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

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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...”

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”)

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

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.

Case: A Deteriorating Patient

- 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.

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.

Does Dr. OB’s behavior warrant temporary suspension?

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

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?

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).

8. Be direct – no proxies, intermediaries, memos, emails. This requires personal courage (a function of preparation).
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

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

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”

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

**Vanderbilt University and Medical Center Policy HR-027

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Categories of Disruptive Behaviors

- **Aggressive (more visible)**
  - Anger outburst, verbal threats, swearing
  - Physical contact and throwing objects
  - Sexual Harassment

- **Passive-Aggressive**
  - Negative comments about institution, hospital, group, etc.
  - Refusing to do tasks
  - Jousting in social media

- **Passive (more common)**
  - Chronically late, not responding to call
  - Inappropriate/inadequate chart notes, not dictating

---

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...

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!’
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.”

Why are we so hesitant to act?
What barriers exist?

Why bother dealing with disruptive behavior?
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 (2nd 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

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.
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What organizational infrastructure is required?

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

Infrastructure for Addressing DB

• Leadership commitment
  • TJC Rec 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%


Infrastructure for Addressing DB

- Supportive institutional policies
  - TJC Std: code of conduct ... defines acceptable & disruptive and inappropriate behaviors. Recomendations: 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...

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

Infrastructure for Addressing DB

- Surveillance tools to capture pt/staff allegations
  - TJC Rec 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.

- 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.”

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

Infrastructure for Addressing DB

• Processes for reviewing allegations
  • TJC Rec 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.
- Rec 4,8,11: Develop process for addressing intimidating and disruptive behaviors; Support surveillance with tiered interventional strategies; Document each level appropriately.

Disruptive Behavior Pyramid

- Pattern persists
- Apparent pattern
- Single “unprofessional” incidents (merit?)

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

The Hard Question: To what extent do you have these (really)?

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

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

Academic vs. Community Medical Center
50% of concerns associated with 9-14% of Physicians

% of Concerns

% of Physicians

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


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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### Incurred Expense By Risk Category

<table>
<thead>
<tr>
<th>Predicted Risk Category</th>
<th># (%) Physicians</th>
<th>Relative Expense</th>
<th>% of Total Expense</th>
<th>Score (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (low)</td>
<td>318 (49)</td>
<td>1</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>147 (23)</td>
<td>6</td>
<td>13%</td>
<td>1 - 20</td>
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<tr>
<td>3</td>
<td>76 (12)</td>
<td>4</td>
<td>4%</td>
<td>21 - 40</td>
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<tr>
<td>4</td>
<td>52 (8)</td>
<td>42</td>
<td>29%</td>
<td>41 - 50</td>
</tr>
<tr>
<td>5 (high)</td>
<td>51 (8)</td>
<td>73</td>
<td>50%</td>
<td>&gt;50</td>
</tr>
<tr>
<td>Total</td>
<td>644 (100)</td>
<td>100%</td>
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* In multiples of lowest risk group


### Disruptive Behavior Pyramid


- Level 3 "Disciplinary" Intervention
- Level 2 "Authority" Intervention
- Level 1 "Awareness" Intervention

Pattern persists
Apparent pattern
Single "unprofessional" incidents (merit?)

Vast majority of professionals-no issues

Mandated issues

### “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)
But does any of this actually work?
Is there a Return on Investment?
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Outcomes Summary thru 2007

Results for first 336 physicians identified as “high risk”:
Improved 195 (58%)
Unimproved/worse 70 (21%)
Departed the medical group 71 (20%)
(just prior to or within a year of intervention)
Total follow-up results 336


Claims Closed with Payments Per MM RVUs

Number of claims closed with payment per million RVUs

Fiscal Year

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

<table>
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<th>TJC Item Excerpt</th>
<th>We Have</th>
<th>We Need</th>
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<td>Leadership commitment</td>
<td>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.</td>
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<td>Processes for reviewing allegations</td>
<td>Recc 4,8,11: Develop process for addressing intimidating and disruptive behaviors; Support surveillance with tiered interventional strategies; Document each level appropriately.</td>
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<td>Multi-level professional/leader training</td>
<td>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.</td>
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<tr>
<td>Resources to help disruptive colleagues</td>
<td>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.</td>
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<td>Resources to help disrupted staff and patients</td>
<td>TJC Recc 3,9,10: Encourage interprofessional 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.</td>
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