"You mean I have to be nice AND smart?"– Professional Behavior in Healthcare

James T Jennings MD
Medical Director
Kentucky Physicians Health Foundation

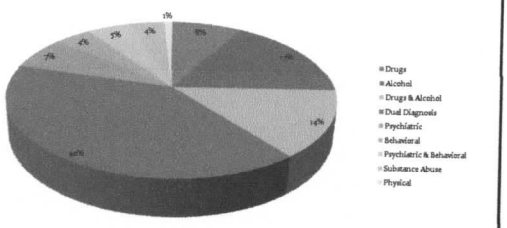
Objectives

- Understand definition, nature and prevalence of disruptive behavior
- Learn about individual and systemic causes
- Understand a rational, staged approach to management
- Clarify the roles of medical leaders in responding to disruptive behavior.

"The age of the cowboy surgeon is over."

Wayne and Mary Sotile
"The Resilient Physician"

KPHF Statistical Breakdown of Current Participant Diagnosis



Case example – Dr. Smith

Dr. Smith is an orthopedic surgeon. Perfectionistic and demanding, he berates a nurse who hands him an incorrect instrument. Frustrated, he throws the instrument to the floor and reaches in front of the nurse to grab the correct instrument from the tray.

Hurt, the nurse filed a complaint saying that the doctor's words and manner violated the hospital Code of Conduct.

Disruptive Behavior

"A physician with disruptive behavior is one who cannot, or will not, function well with others to the extent that his or her behavior, by words or actions, interferes or has the potential to interfere with quality health care delivery."

"Where is it written that I have to be nice?"

orthopedic surgeon

Professionalism

AMA Code of Ethics:

- Practice the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.
- Treat your colleagues with dignity and as persons worthy of respect.
- Collaborate with other physicians and health professionals
- Protect and enhance your own health and wellbeing...

KPHF Roles

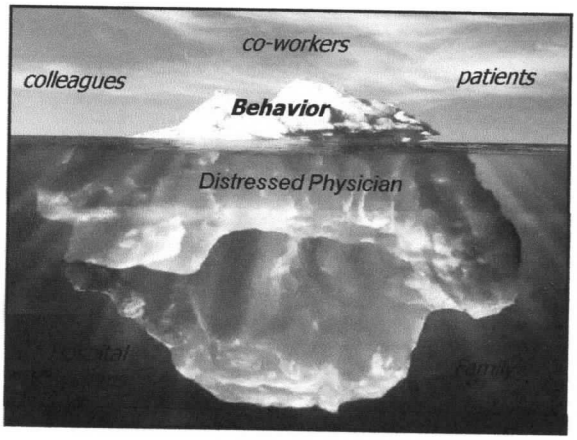
- Communicator, collaborator, manager, advocate, professional

Codes of Conduct:

- Most hospitals have or are developing
- Values
  - Compassion,
  - Respect,
  - Teamwork,
  - Accountability
- Policies to manage problem behavior

Joint Commission July 2008 Mandates

1. EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors
2. EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors



PHP experience:

- Approx. 4% of physician referrals due to conduct problems specifically (about 15 per year)
- Many referred with other problem types display disruptive behavior
- 88% male
- ***One third surgeons***
- Ob-gyn, anesthesiologists approx. 10% each.

Examples:

Abusive and aggressive behavior

- Intimidation, bullying, physically threatening, throwing objects
- Blaming, shaming, belittling language
- Unnecessary sarcasm or cynicism

"It's like a summer rain shower – short, sharp, then over."

-Surgeon referring to the impact of his behavior on others.

Examples:

Passive-aggressive behavior

- Late or no replies to pages
- Non-compliance with policies and procedures
- Non-attendance at committee meetings
- Rigid, inflexible or non-responses to requests for cooperation
- Lack of respect for dignity and comfort of others

Examples:

Boundary crossings

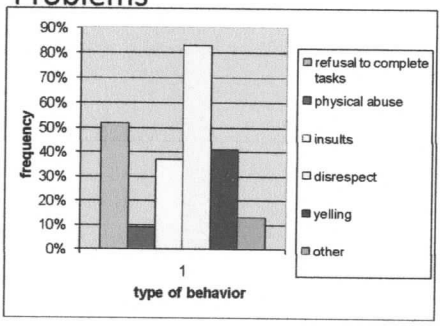
- Sexual comments or innuendoes
- Sexual harassment – unwelcome flirtation
- Inappropriate touching
- Interference with management of other doctors' patients

Examples:

Other

- Racial, cultural slurs
- Disparaging remarks about colleagues and administrators (including hostile e-mails, notes in patient records)
- Refusing to see certain categories of patients
- Cold, aloof, unapproachable demeanor

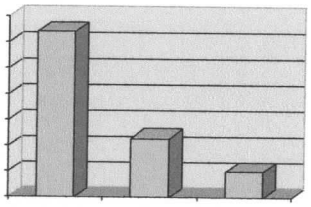
Breakdown of Typical Problems



ACPE 2004 Physician Behavior Survey

Prevalence

Nursing experience



Diaz ('91) – California

Prevalence, cont'd (UK examples)

- 37% junior physicians reported being bullied in the prior year
- 84% witnessed bullying aimed at fellow junior physicians

(The No Asshole Rule: Building a Civilized Workplace and Surviving One That Isn't, Sutton, R.I.)

Paradox:

The doctor's brusque, rude, demanding behavior towards co-workers in the name of improved patient care erodes efficient team work and has a negative impact upon patient care.

Is there a classic DB Profile?

- Expert in their field, usually surgical, male
- Always busy & champion for their patients
- Very skilled, see themselves as clinically superior (and often are!) & others as less competent
- Lack of insight: perplexed by reactions of others
- Tend to view source of problems as external to them
- Not psychologically minded
- Isolated, rarely seek assistance

What Disruptive Behavior isn't:

- Healthy criticism offered in good faith with the intention of improving patient care or facilities
- Making a complaint to an outside agency
- Testifying against a colleague
- Good faith patient advocacy

Causes

Personal

- Immaturity, "Doctor behavior"
- Mismanaged stress – "shoot the first thing that moves."
- Burnout
- Psychiatric disorders
  - Mood and anxiety disorders such as bipolar type II and OCD
  - Adjustment disorders
  - Character problems and disorders
- Substance use disorders

"Doctor Behavior"

- Perfectionism
- Like to be 'In-Control'
- Dedication to patients above all
- Problem solvers, solution focused
- Successful in achieving goals
- Resist Change

Causes

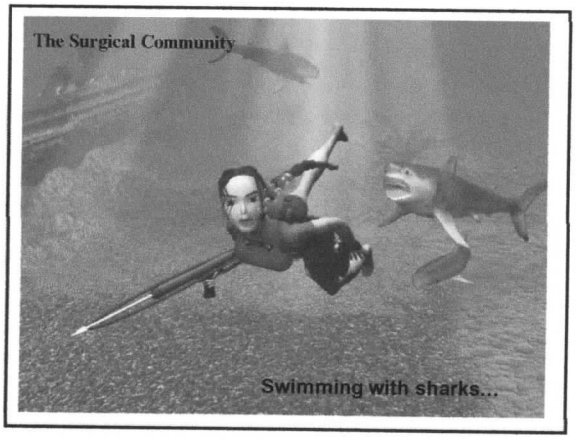
Family

- Marital tension, divorce
- Child, parenting challenges
- Illness in family member
- Aging parents

Causes

Hospital – Institutional

- Some degree of dysfunction in department / team
  - Morale, leadership, personality conflicts
- Conflict between physicians and administration
- Difficult mergers, culture clashes
- History of repeated incidents incompletely and inconsistently addressed
  - "chat", letter, anger management (maybe), no follow-up
- Tacit approval of behavior



Swimming with the sharks:

- Any unidentified colleague is a shark until proven otherwise.
- Be sure not to bleed: it attracts sharks.
- Get out of the water if another is bleeding.
- Counter aggression with more aggression.

Krizek TJ; Surgery...Is it an Impairing Profession? J Am Coll Surg; 2002 Mar; 194(3): 352-66

The Operating Room Culture:

If you shouldn't say it, or do it, at a little league game, can you say it or do it in the OR?

Healthy professional community

- Respect for colleagues and co-workers
- Accept differences in others
- Mentorship
- Participate in team building, medical politics
- Offer help and support to others
- Develop willingness to reach out to others

Management of Problem Behavior

(Behavior is not a diagnosis)

Management Principles

1. Reporting:
- Permissive culture, safety
- Documentation
- Notify doctor of complaint and process
- Timeliness
- Knowledge of process
- Confidentiality

2. Evaluate / Validate:
- Focus on behavior
- Interview complainant, witnesses and doc
- Review pertinent records
- Rule out frivolous complaints
- Determine risk and urgency
- Understand context and issues
- Consider expert assessment(s)

3. Resolution:
- Clarify, reinforce behavioral expectations
- Negotiate agreement
- Address contributing issues
- Implement remediation strategies
- Identify and discuss contingencies if recurrence

4. Reconciliation:
- Apology
- Address broken trust issues
- Facilitate healing discussions

5. Follow-up and Maintenance:
- Scheduled interviews / progress / performance reviews with supervisor
- Reports from outside resources
- "360" behavioral surveys
- Contractual monitoring and accountability
- Follow through with systemic interventions
- Consider duration

Management principles

1. **Reporting**
2. **Evaluation**
3. **Resolution**
4. **Reconciliation**
5. **Follow-up**

Applied in a rational, staged process:

Stage One

Behavior
- First instance(s)
- Minor severity
- Anger outburst(s)
- Patient/staff complaint
- Non-adherance to hospital policies and Code of Conduct

Response
- Document
- Validate
- Discuss
- Consider counseling or
- Coaching
- Education
- Follow-up interview
- Accountability?

Dr. Smith: Stage one response

- Complaint from nurse investigated and validated according to harassment policy
- Chief of surgery discussed incident with Dr. Smith promptly
- Dr. Smith acknowledged inappropriate comments but stated certain nurses needed more training.
- Nursing supervisor advised
- Incident fully documented
- Dr. Smith reminded he could seek personal counseling

Stage Two

Behavior
- Persisting pattern despite stage one intervention
- Increasing intensity
- Multiple complaints

Response
- Validate
- Discuss
- Comprehensive assessment
- Legal counsel
- Management plan
- Clinical treatment
- Education
- Counseling
- Monitoring/Feedback

Dr. Smith: Stage two response

- Two further incidents of similar nature and now some nurses refuse to work on cases with Dr. Smith
- Referral for assessment and plan
- Multiple problems diagnosed and treated
  - Mood disorder, narcissistic and obsessive character traits, poor communication skills, marital problems
- Facilitated education and discussion sessions with nursing staff instituted
- Monitored by PHP for two years including 360 behavioral surveys

Assessment, Management, Follow-Up

- Many good resources exist
- Management strategies should be stage appropriate
- Choosing appropriate and effective resources depends upon good assessment
- Context matters, can be assessed and supported with a range of services
- Interventions selected linked to risk of recurrence
  - "zero tolerance" goal unreasonable
  - Progress to the point of usual acceptable standard is a must

Stage Three

Behavior	**Response**
•Continuing pattern of behavior despite Stage Two interventions	•Administrative (privileges or employment)
•Obvious substance abuse or psychiatric disorder	•Appropriate intervention and referral for clinical services
•Dangerous behavior	•Reports to authorities
•Criminal behavior	

Dr. Smith: Stage three response

- Dr. Smith is angered by a nurse whom he claims has called him to the ward needlessly. He shoves her into a room, yelling, gesticulating, blocking the nurse's exit.
- Dr. Smith is still being monitored for previous incidents of disruptive behavior and is engaged in a rehabilitation program.
- Dr. Smith is asked to stop working and the MEC meets and recommends suspension of his hospital privileges.

Challenges:

- Absent Codes with procedural guidance
- Leaders insufficiently trained and / or willing
- Absent expert infrastructure to offer other than the simplest interventions
- Rational matching of interventions to problem intensity
- Hospitals unwilling to look at themselves from a more systemic perspective

Challenges:

- Clashing or hidden agendas:
  - Hospital: fix quickly or get rid of the doctor
  - Lawyers: use adversarial approach
- Reluctance to spend time and money required for thorough, effective approach
- Timely, affordable assessments not always easy to arrange
- Insufficient research, published evidence to support rehabilitative approach
- Shift of medical culture!

Role of Medical Training

- Professionalism taught and modeled in all levels of medical training.
- Professional behavior evaluation built into curriculum.
- Unresolved disruptive behavior should preclude successful completion of program.
- Faculty must be held to same high standard of professional behavior

Role of Health Care Institution

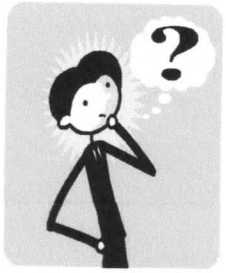
- Develop comprehensive Code of Conduct with associated policies and procedures.
- Recruit, credential and renew privileges with professionalism in mind.
- Train management and medical leaders in policies and leadership.
- Become familiar with available helping resources and how to access them.
- Become self-aware: be willing to evaluate and remediate systemic problems.
- Define and create a culture conducive to professionalism, high quality patient care, ***joy for all who work there.***

Skill Building

A ssess

B reathe

C hoose



Paradigm change:

Old:	New
•The physician is a "jerk"	•The physician / hospital needs help
•These physicians are bad	•These are usually good doctors
•It's all the doctor's fault	•Context matters
•Be cautious, delay action	•Act promptly and decisively
•"Fix" the doctor	•Consider the entire system
•The situation is incorrigible	•Use a rational, staged approach
	•This is an opportunity for constructive change

Adapted from Kent Neff