SENTACT

Troublesome Physicians and Providers

Your Questions Answered

1

Q: For a practitioner who needs help recognizing disruptive behavior, what programs do you the hospital setting/away from his or her peers?

A: The most common option for this is to refer the physician to the state's PHP program; they often have outside programs with whom they work and will make a referral based upon the individual's needs. CPEP (Center for Personalized Education for Professionals) offers a number of courses that can be helpful in this arena, including patient communication, inter-professional communication, and ethics & boundaries courses. A series of online courses from PBI education is offered in conjunction with the UC Irvine School of Medicine, and the University of Virginia School of Medicine offers an ECCS program (Effective Coping and Communication Skills) for physicians. The University of California at San Diego PACE program (Physician Assessment and Clinical Education) is another resource for evaluation and education. If a physician has significant insight and wants a more intensive approach, Acumen Assessments has an excellent program; this can also be a place where physicians may be mandated to attend for both evaluation and educational courses as a "final option" prior to termination of privileges. Voluntary participation by the provider usually increases chances for successful remediation. However, there are circumstances in which attendance and active participation must be mandated. In those circumstances, it is important to ensure that the provider signs a release allowing the evaluating entity to share findings and recommendations with medical staff leadership.

2

Q: Can an anger management course be mandated if the disruptive behavior pattern persists despite casual conversations (known as coffee conversations)?

A: Yes, and how that mandate is generated depends upon local facility bylaws; it is important to ensure that the proper framework has been established to manage disruptive behavior in a stepwise fashion. Depending upon how that framework has been constructed, this type of mandate needs to come from the Medical Executive Committee (MEC), directly from the Chief Medical Officer (CMO), or potentially directly from a citizenship committee. This option can also be used as an "unplayed trump card" in order to persuade a physician that behavior course correction would be a better alternative to a mandated course. When mandated participation is being contemplated, be sure to involve hospital counsel early in the process.

3

Q: When disruptive behavior and health impairments occur at the same time, causing potential harm to patients, are clinical issues addressed in peer review and impairment issues addressed separately to protect confidentiality of the health issue?

A: All clinical care concerns should land in peer review, without the influence of potential behavior or impairment issues, if possible; at times, these issues will become obvious to the peer review committee and a referral can be made to the citizenship committee. When there are combined clinical and behavior issues, both evaluation arms will pass them to the medical executive committee, where the "whole picture" can be evaluated for disposition. Although a provider experiencing health concerns that may be affecting clinical performance is entitled to basic elements of PHI confidentiality, it cannot obstruct efforts to ensure patient safety.

4

Q: Should HR be included in conversations and/or be made aware of a practitioner's disruptive behavior and/or impairment?

A: There are two instances in which HR will potentially need to be drawn into these discussions. The first is when disruptive behavior affects employed staff members; their complaints require appropriate evaluation and disposition. Employee morale and comfort level in the workplace depends, in part, on how seriously they feel complaints about disruptive physician behavior are taken. The second is when an employed physician exhibits disruptive behavior; how the employment is arranged can affect the exact mechanism by which the issue is addressed, but employment contracts should include verbiage regarding management of disruptive behavior as well. How and when to "pull the HR trigger" with an employed physician should involve discussions between the CMO and the physician employee's director. Issues that arise within the hospital setting that are felt to be relatively minor may be handled in that arena, but the medical director should have awareness of the situation.

5

Q: As a general rule, if known, is disruptive physician behavior (to both staff and patients) reportable to state medical boards?

A: If disruptive behavior is reported to the Boards by support staff, it is generally investigated. State Medical Boards are complaint driven—they can respond only to complaints that are sent, which includes complaints about disruptive behavior. The Boards are required to evaluate every complaint, even those that are anonymous, regardless of origin. The Board's responsibility in those situations is to determine if the behavior has caused, or has the potential to cause, patient harm or jeopardize patient safety. Disruptive behavior that results in disciplinary action is reportable to the National Practitioner Database (NPDB) and State Boards will investigate.

6

Q: How can the reporting of a disruptive physician be encouraged without creating an environment of finger pointing, looking over your shoulder, and lack of camaraderie?

A: Excellent and challenging question, and speaks to the need to cultivate and carefully maintain a culture of safety. Everyone in the facility should feel free to express concerns— whether urgently in a clinical setting to prevent a mistake or when there is a concern that physician behavior is worrisome—without the fear of reprisal. It can be valuable to establish a "complaint hotline" as well as employ more formal reporting structures (Midas, Datix) that can be utilized for both clinical and behavioral concerns. Staff members who make reports deserve attention to their concerns and follow-up with loop closure; apathy is the direct result of a lack of follow-up, accompanied by a fear of retaliation. Non-retaliation clauses in privileging documents and Code of Conduct for physicians should be clear regarding what constitutes potential retaliation and the consequences of pursuing those actions.

7

Q: When a collegial conversation takes place, is the first Interaction documented in the event it becomes a trend? Should there be a witness to the meeting with the practitioner? Should the practitioner sign a document that summarizes the discussion?

A: Optimally, the collegial conversations are generated from a citizenship/professionalism committee in response to a complaint; in that way the "paper trail" is initiated, with documentation of both the discussion in the committee and subsequent follow-up in the next meeting to review the conversation. As these steps are not formal disciplinary actions, there would be no need to have the practitioner sign the document unless that is desired by the facility.

8

Q: What has been your approach when the physician is not coachable?

A: Responses to coaching vary, from significant improvement to the situation in which the physician is working "within bounds" but requires intermittent soft redirection. The truly uncoachable physician should be managed in a tiered, appropriate response fashion with each issue raising the level of intervention until they have exhausted the options available. At that juncture, mandatory external courses and evaluations have an important role; if the physician is successful, adding the assistance of an external physician coach can be helpful to maintain behavior stability. In the event that the behaviors do not improve or the physician returns to disruptive actions, the documentation should be, by that point, adequate to pursue privilege termination and/or employment separation. Credentialing and exercise of privileges within a facility is not a right but, rather, an opportunity granted for professional practice that comes with responsibilities that include collegial behavior.

9

Q: Have you had to deal with physicians who are members of a physician union?

A: Neither of us has dealt with physicians in a union. However, the expected behavior requirements, and consequences for poor behavior, can be built into the union contract in a similar manner to an employed physician's contract. The union then must assume their shared responsibility for intervention when needed.

10

Q: Are there guidelines to deal with "petty complaints?"

A: If a citizenship/professionalism committee is in place, the process of documenting complaints and their evaluation provides a way of addressing repeated petty complaints. That committee has the ability to refer those individuals to their appropriate managing department (nursing, etc.) for counseling and discussions regarding expectations. Because those individuals are separate from the medical staff, it is important to ensure HR representation during those discussions.

11

Q: Can documented physician disruptive behavior be submitted to the national practitioner database (NPDB)?

A: Individuals cannot submit a report to the NPDB, but there are legal requirements for entities that must report (hospitals, medical malpractice payers, etc.). A physician who has been suspended, lost or had restricted privileges, or resigned privileges while under investigation at a facility, regardless of the cause (including disruptive behavior), must be reported to the NPDB.

12

Q: Should citizenship / professionalism committee members participate in "coffee cup conversations" or just next-level intervention?

A: The citizenship/professionalism committee members are perfectly positioned to have those initial conversations and then provide follow-up to the committee. The decision on which committee member does so should involve careful thought on the part of the committee chairperson to ensure as smooth an interaction as possible.

13

Q: In your opinion, how related are provider burnout and behavior issues?

A: Burnout, and the responses to it, comes in a variety of forms. Unquestionably, some providers respond to burnout and stress with inappropriate behaviors, and addressing both issues is important. The practice of medicine is, by its nature, stressful, some specialties more so than others. Physical, mental, and emotional fatigue can manifest in atypical and disruptive behavior. Using local and state resources to evaluate for identifiable causes is an important part of the overall process. For the "repeat offender" group, there are often underlying personality and behavioral issues that exist regardless of the degree of stress or burnout present.

14

Q: How are members selected for the citizenship committee?

A: It is helpful to have a chairperson who has had other leadership roles in the organization, and, in particular, peer review. A broad section of specialties is helpful as well, and, in general, selecting individuals who are well regarded by their peers as being collegial, focused on patient care, helpful, and responsive is an excellent step. This can provide introduction to other committee work for younger physicians, but do not omit the more seasoned physicians who have a longer perspective to offer. APP representation on the committee should also be sought, ensuring a true peer-to-peer evaluation of the complaints that arise.

15

Q: Can you give more information about the citizenship committee?

A: A citizenship committee is designed to take behavior complaints off the plate of the CMO and place them with the physician's or APP's peers for evaluation. As a result, the committee's membership should reflect the makeup of the facility's medical staff, with the CMO present as a non-voting member. Medical staff service personnel should be present to ensure documentation, access to bylaws and behavior expectations, historical documentation about a particular individual, etc. Issues involving concerns about clinical care should be referred to peer review. Actions available to the committee should be well delineated in the facility's bylaws. The chairperson is generally responsible for assigning a committee member to evaluate a complaint, conduct interviews as needed, and speak with the individual practitioner; this committee member then reports to the committee as to his or her findings and recommendations. Early intervention and a focus on provider wellness are key elements for success.

16

Q: When is it mandatory to report to the NPDB?

A: A mandatory report to the NPDB is generated whenever a physician resigns their privileges while under investigation, as well as when the physician's privileges are revoked. Optimally, a facility will not allow a physician to withdraw their privileges when found to have unacceptable behavior or clinical care concerns.

17

Q: How do you recommend utilizing FPPE to monitor adherence to performance improvement plans related to behavior?

A: The FPPE process is designed to be tailored to the individual physician's improvement needs. Identifying individuals to monitor behavior activities in areas where the physician has had issues (for example, OR manager, ED supervisor, ICU manager, etc.) with regular reporting ensures a team approach and prevents the fatigue that results in "taking your eye off the ball." Depending upon the situation, an over-the-shoulder peer coach or monitor can be extremely helpful. As always, the FPPE follow-up must be clearly and completely documented. Remember that, as opposed to OPPE, a well-designed FPPE is active and contemporaneous with clinical care as it's being delivered, so active monitoring is a must.

18

Q: How are physicians best dealt with who are not self-aware and in denial about their behavior?

A: Not an uncommon scenario. This is a situation in which professional evaluation and coaching become the best tools to utilize. Use of outside resources mentioned previously can be very helpful. After the initial evaluation and counseling process takes place, an appropriate proctor/mentor can be an "in the moment" guide to redirect a physician who does not see the effects of their behavior.

19

Q: What are next steps if the CMO does not listen or take action?

A: Hospital staff members have the dual avenues of advancing those concerns through their departments (e.g., nursing) as well as taking them to HR. MEC members may be asked to weight in if the CMO has not responded to behavior concerns in a timely way. Ultimately, if deep and unaddressed concerns remain, a formal complaint to the State Medical Board is another option.

20

Q: This is just a comment about retaliation: when we've sent follow-up letters to providers after a conversation about disruptive behavior, our letters usually say something like, "The medical staff professionalism procedure specifies that any retaliatory actions are, themselves, unprofessional behavior. Even efforts to simply identify those individuals or to speak with them about the report may be considered retaliatory, and you are advised not to take any such actions."

A: That's a great idea and is absolutely perfectly worded!

21

Q: Should AHPs be treated the same as physicians?

A: Absolutely; the same behaviors that are unacceptable for physicians are unacceptable for anyone who has privileges to provide care in your facility. The mechanisms with which to deal with those concerns vary depending upon privileging and employment status, but the citizenship/professionalism committee can play a helpful role.

22

Q: If the disruptive physician and the person who was harassed/harmed are both employed, should HR and the medical staff conduct investigations/hearings, or should just one of them?

A: For issues that arise in a hospital facility, the medical staff process must take place as it potentially affects privileging. The harassed employee should have his or her concerns concurrently evaluated by HR as well as being potentially interviewed by the CMO and citizenship committee. Ideally, the medical staff process works hand in glove with HR to ensure that significant concerns regarding the physician are provided to HR for further disposition.

23

Q: Does the potential for professional backlash exist for those seeking mental health treatment?

A: State Medical Boards typically have a safe harbor rule for physicians who voluntarily seek out help from their PHP, such that as long as the PHP does not believe patient care is at risk or a felony has been committed, a report to the Board (or hospital, professional society, etc.) is not required. This protects confidentiality, dignity, and patient safety; the PHP would be required to report more serious concerns or if the physician fails to follow through with treatment and monitoring (if needed).

24

Q: What should a medical staff professional do if leadership believes in the "good ole boys club" and likes to sweep issues under the rug?

A: This is a situation in which clear and accurate documentation is crucial to demonstrate patterns of behavior and the facility's responses. The physicians in medical staff leadership tend to be reasonably sympathetic to this concern, as they are not interested in dealing with problematic individuals who "get a pass," and they can be helpful in bringing concerns forward. In a larger system there may be avenues to ensure appropriate evaluation, particularly through HR. Again, as a last resort, significant patient care issues that go unaddressed by leadership can be reported to the State Medical Board, who may choose to investigate the specific behavior as well as the leadership's failure to take action. Most state licensing requirements include a duty to report behaviors that affect patient safety.

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