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

Gerald B. Hickson, MD

Center for Patient & Professional Advocacy
Vanderbilt University School of Medicine

A Case of:
A Deteriorating Patient

©CPPA, 2008
Case: A Deteriorating Patient

• CI, 28 y/o primagravida.
• 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

• CI developed sudden vag bleeding, OB paged. Given Methergine IM. 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.
Case: A Deteriorating Patient

- Nurse paged OB again. A CBC ordered earlier indicated that CI’s Hgb had fallen from 14.1 to 6.4.
- OB ordered 2 unit PRBCs, left to attend other pt. While blood was infusing CI became more tachycardic, BP=82/22. Nurse started 2nd IV, called for OB
- When the OB arrived he seemed...

Case: A Deteriorating Patient

- Nurse asserted CI was bleeding out
- OB became even more enraged... who is the....
- Fortunately, second nurse stat paged Anes who arrived....
Does Dr. H’s behavior warrant temporary suspension?

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

Guiding Principles for Action

- Justice
- Certainty
- Insight
- Redemption

©CPPA, 2008
Infrastructure for Addressing Unprofessional Behavior

- Leadership commitment
- Model to guide graduated interventions
- Supportive institutional policies
- Surveillance tools to capture pt/staff allegations
- Processes for reviewing allegations
- Multi-level professional/leader training
- Resources to help disruptive colleagues
- Resources to help disrupted staff and patients


What constitutes disruptive behavior?
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 interp as threatening;
- passive aggressive behaviors: e.g., sabotage and bad-mouthing colleagues or organization
- behavior that creates potentially stressful or traumatic environment and interferes with others’ effective functioning

But More Common:

- “XX came late to the meeting, then spent the remaining time on a Blackberry... didn’t listen to the discussion”
- “XX doesn’t exactly say anything you could object to, but always rolls her/his eyes and makes a face in meetings...not helpful”
- “XX doesn’t talk at meetings, but later mocks the discussion...disputes wisdom of decisions”
Why bother dealing with disruptive behavior?

Spectrum of Disruptive Conduct: Patient Perspective

- Lawsuits (tip of the iceberg)
- Voiced Complaints
- Errors
- Drop out
- Non adherence
- Bad-mouthing the practice to others
Failure to Address Disruptive Conduct Leads To

- Team members may adopt disruptive person’s negative mood/anger (Dimberg & Ohman, 1996)
- Lessened trust among team members can lead to lessened task performance (always monitoring disruptive person)... effects quality and pt safety (Lewicki & Bunker, 1995; Wageman, 2000)

Disrup Behav Leads to Comm Problems...
Comm Problems Lead To Adverse Events

- Communication breakdown factored in OR errors 50% of the time
- Communication mishaps were associated with 30% of adverse events in OBGYN
- Communication failures contributed to 91% of adverse events involving residents

“RN did not call MD about change in patient condition because he had a history of being abusive when called. Patient suffered because of this.”


©CPPA, 2008

Why are we so hesitant to act?
Balance Beam Approach to Decision Making

“Pros”

“Cons”

—©CPPA, 2008

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

—©CPPA, 2008
Why Might a Medical Professional Behave in Ways that are Disruptive?

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

ABC Analysis

- A – Antecedents
  • Anything which precedes and sets the stage for behavior
- B – Behavior
  • An observable act
- C – Consequences
  • Anything which directly follows from the behavior

Thomas Krause, PhD
Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007
©CPPA, 2008
What controls behavior?

Thomas Krause, PhD
Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007

©CPPA, 2008

What’s Right in Health Care™ | Evidence to Outcomes

If I act, is there a ROI?

©CPPA, 2008

What’s Right in Health Care™ | Evidence to Outcomes
Med Mal Research Background

- 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
- Some MDs attract more suits
- High risk today = high risk tomorrow
- Non-$ factors motivate pts to sue
- Unsolicited complaints predict claims
- Complaint profiles make very effective intervention tools re: med mal risk and unprofessional behavior

Can high risk doctors be identified by means other than counting lawsuits?

Do unsolicited complaints link to malpractice risk?
9% of MDs Accounted for 50% of Complaints (6-year study period)

Note: 35-50% get NO complaints


Predictors of Risk Outcomes (logistic regression)

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

Predictive concordance of risk models ranges from 81-92%


©CPPA, 2008
Frequency Distribution of Complaint Indexes: "You are Here"
Audit Period: mm/dd/yy - mm/dd/yy

Complaint Indexes

Distribution is based upon unsolicited patient/family complaints recorded by the Patient Relations representative. The Index 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: as set forth under "State Peer Review Statutes"

Incurred $s By Risk Category

<table>
<thead>
<tr>
<th>Pred Risk Category</th>
<th># (%) MDs</th>
<th>Mean $ Paid*</th>
<th>% of Tot. $</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>
</tr>
<tr>
<td>3</td>
<td>76 (12)</td>
<td>4</td>
<td>4%</td>
<td>21 - 40</td>
</tr>
<tr>
<td>4</td>
<td>52 (8)</td>
<td>42</td>
<td>29%</td>
<td>41 - 50</td>
</tr>
<tr>
<td>5 (hi)</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>1</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

* In multiples of lowest risk group


©CPPA, 2008
The PARS® Project

- Systematically aggregates, analyzes, and codes unsolicited patient complaints
- Identifies physicians with high malpractice related risk
- Provides a multi-level peer based intervention program for physicians identified with high risk
- Process, tools can help promote change, reduce med mal $$

Interim Observations

- More than 1,000 interventions completed
- All messengers emerged intact (so far)
- <2% responded with hostility
- Most responded professionally:
  - Asked Patient Relations to shadow, give ideas
  - Went to Chief: Asked for resources
  - Reorganized the unit
- ~15% go to Level II Interventions (Persistent pattern needing an improvement plan)
- Follow-ups ongoing
# PARS® Progress Report

Follow up Results:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good – Interv. visits suspended</td>
<td>132</td>
<td>39%</td>
</tr>
<tr>
<td>Good – Anticipate susp. in '08-'09</td>
<td>35</td>
<td>10%</td>
</tr>
<tr>
<td>Better – Still need tracking</td>
<td>31</td>
<td>9%</td>
</tr>
<tr>
<td>Unimproved/worse</td>
<td>71</td>
<td>21%</td>
</tr>
<tr>
<td>Departed</td>
<td>71</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>198</strong></td>
<td><strong>58%</strong></td>
</tr>
<tr>
<td><strong>Total follow-up results</strong></td>
<td><strong>340</strong></td>
<td></td>
</tr>
<tr>
<td>First follow-up later in '08-'09</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td><strong>Total Interventions</strong></td>
<td><strong>417</strong></td>
<td></td>
</tr>
</tbody>
</table>

## Intervention Study Claims and Exposure Years Among High Risk Physicians (Surgeons)

![Graph showing claims and exposure years](image-url)
But not everyone responds

- Ortho surgeon with 6 $ claims pre...7 $ claims post
- (refused intervention)

The Gap is Intolerable

© Studer Group, 2007

©CPPA, 2008
What if ‘L’ is a physician?

Infrastructure for Addressing Unprofessional Behavior

- Leadership commitment
- **Model to guide graduated interventions**
- Supportive institutional policies
- Surveillance tools to capture pt/staff allegations
- Processes for reviewing allegations
- Multi-level professional/leader training
- Resources to help disruptive colleagues
- Resources to help disrupted staff and patients

**Disruptive Behavior Pyramid**

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

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


**The Missing Conversation:**

"A Cup of Coffee"

©CPPA, 2008
Case: Never on Wednesday

- Daughter reported: “the doctor my mom 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. became even more upset...

The story continues:

- “Sensing that the doctor was in a hurry, I said that my mom 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!’ Turning back to the receptionist, he demanded, ‘Who consulted me?’”
The doctor walks out

- “Dr. yelled so the whole area could hear, ‘You didn’t do anything wrong. The staff did!...You need to go where they know what they are doing...I don’t do consults on Weds... months before I can book you an appt.’”

- “Then he turned and left me standing there. I don’t think that was very professional.”

- What might a member of your team do if they witnessed this event?

What would members of your team do?

1. Go see another patient...
2. Decide to investigate more before...
3. Seek to provide service recovery...
4. Report event to (pt affairs, risk, supervisor, etc.)
5. Approach directly, “I heard ...you can’t do that...”
6. Approach, “I just saw/heard...don’t understand...”
7. Send respected team member...save yourself for serious events...
8. Call a code...
9. Something else?
Balance Beam Approach to Decision Making

“Pros”

“Cons”

Infrastructure for Addressing Unprofessional Behavior

- Leadership commitment
- Model to guide graduated interventions
- Supportive institutional policies
- Surveillance tools to capture pt/staff allegations
- Processes for reviewing allegations
- **Multi-level professional/leader training**
- Resources to help disruptive colleagues
- Resources to help disrupted staff and patients


©CPPA, 2008
What's Right in Health Care

**Disruptive Behavior Pyramid**

- Vast majority of professionals-no issues
- Single "unprofessional" incidents (merit?)
- Apparent pattern
- Pattern persists
- Level 1 "Awareness" Intervention
- Level 2 "Authority" Intervention
- Level 3 "Disciplinary" Intervention
- Mandated Issues

---

**Case: Never on Wednesday**

- What might an "informal" intervention - a "cup of coffee" conversation - look like?

---

©CPPA, 2008

What's Right in Health Care™ | Evidence to Outcomes
Opening the Conversation

- “I heard...,” “I saw...”
- Review incident in as much detail as appropriate.
- Ask for colleague's view.
- Invite, respond to questions, concerns.
- Offer thanks, sincere appreciation: “You’re important, if you weren't, I wouldn't be here.”

Ending the Discussion

- Appreciation, affirmation
- Assure: conversation confidential, known only to ...
- Empathy: “Now I feel I understand, but...”
- Accountability: "But we've all got to respond professionally..."
- Reminder: “incident not consistent with policy.”
- Charge: "reflect on the issues, think about ways to prevent recurrence."
- Follow-up: “I am confident it won’t be necessary, but I'll return if ..."
A Few Guidelines/Principles for “Informal” Conversations

1. Approach like giving bad news to pts.
2. Avoid evening meetings when fatigued, rushed. Aim to minimize distractions.
4. Anticipate responses ranging from acceptance to denial to anger to hurt.

5. The higher in the hierarchy, the higher the shame and guilt (and more extreme reaction) associated with the intervention.
6. Your role is to report a serious, correctable matter. It’s not a control contest.
7. Don’t expect thanks or to feel great afterwards (but you can hope).
8. Know message and “stay on message”
Anticipate Various Reactions

- Rationalizations, explanations of behavior
- Requests for help with change
- Acceptance, professionalism
- Denial, anger, narcissistic hurt
- End-around the chain of command
- Many others

Why Bother With Such “Chats”?*

Are there any benefits for the:
- Physician?
- “Messenger”?
- Other Staff?
- Institution and/or Medical Group?
- Others?
Balance Beam Approach to Decision Making

“Pros”  “Cons”

• Fear
• Loyalty
• Culture
Enablers and Protectors

Disruptive behavior can be enabled by both individuals and/or institutions

Infrastructure for Addressing Unprofessional Behavior

- Leadership commitment
- Model to guide graduated interventions
- Supportive institutional policies
- Surveillance tools to capture pt/staff allegations
- Processes for reviewing allegations
- Multi-level professional/leader training
- Resources to help disruptive colleagues
- Resources to help disrupted staff and patients

Upcoming CPPA Conferences at Vanderbilt:

The Why and How of Dealing with “Special” Colleagues: Discouraging Disruptive Behavior
June 26-27, 2008; November 12-13, 2008

The How and When of Communicating Adverse Outcomes and Errors
August 7-8, 2008; March 5-6, 2009

Thank You for Participating in This Program

Comments and Questions
Now or Later
www.mc.vanderbilt.edu/cppa
Gerald.Hickson@Vanderbilt.edu
Jim.Pichert@Vanderbilt.edu