Center for Patient and
Professional Advocacy
at Vanderbilt

The Why and How of Dealing with "Special" Colleagues: Discouraging Disruptive Behavior

James W. Pichert, PhD

Co-Director, Center for Patient & Professional Advocacy

Professor of Medical Education

Vanderbilt University School of Medicine

jim.pichert@vanderbilt.edu

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About Vanderbilt and other Nashville hospitals:

"You take your kids there…or go if you've got some rare disease…or if you are about to die…otherwise, you should go to…"

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Consumer Hospital Preference* Davidson County, TN

- 1996: Vanderbilt University Medical Center 4th at 7.8%, just above "uncertain"
- Since 2006: VUMC #1 and the gap between VUMC and others is growing

*Based on a survey of 1,900 households

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Things We Did Right

- Invested in biomedical informatics
- Set goals for the clinical/academic enterprise
- Committed to service renewal - ELEVATE – Studer Group
- **Committed to a culture of professionalism with the associated requirement of self- regulation (and dealing with "special colleagues")**

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Professionalism and Self-Regulation

Conceptual Framework – Professionalism

- Physicians have joined a profession
- Professionals commit to:
  - Confidentiality
  - Clear and effective communication
  - Modeling respect
  - Being available
- Professionalism promotes teamwork

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Professionalism and Self-Regulation

Professionalism demands self-regulation

- Personal
- Discipline specific
- Group
- Systems focused

All require the skills to provide and receive feedback

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Case: A Deteriorating Patient

- An experienced L&D RN who cared for CI, 28 yo primigravida, reports the following:
- SROM at 0800, completely dilated by 1030. CI pushed for 3½ hours, C/S w/o difficulty for CPD. Infant to nl nursery. Est. blood loss = 600 ccs.
- First 2 hrs post delivery "normal" including unremarkable vitals, good pain control with PCA pump.

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Case: A Deteriorating Patient

- CI developed sudden vag bleeding, OB paged. Given Methergine IM + uterine massage. Vag exam revealed handful of large clots. Blood loss ~ 1000 ccs.
- OB left CI to tend to other pt. Over next 30 min nurse changed bed linens 3 times due to blood loss, CI began to complain of low back pain, cold hands and feet (symptoms of shock).
- Nurse paged OB again. A CBC ordered earlier indicated that CI's Hgb had fallen from 14.1 to 6.4.

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Case: A Deteriorating Patient

- OB ordered 4 units PRBCs, left to attend other pt. While blood was infusing CI became more tachycardic, BP=82/22. Nurse started 2nd IV, called for OB & Anesth. When Anesth arrived CI said she felt lightheaded.
- When the OB arrived Anesth still at bed-side. OB seemed irritated.
- Vigorous discussion ensued in CI spouse's presence...

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Case: A Deteriorating Patient

- Anesth asserted CI was bleeding out, needed stat surgery. OB insisted "long differential, including a PE."
- Anesth: "Well, if you really believe that, you don't treat PE with blood, so why did you order the 4 Units PRBCs?"
- CI arrested, CPR initiated. Nurse escorted husband to private waiting room. He had lots of questions.

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Does Dr. OB's behavior warrant temporary suspension?

1. Absolutely
2. Probably
3. Uncertain
4. Probably not
5. Absolutely not

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But can I really do anything?

What about legal?

I (we) might get sued…

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Practical Magic

1. Know your contract/bylaws/handbook and other sources of authority (ACGME for residents) before doing anything.
2. Know "your" data – Chief of Staff file, evaluations, surveys, complaints, U/R, Q/A, email, committee minutes.
3. Way finding – is it quality, safety, interpersonal behavior, harassment, discrimination, terms of employment, compliance?

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Practical Magic

4. Have a goal – stay and change, go, rehab, remedial education, etc.
5. No hatchet jobs – avoid conflicts of interest, professional jealousy, passive/aggressive behavior, bias, humiliation, etc.
6. Trust, but verify – skepticism is healthy, so doubt everything. But remember – trust is reciprocal.
7. If you do fight, win (or don't fight).

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Practical Magic

8. Be direct – no proxies, intermediaries, memos, emails. This requires personal courage (a function of preparation).
9. Process regularity provides litigation protection.
10. Be just – awesome responsibility requires a sense of purpose, primary source verification and a deliberative process.

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Guiding Principles for Action*

- Justice – Fairness for all
- Certainty that the "egregious" event in question or pattern of "evidence" shows that the physician in this case (or other professional in other cases) stands out from peers
- Insight into causes is the first, short-term goal
- "Redemption," "Restoration," or problem resolution is the 2nd goal
- No Conflict of Interest

*Charles Reiter, III, General Counsel, Loyola University Medical Center

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Definition of Disruptive Behavior

Behavior that interferes with work or creates a hostile environment, e.g.:

- verbal abuse, sexual harassment, yelling, profanity, vulgarity, threatening words/actions;
- unwelcome physical contact; threats of harm; behavior reasonably interpreted as intimidating;
- passive aggressive behaviors: e.g., sabotage and bad-mouthing colleagues or organization
- **behavior that creates stressful environments and interferes with others' effective functioning**

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Vanderbilt University and Medical Center Policy #HR-027

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But More Common:

"___ came late to the meeting, then spent the remaining time on a Blackberry…doesn't exactly say anything you could object to, but always rolls her/his eyes and makes a face in meetings…not helpful"

"___ doesn't talk at meetings, but later mocks the discussion…disputes wisdom of decisions"

" ___ has a website containing an on-line blog that can be read by anyone in which he writes disparaging remarks about our staff"

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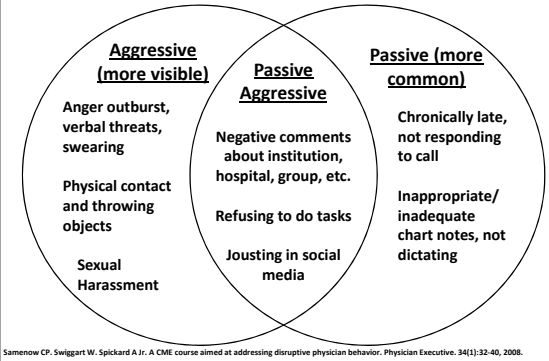
Categories of Disruptive Behaviors



Samenow CP. Swiggart W. Spickard A Jr. A CME course aimed at addressing disruptive physician behavior. Physician Executive. 34(1):32-40, 2008.

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Case: Never on Wednesday

Daughter reported: "The doctor my father was to see entered the ED acting agitated… talked down to girl at desk: "Answer my questions immediately with a yes or no…don't need any extra conversation…I'm here to see one of my patients." Receptionist replied "no," and said, "but there's the consult we called about." Dr. looked at the chart and became even more upset…

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The story continues:

- "Sensing that the doctor was in a hurry, I said that my dad was ready to be seen. Dr. whirled toward me, made a "T" sign with his hands and barked, 'Time out! It's not your turn to talk!'

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The doctor turned on the staff

"Turning back to the receptionist, he yelled so the whole area could hear, 'Who consulted me?...You need to tell this patient to go where they know what they are doing…I don't do consults on Weds… months before I can book them an appt.' Then, without acknowledging us, he turned and left. I don't think that was very professional."

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Why are we so hesitant to act?

What barriers exist?

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Why bother dealing with disruptive behavior?

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Why Might a Medical Professional Behave in ways that are Disruptive?

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Why Might a Medical Professional Behave in Ways that are Disruptive?

1. Substance abuse, psych issues
2. Narcissism, perfectionism
3. Spillover of family/home problems
4. Poorly controlled anger (2° emotion)/Snaps under heightened stress, perhaps due to:
   a. Poor clinical/administrative/systems support
   b. Poor mgmt skills, dept out of control
   c. Back biters create poor practice environments

Samenow CP. Swiggart W. Spickard A Jr. A CME course aimed at addressing disruptive physician behavior. Physician Executive. 34(1):32-40, 2008.

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Why Might a Medical Professional Behave in Ways that are Disruptive?

5. Family of origin issues—guilt and shame
6. Well, it seems to work pretty well (why? See #7)
7. No one addressed it earlier
8.
9.

Samenow CP. Swiggart W. Spickard A Jr. A CME course aimed at addressing disruptive physician behavior. Physician Executive. 34(1):32-40, 2008.

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What organizational infrastructure is required?

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Infrastructure for Addressing Disruptive Behavior (DB)

1. Leadership commitment
2. Supportive institutional policies
3. Surveillance tools to capture pt/staff allegations
4. Model to guide graduated interventions
5. Processes for reviewing allegations
6. Multi-level professional/leader training
7. Resources to help disruptive colleagues
8. Resources to help disrupted staff and patients

Hickson GB, Pichert JW, Webb LE, Gabbe SG. A Complementary Approach to Promoting Professionalism: Identifying, Measuring and Addressing Unprofessional Behaviors. Academic Medicine. November, 2007.

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Infrastructure for Addressing DB

- Leadership commitment
  - TJC Recc 2: Hold all team members accountable for modeling…enforce code of conduct consistently and equitably among all regardless of seniority … through reinforcement as well as punishment.
  - Does not blink…

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Barriers to Addressing DB

- Lack of awareness of the impact of disruptive behaviors on outcomes: **30%**
- Lack of policies to deal with disruptive behaviors: **30%**
- Lack of training to deal with disruptive behaviors: **48%**
- Leaders don't apply policies consistently: **69%**

June 2009, Unprofessional Behavior in Healthcare Study, Studer Group and Vanderbilt Center for Patient and Professional Advocacy

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Infrastructure for Addressing DB

- Supportive institutional policies
  - TJC Std: code of conduct … defines acceptable & disruptive and inappropriate behaviors. Recc 3: …implement policies, that address "Zero tolerance" for the most egregious … Protect those who report or cooperate …non-retaliation clauses in all policy statements that address disruptive behaviors...

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Infrastructure for Addressing DB

- Credo
  - I make those I serve my highest priority
  - I communicate effectively
  - I conduct myself professionally
  - I respect privacy and confidentiality
  - I have a sense of ownership
  - I am committed to my colleagues
- Supportive institutional policies
  - VUMC "Professional Behavior" policy: conveys expectations, reporting lines, pathways, "right things to do."

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Policies will not work if Disruptive Behavior goes unreported and unaddressed

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Infrastructure for Addressing DB

- Surveillance tools to capture pt/staff allegations
  - TJC Recc 6,7: Develop, implement systems for assessing staff perceptions of seriousness, extent of unprofessional behaviors and risk of harm to pts … implement a reporting/surveillance system (possibly anonymous) for unprofessional behavior.

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Infrastructure for Addressing DB

- Surveillance tools to capture pt/staff allegations
  - VUMC: Online event reporting, including both risk management incidents *and* behavior issues
  - Advocates (ombudsmen) record patient/family comments and observations; inpatient video; HEART/HEARD program; manager training; signage, videos and promotional campaigns that "we want to hear from you."
  - Compliance Office; Opportunity Development Center (for allegations of harassment, bias, etc.)

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Reports to the Office of Patient Relations

- Pt reported: "I had questions about my condition and treatment. Dr.__ looked up and asked, 'Are you illiterate?' I said, "No." Dr.__ responded, 'Oh, I just gave you several pamphlets that explain all of this. Since you didn't get it, I thought that maybe you were illiterate.'"
- Pt. reported: "The doctor said angrily, 'Can I get a little help from one of your girls?' I could feel the negativity…made me nervous."

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Staff complaints

- Physician complained: Dr. ___ may not return pages for 20-30 minutes, which delays movement through the department.
- Nurse supervisor complained that Dr. ___ has a website containing an on-line blog that can be read by anyone in which he wrote disparaging remarks about the unit nursing staff

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Infrastructure for Addressing DB

- Processes for reviewing allegations
  - TJC Recc 6,11: Assess staff perceptions of disruptive behavior; Document all attempts to address intimidating and disruptive behaviors.

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Infrastructure for Addressing DB

- Model to guide graduated interventions
  - TJC Std: Leaders create, implement a process for managing disruptive and inappropriate behaviors.
  - Recc 4,8,11: Develop process for addressing intimidating and disruptive behaviors; Support surveillance with tiered interventional strategies; Document each level appropriately.

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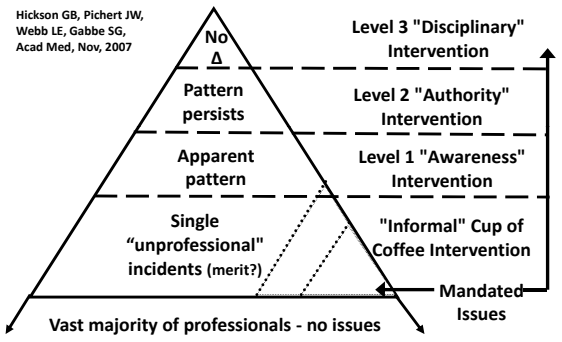
Disruptive Behavior Pyramid



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Training: 3 Critical Conversations:

Informal: Cup of Coffee Conversation

Awareness: An Awareness Visit

Authority: EDICTS Conversation

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But training in conversation is of little value without the other essential elements

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The Hard Question: To what extent do you have these (<u>really</u>)?

1. Leadership commitment
2. Supportive institutional policies
3. Surveillance tools to capture pt/staff allegations
4. Model to guide graduated interventions
5. Processes for reviewing allegations
6. Multi-level professional/leader training
7. Resources to help disruptive colleagues
8. Resources to help disrupted staff and patients

Hickson GB, Pichert JW, Webb LE, Gabbe SG. A Complementary Approach to Promoting Professionalism: Identifying, Measuring and Addressing Unprofessional Behaviors. Academic Medicine. November, 2007.

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But can this really make a difference?

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Med Mal Research Summary

- 1-6%+ hosp. pts injured due to negligence
- ~2% of all pts injured by negligence sue
- ~2-7 x more pts sue w/o valid claims
- Non-$$ factors motivate pts to sue
- **2-8% of doctors attract more suits**
- **High risk today = high risk tomorrow**

www.mc.vanderbilt.edu/CPPA

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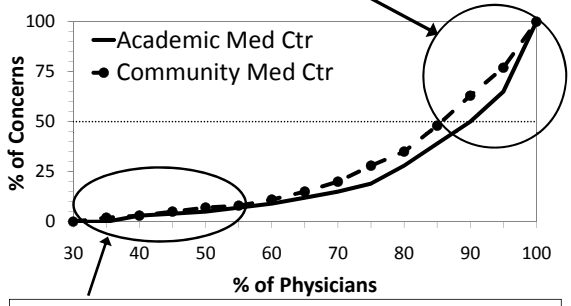
Academic vs. Community Medical Center

50% of concerns associated with 9-14% of Physicians



Note: 35-50% get NO complaints, this half accounts for 4% of RM expenditures

Hickson GB, et al. Patient complaints and malpractice risk in a regional healthcare center, So Med J. 2007;100:791-6

Predictors of Risk Outcomes

(logistic regression)

- Gender
- Physician specialty
- Volume of service
- Unsolicited patient complaints

Predictive concordance of risk models ranges from 81-92%

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Hickson et al, JAMA. 2002 Jun 12;287(22):2951-7.

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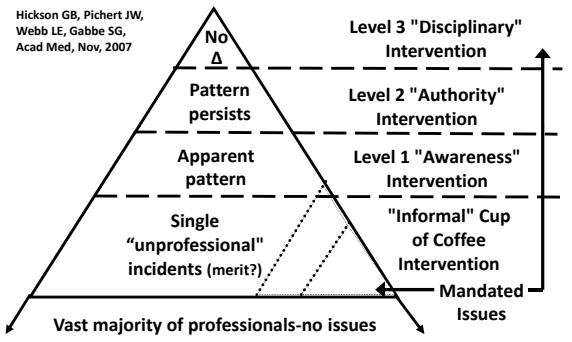
Incurred Expense By Risk Category

Predicted Risk Category	# (%) Physicians	Relative Expense	% of Total Expense	Score (range)
1 (low)	**318 (49)**	**1**	**4%**	**0**
2	147 (23)	6	13%	1 - 20
3	76 (12)	4	4%	21 - 40
4	52 (8)	42	29%	41 - 50
5 (high)	**51 (8)**	**73**	**50%**	**>50**
Total	644 (100)		100%	

*** In multiples of lowest risk group**

49 **Moore, Pichert, Hickson, Federspiel, Blackford. Vanderbilt Law Review, 2006**

Disruptive Behavior Pyramid



"Messenger" Physician Peers:

- Are committed to confidentiality
- Are respected by colleagues
- Are willing to serve (8 hours of training)
- Have risk scores that are mostly okay (but at several sites physicians intervened upon are messengers)
- Agree to review, then take data to 1-3 physicians at request of local messenger committee chair

(Committee formed under existing QA/Peer review)

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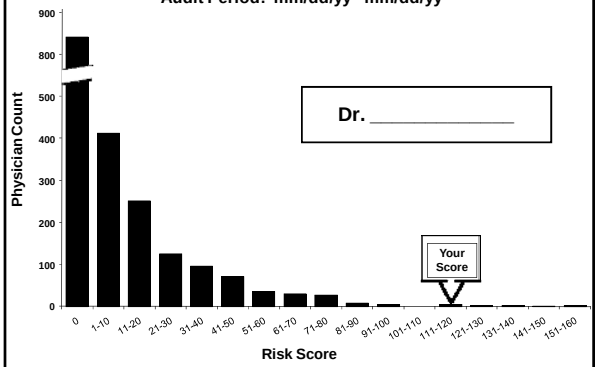
Frequency Distribution of Risk Scores: "You are Here"
Audit Period: mm/dd/yy - mm/dd/yy



Distribution is based upon unsolicited patient/family complaints recorded by the Patient Relations representative. The Risk Score reflects the complaints with which each physician was associated. It is based on an algorithm that weights complaints recorded in the past year more heavily than those recorded in prior years.

Confidential:...set forth under "State Peer Review Statutes"

Complaint Type Summary
Dr. _____
Audit Period: Date 1 – Date 2

Complaint Type Categories	Number of Complaints		Distribution of Complaints	
	Your Complaints	Average for Dermatology	Your Complaints	Average for Dermatology
Care & Treatment	19	4.5	30.2%	39.8%
Communication	15	2.9	23.8%	25.7%
Concern for Person	14	1.3	22.2%	11.5%
Access/Availability	9	1.9	14.3%	16.8%
Safety of Environment	0	0.0	0.0%	0.0%
Money/Payment Issues	6	0.7	9.5%	6.2%
Total # of Complaints	**63**	**11.3**		

Total Number of Reports **Note:** each report may contain multiple complaints		
Past 48 months	**26**	**5.9**
Past 12 months	**6**	**1.7**

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But does any of this

actually work?

Is there a Return on Investment?

Outcomes Summary thru 2007[1]

Results for first 336 physicians identified as "high risk":

Improved	195	(58%)
Unimproved/worse	70	(21%)
Departed the medical group (just prior to or within a year of intervention)	71	(20%)
Total follow-up results	336	

[1]Pichert JW, Hickson GB, Moore IN: "Using Patient Complaints to Promote Patient Safety." In: AHRQ (Eds). Advances in Patient Safety: New Directions and Alternative Approaches, 2008.

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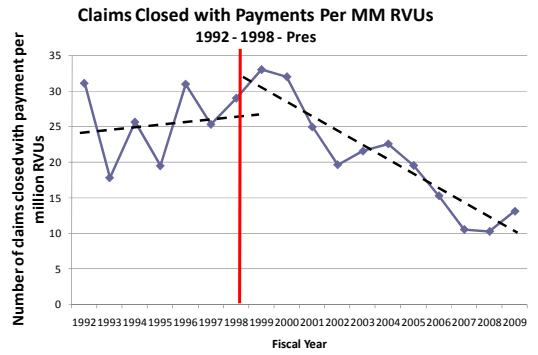

Upcoming CPPA Conferences

The Why and How of Dealing with "Special" Colleagues: Discouraging Disruptive Behavior
June 3-4, 2010

The How and When of Communicating Adverse Outcomes and Errors
TBD, 2010

http://www.mc.vanderbilt.edu/centers/cppa/courses.htm

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Gap Analysis Worksheet

Infrastructure Element	TJC Item Excerpt	We Have	We Need
Leadership commitment	TJC Recc 2: Hold all team members accountable for modeling…enforce code of conduct consistently and equitably regardless of seniority … through reinforcement as well as appropriate measures designed to reduce unprofessional behaviors.		
Supportive institutional policies	TJC Std: code of conduct … defines acceptable & disruptive and inappropriate behaviors. Recc 3: …implement policies, that address "Zero tolerance" for the most egregious … Protect those who report or cooperate …non-retaliation clauses in all policy statements that address disruptive behaviors...		
Surveillance tools to capture pt/staff allegations	TJC Recc 6,7: Develop, implement systems for assessing staff perceptions of seriousness, extent of unprofessional behaviors and risk of harm to pts … implement a reporting/surveillance system (possibly anonymous) for unprofessional behavior.		
Model to guide graduated interventions	TJC Std: Leaders create, implement a process for managing disruptive and inappropriate behaviors.		

Notes:

Infrastructure Element	TJC Item Excerpt	We Have	We Need
Processes for reviewing allegations	Recc 4,8,11: Develop process for addressing intimidating and disruptive behaviors; Support surveillance with tiered interventional strategies; Document each level appropriately.		
Multi-level professional/leader training	TJC Recc 1,5: Educate all team members – physicians and non-physicians – on appropriate professional behavior defined by the organization's code of conduct… should emphasize respect …Provide skills for giving feedback on unprofessional behavior, coaching re conflict.		
Resources to help disruptive colleagues	TJC Recc 10: Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.		
Resources to help disrupted staff and patients	TJC Recc 3,9,10: Encourage inter-professional dialogues [to address] conflicts… move forward; … org. commitment to health/ well-being of all staff; Respond to pts/families who are involved in or witness intimidating and/or disruptive behavior.		

Notes: