</p> <p>Establish specific policies and procedures about how all individuals will be held accountable.</p> <p>Recognize that if the responsibility for accountability is too diffuse, accountability is unlikely to be achieved.</p>

Promote Accountability

Strategy	Tactics
When expectations about respect and dignity are not met, leaders must champion transparency, fairness, and a just culture, [‡] rejecting a culture of shame or blame.	<p>Leaders should be transparent about the processes that are used to learn from such incidents and prevent them from happening again.</p> <p>Leaders should balance the value of transparency with sensitivity about the ways in which widely sharing incident details can lead the involved parties to experience shame or blame.</p> <p>Ensure that the policies and procedures are appropriately, consistently, and fairly applied, regardless of the role or seniority of the involved parties.</p> <p>Ensure individuals are held accountable for any unprofessional behavior, and that they are not held accountable for systems issues over which they lack control.</p> <p>Ensure leaders are held accountable for systems issues over which they have control.</p> <p>Prevent retaliation against people who report episodes of disrespect.</p>

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Sidebar 1. (continued)	
Promote Accountability	
Strategy	Tactics
Board members and chief executives must remain actively involved in ensuring accountability throughout their tenure.	<p>Periodically ask all leaders to account for the ways in which they are supporting and contributing to the practice of respect.</p> <p>Board members and chief executives must support, approve, and periodically review the incident analysis processes—and the proposed changes arising from them—to ensure organizations effectively learn from harm events and make meaningful and timely improvements as a result of them.</p> <p>Board members and chief executives must periodically review whether the expectations regarding the practice of respect set out in the code of conduct are being met and incorporate that knowledge into strategic planning.</p>
Engage and Support the Health Care Workforce	
Strategy	Tactics
Foster a healthy work environment by addressing individual and system factors that promote respect among professionals and reduce burnout.	<p>Encourage staff to speak up about respect and dignity concerns.</p> <p>Promote “joy in work”⁸ initiatives.</p> <p>To reduce the stress on health care professionals, decrease their workload (by decreasing the number of tasks and/or making it easier to perform them) and/or increase their capacity for work (by increasing the number of people available to do the work and/or the amount of time they have available to work).</p> <p>Ensure professionals have access to care and specialized services for any physical or mental health needs.</p> <p>Promote professional self-awareness or mindfulness training that explores moral distress as well as the factors that may contribute to it. Recognize that such factors may exist at the intra-personal, inter-personal, and system levels and may include a low tolerance for uncertainty, fear of death, low self-confidence, (un)conscious bias, and the hierarchy.</p>
Support health care professionals who experience disrespect from other health care professionals, patients, and/or family members.	<p>Develop systems to address intra- and inter-professional disrespect through peer-to-peer interactions that can raise awareness, review expectations, and offer support.</p> <p>Develop policies and procedures for situations where health care professionals are treated with disrespect.</p> <p>Coach health care professionals to improve the way they work with and respond to patients, families, and other health care professionals who are disrespectful.</p> <p>Develop programs to mitigate the risk of workplace violence, including physical and verbal threats to health care professionals.</p> <p>Use periodic facilitated meetings to reflect upon clinical encounters where a health care professional experienced disrespect from a patient and/or family member and discuss the factors that may have contributed to that experience.</p>
Engage health care professionals in understanding the connections among respect, dignity, safety, quality, ¹¹ outcomes, and the experience of care.	<p>Engage learners about respect and dignity at all stages of health professions education, including in undergraduate, graduate, and postgraduate programs.</p> <p>Use respect/disrespect storytelling as part of training.</p> <p>Communicate to health care professionals that patient-centered care is a domain of quality that deserves equal attention with the other domains, such as efficiency.</p> <p>Coach health care professionals to explore the ways in which others experience respect and dignity, to recognize that patients have a broad range of preferences about how they and their families are engaged or involved in their care, and to expand their ability to approach patients with acceptance and flexibility.</p> <p>Coach health care professionals to raise awareness about health and health care disparities, and about how bias, cultural and linguistic factors, and social determinants of health can affect the quality of care, outcomes, and the experience of care.</p> <p>Coach health care professionals to improve their practice of culturally and linguistically appropriate care.</p> <p>Coach health care professionals to improve their practice of empathy, drawing upon patient and family perspectives as well as interdisciplinary resources.</p>

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Sidebar 1. (continued)	
Partner with Patients and Families[#]	
Strategy	Tactics
Set the expectation that patients and families have a right to always be treated with respect by health care professionals; they should likewise treat health care professionals with respect.	Develop methods of effectively communicating expectations about respect and dignity to patients, family members, and health care professionals. Recognize that in environments accustomed to chronic disrespect, the involved parties may have low expectations about what constitutes a reliable practice of respect. Such expectations may need to be revised as a prerequisite to meaningful improvement.
Organizational leaders should partner with patients and families to develop a shared vision of the practice of respect.	Develop patient-family engagement programs if they do not already exist, or incorporate the practice of respect into existing forums. Encourage patients and families to share their observations and experiences about the practice of respect, and mitigate barriers to that process. Utilize innovative ways to engage patients and families in the discussion about respect and dignity, such as social media.
Since what constitutes respect may vary among patients and families, health care professionals at the point of care must partner with them to learn how best to honor their goals, values, and preferences.	Review and strengthen organizational policies about shared decision making, recognizing it is a fundamental framework for the reliable practice of respect in a broad variety of clinical situations. Build the elicitation of patient goals, values, and preferences into clinical work flows. Recognize that many factors may be involved in a patient’s goals, values, and preferences, including prior experiences in health care, religious beliefs, socioeconomic factors, and cultural traditions.
As part of the practice of respect, promote health equity by engaging and partnering with individuals and communities that experience disparities.	Develop mechanisms of eliciting feedback from patients who experience health and health care disparities. Consider language and literacy barriers, as well as the role of cultural norms. Ensure patient-family advisors represent the diversity of the populations that health care organizations serve. Partner with community organizations that advocate for populations that experience health and health care disparities.
Establish Systems to Learn About and Improve the Practice of Respect	
Strategy	Tactics
Recognize, celebrate, and learn from respectful behavior and positive experiences.	Share positive stories in internal communications and invite media to report on them. Examine cases of exemplary respect to understand what helped make them possible and use that information to optimize improvement efforts.
Ensure that episodes of disrespect are acknowledged and addressed in a timely fashion, supporting all involved parties.	Develop and implement programs for communication, apology, and reconciliation after adverse events, and consider the concept of “service recovery.” Develop and implement peer support programs for health care professionals. Ensure ongoing support for patients and families with unresolved harms.
Learn from episodes of disrespect by recognizing, capturing, categorizing, and analyzing them, as is done through incident analysis.	Engage existing patient safety professionals and coach them to recognize, capture, categorize, and analyze episodes of disrespect. Actively solicit input from groups less likely to be represented. Reduce other reporting barriers. Develop methods of analyzing incidents that consider not just the actions of health care professionals toward patients, families, and each other, but also any system factors. If consensus is lacking about the importance of violations of respect and dignity and/or resources are limited, focus on the subset of incidents that represent the greatest risk of future harm.
Beyond incident analysis, develop and utilize other methods of learning about the practice of respect.	Develop active surveillance systems to proactively identify areas of risk, rather than relying solely on passive reporting of harms that have already occurred. Use process mapping, failure mode and effects analyses, and other process improvement methods to learn about the practice of respect. Use observations, focus groups, and individual interviews to learn about the practice of respect.
Embed organizational systems for learning about and improving the practice of respect in operational structures to ensure their success and sustainability.	Ensure that systems for learning are sufficiently staffed with professionals with appropriate qualifications and training. Identify existing initiatives and programs that align with the practice of respect (such as end-of-life care improvement, the patient experience and patient engagement, Magnet certification, etc.) and promote any synergies to accelerate improvement.
Within organizations, develop methods for effectively sharing what is being learned about the practice of respect to broaden engagement and promote improvement.	Share results through internal communications, as well as on metric dashboards or scorecards. Integrate the language and principles of the practice of respect into existing initiatives and programs.

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Sidebar 1. (continued)	
Establish Systems to Learn About and Improve the Practice of Respect	
Strategy	Tactics
Prevent future harm by designing and implementing changes based on what is learned about the practice of respect.	<p>Develop methods for reliably eliciting patient goals, preferences, and expectations, and aligning care to them.</p> <p>Recognize that achieving health and health care equity will require changing existing organizational structures and processes that contribute to health and health care disparities.</p> <p>Incorporate the concepts of respect and dignity into existing care processes (e.g., rounding, room entry, physical examination, handoffs, etc.).</p> <p>Design changes with the aim of achieving high reliability, drawing upon systems theory** and human factors.††</p> <p>Consider the risk of unintended consequences as a result of proposed changes (e.g., changes to an existing work flow may add significant strain on health care professionals and unintentionally increase the risk of harm to patients and families).</p> <p>Carefully consider the scope of any implementation. Rather than rushing to systemwide campaigns, it may be more efficient to test and refine changes on a smaller scale first, only spreading once they have been shown to be effective.</p> <p>Consider innovative methods of designing changes such as collaborations with professionals and organizations outside of health care.</p>
Expand the Research Agenda and Measurement Tools, and Disseminate What Is Learned	
Strategy	Tactics
Expand the research agenda to define the nature, scope, and connections among the topics of nonphysical harm, respect, and dignity.	<p>Potential research topics:</p> <ul style="list-style-type: none"> • How to define (dis)respect and (in)dignity • The drivers of respect and dignity within health care • Effect of disrespect on safety, quality, outcomes, and the experience of care • Effect of disrespect on employee retention, turnover, engagement, and intra- and inter-professional collaboration • The connections between the practice of respect, market share, and financial outcomes • The concepts of reporting requirements and pay-for-performance programs, and the unintentional consequences such interventions could have <p>Given the biopsychosocial components of this work, consider a broad range of research methods, including direct observations of interactions, focus groups, surveys, literature reviews, and scientific panels.</p>
Further develop measures to guide improvement toward, and demonstrate success in, the reliable practice of respect.	<p>Further develop measures about the degree to which patient and family expectations about respect are, or are not, met.</p> <p>Consider developing and testing reporting requirements for severe disrespect. Consider the unintended consequences such requirements might have.</p> <p>Identify the optimal methods for communicating with stakeholders about measures of respect and dignity.</p>
Identify, compile, and share successful strategies at all sites, including non-health care sites.	<p>Create a centralized repository of research about the practice of respect.</p> <p>Create an annual forum to discuss the practice of respect, disseminate learnings, and facilitate spread of successful strategies.</p> <p>Consider the use of social media and other Internet-based modalities to promote dialogue and sharing.</p>
<p>*<i>Health disparities</i> and <i>health care disparities</i> refer to differences in health and health care among population groups, and they can occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation.^{33,34}</p> <p>†For purposes of this statement, the term <i>health care professional</i> refers not only to clinically trained individuals involved in direct patient care but also to individuals who are not clinically trained. Examples of nonclinical professionals include those working in food service, transportation, health information management, and administration.</p> <p>‡The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network defines <i>just culture</i> as one that “focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. It distinguishes between human error ([e.g.], slips), at-risk behavior ([e.g.], taking shortcuts), and reckless behavior ([e.g.], ignoring required safety steps). . . . In a just culture, the response to an error or near miss is predicated on the type of behavior associated with the error, and not the severity of the event.”³⁵</p> <p>§<i>Joy in work</i> can be defined as intellectual, behavioral, and emotional commitment to meaningful and satisfying work.³⁶</p> <p> <i>Quality</i> is defined by the Institute of Medicine as safe, effective, efficient, timely, patient-centered, and equitable care.³⁷</p> <p>#For purposes of this statement, <i>patient</i> is broadly defined as a person who seeks care from a health care professional or health care organization, regardless of that person’s state of health. <i>Family</i> is broadly defined to include all the individuals the patient wants involved in his or her care, regardless of whether they are related biologically, legally, or otherwise.³⁸</p> <p>**Systems theory is an approach to thinking about organizations and processes that considers them to have multiple interdependent parts, each with its own specific function and interrelated responsibilities.³⁹</p> <p>††Human factors is a scientific discipline concerned with understanding the interactions among humans and other elements of a system, applying theory, principles, data, and methods to design in order to optimize human well-being and overall system performance.^{40,41}</p>	

Participants expressed that leaders must be engaged around the topic of respect, must model respectful behavior, communicate its importance to others in their organizations, and set clear expectations as a prerequisite for accountability. Participants also emphasized that leadership support for people, processes, and systems was essential.

The topics of health disparities and health care disparities were also raised during the Delphi process. These terms refer to differences in health and health care among population groups, and they can occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation.^{33,34} Although survey comments revealed a range of opinions, ultimately consensus was achieved to include the concept of health equity (Table 3, strategy 4).

Promote Accountability

Participants in the Delphi process emphasized the importance of accountability when disrespect occurs. Although this topic is closely associated with leadership, participants believed that it warranted its own recommendation and described its components with two strategies—(1) when expectations about respect and dignity are not met, leaders have a central role in championing transparency, fairness, and a just culture³⁵; and (2) high-level leaders have an active and ongoing responsibility to sustain the pursuit of accountability. In tactics, participants emphasized that high-level leaders cannot be exempt from the expectations about respect and dignity and that they have a unique responsibility for system-level problems (Sidebar 1).

Engage and Support the Health Care Workforce

All Delphi participants agreed that engaging and supporting the health care workforce was essential to building a practice of respect. For purposes of this recommendation and its associated strategies and tactics, the term *health care workforce* refers to the totality of health care professionals working for an organization, and the term *health care professional* refers not only to clinically trained individuals involved in direct patient care but also to individuals who are not clinically trained. Nonclinical professionals include those working in food service, transportation, health information management, and administration, and they are integral to the practice of respect, given their interactions with patients, families, and other professionals, and because of their roles in designing and maintaining organizations' operating systems.

The term *health care professional* was purposefully chosen rather than *provider*, *physician*, *nurse*, *employee*, or *staff* to emphasize that the commitment to respect others must be universal and consistent regardless of an individual's title or role in an organization. Participants noted that this expectation is a prerequisite for effective accountability.

The first strategy under this recommendation focuses on health care professional well-being, and the second describes ways to support professionals who experience disrespect.

The third strategy focuses on how to engage health care professionals to improve their practice of respect. In tactics, the term *coach*—instead of the term *educate*—was chosen to recognize the depth of experience and skill many health care professionals bring to the practice of respect and to avoid unintentionally implying a hierarchical learner-teacher dyad.

Partner with Patients and Families

All participants agreed that achieving a reliable practice of respect would require partnering with patients and families. For purposes of this statement, *patient* is broadly defined as a person who seeks care from a health care professional or health care organization, regardless of that person's state of health. *Family* is broadly defined to include all the individuals the patient wants involved in his or her care, regardless of whether they are related biologically, legally, or otherwise.³⁸

The first strategy associated with this recommendation sets the expectation that everyone who works in health care organizations has a role to play in partnering with patients and families. Two other strategies under this recommendation highlight particularly important roles—leaders need to develop reliable systems for engaging patients and families; and frontline health care professionals must collaborate with patients and families at the point of care to understand their goals, values, and preferences, and adjust care accordingly. As part of striving for health equity, participants highlighted the need to specifically partner with individuals and communities that experience disparities.

Establish Systems to Learn About and Improve the Practice of Respect

Although this recommendation appears fifth, it had the largest number of associated strategies and tactics, and participants suggested that this may be where some organizations first engage with the practice of respect. Participants noted that organizations will discover that their practice of respect is exemplary in some situations and that there is room for improvement in others. Focusing on discrete episodes of respect and disrespect generates stories that can be shared to promote engagement. One strategy emphasizes how it is critical that organizations prioritize care for the patients, families, and health care professionals involved in episodes of disrespect, so as to avoid compounding those harms by failing to acknowledge them. Participants also emphasized the importance of maintaining confidentiality and privacy when sharing the learning from such episodes.

Passive adverse event reporting is unlikely to provide complete information about an organization's practice of respect, so beyond focusing on discrete episodes of respect or disrespect, one strategy suggests pursuing more active methods of learning. Two other strategies articulate the importance of sustaining organizational systems for learning and of sharing what is being learned within organizations. The final strategy under this recommendation describes ways to prevent harm from disrespect and to build high reliability in the practice of respect.

Expand the Research Agenda and Measurement Tools, and Disseminate What Is Learned

As described in the preceding recommendation, Delphi participants believed that each organization should develop internal systems and processes to learn about and improve its own practice of respect. Participants also voted to include the recommendation that generalizable knowledge be shared among organizations to build awareness, create a sense of urgency, and accelerate improvement. This recommendation was placed last, in part because participants did not intend for it to apply to organizations or professionals that do not have the capacity to conduct research or disseminate their findings.

The first strategy describes some ways to consider expanding the research agenda. Participants noted that to maintain engagement and most efficiently utilize limited resources, it will be important to demonstrate positive results prior to scaling up or spreading specific initiatives. The second strategy describes how measures are critical for guiding and assessing progress toward a reliable practice of respect. Participants emphasized the need to be sensitive to the risk of measurement fatigue and aware of the complexity of crafting specific, attainable, relevant, and valid measures. Participants noted that individual stories and narrative descriptions will remain valuable regardless of what measures are developed. The last strategy is about sharing what is learned to accelerate improvement.

DISCUSSION

An interdisciplinary, diverse group of experts, using a modified Delphi process, came to consensus on six high-level recommendations and 25 associated strategies that articulate a road map for health care organizations seeking to engage in the practice of respect. Our work builds on the seminal work of those who have highlighted the critical importance of respect in health care,^{6,13,27} particularly the ACHE and the NPSF's LLI, which recommend that CEOs and other health care leaders should "Value Trust, Respect, and Inclusion."²⁸

Although we focused on respect, many of the strategies and tactics in our consensus statement relate to trust and inclusion, suggesting important relationships among these three concepts. Trust can be considered a component of respect: Giving people the benefit of the doubt—trusting them—may be considered one way of demonstrating respect toward others.⁴² Conversely, some view respect as a prerequisite for trust, and existing trust can be broken when disrespect occurs.⁵ Inclusion, too, may be considered a form of respect, particularly when we consider that the converse—exclusion—is often experienced as a form of disrespect.⁴²

Our work adds to the work of the ACHE and the NPSF's LLI by reiterating the critical role of leaders in establishing a practice of respect in their organizations and by suggesting strategies and tactics for health care leaders. Interestingly,

recent work found that patient and family perceptions of respect and dignity are determined not only by factors at the organizational level but also by factors within the microsystems that exist among health care professionals, patients, and families.⁶ Our Delphi participants confirmed that responsibility for the practice of respect is shared by the entire health care workforce.

The recommendation "Engage and support the health care workforce" and its associated strategies and tactics make it clear that achieving a reliable practice of respect with patients and families will require a reliable practice of respect among health care professionals. The strains on frontline health care professionals have been well documented and must be addressed by leaders as a fundamental matter of respect for their employees. This recommendation also aligns with prior work suggesting that health care leaders should engage frontline health care professionals as they develop organizational approaches to improve the patient experience and making care more patient-centered.^{43,44} Delphi participants also described an essential need to "Partner with patients and families" at the point of care. Some stakeholders may be concerned that efforts to improve partnerships at the point of care could further strain health care professionals, but evidence suggests that such efforts have the potential to improve relationships with patients who have experienced disrespect,⁴⁵ decrease health care professionals' burnout, and increase their joy in work.⁴⁶ More work is needed to foster, support, and sustain such partnerships.

Also notable in our work is the topic of persistent disparities in health and health care among populations.⁴⁷ Many patients will perceive disparities as evidence of disrespect on the part of the health care system and health care professionals.⁴⁸ With this in mind, we found that language focused on working toward a positive goal—the concept of "striving for health equity"—garnered more support than language focused on eliminating disparities.

Our study had a number of limitations. First, although we believe that our Delphi participants brought a broad range of perspectives, the methods we used to identify participants are not easily reproducible. As the science around the practice of respect progresses and we revisit this consensus statement, it will be important to use a reproducible set of criteria to identify panel experts that results in representation from the full range of diverse stakeholders. Second, our Delphi participant panel was approximately half of the Convening group, and on the low side of the number of respondents for most Delphi studies.²⁹ This may have limited the diversity of perspectives in ways that biased the consensus statement. Third, given the breadth of our comprehensive approach to the concept of respect in health care, there are many untested ideas. For this reason, we did not ask Delphi participants to quantify their consensus about the suggested tactics. We also chose not to include or recommend specific methods, measures, or interventions at this time with the hope that future work will reveal best practices.

Beyond developing and testing specific ways of improving the practice of respect, future work could explore how health care organizations can best utilize our road map. We plan to publicize the road map in collaboration with the endorsing individuals and organizations (see Collaborators section) through presentations and workshops. Additional ways of promoting its use include developing organizational needs assessments to help health care leaders most effectively engage with the practice of respect by focusing their initial efforts on a customized subset of recommendations, strategies, or tactics; expanding the scope of educational programs about incident analysis to include approaches to harm from disrespect; and exploring how accrediting and measurement organizations might incorporate elements of the road map into their assessment frameworks.

CONCLUSION

Harm from disrespect is the next frontier in preventable harm. Organizations should strive to eliminate disrespect to patients, to families, and among health care professionals. Our consensus statement—crafted by an interdisciplinary and diverse group of stakeholders in health care—provides a road map for those who are interested in developing a more reliable practice of respect throughout their organizations. More work is needed to further develop the tactics that will ultimately prevent harm from disrespect. Given the foundational nature of respect in health care, we believe that this work is a challenging but critical step toward achieving high quality and high reliability. With humility and a commitment to continuous learning, we encourage others to join us in the practice of respect.

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SUPPLEMENTARY MATERIALS

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