Spot at-risk behavior, intervene early

Patients can be the eyes and ears for detecting physician behavior that poses a risk to patient safety, a Vanderbilt group has learned. Over 10 to 15 years, Vanderbilt has developed a model for addressing inappropriate behavior that relies on unsolicited patient complaints as an early warning system for at-risk behavior and outlines interventions.

Often, these physicians don’t realize their behavior is a problem. If no one intervenes early, it can become a pattern, says Gerald Hickson, MD, associate dean for clinical affairs and director of Vanderbilt’s Center for Patient and Professional Advocacy, which provides education and consulting on the model.

Intimidating and disruptive behavior is often noticed by patients and families, and they may take their concerns to the hospital administration.

A handful of physicians

In a study analyzing thousands of patient complaints at Vanderbilt, Dr. Hickson and his colleagues discovered a handful of physicians—8%—who had the most patient complaints also accounted for more than 40% of the hospital’s malpractice claims and 50% of related costs.

That discovery became the basis for the Vanderbilt model, now used in at least 34 organizations across the country.

“I think increasingly, people understand the value of addressing this behavior early but fairly,” Dr. Hickson told OR Manager.

The model has these major elements:

• a surveillance system called PARS (Patient Advocates Reporting System), guided by a physician committee, which tracks and categorizes patient complaints to identify behavior patterns of at-risk physicians
• a model with 4 levels of interventions for identifying and addressing disruptive behavior (sidebar)
• physicians trained to intervene with peers.

“Cup of coffee” conversation

The first-level intervention, called a “cup of coffee” conversation, is for a single incident of unprofessional behavior, which happens in 20% to 25% of medical professionals, Dr. Hickson notes. The incident may be isolated or the first in a pattern. All clinicians should be trained and empowered to address these individual incidents, he says.

A “cup of coffee” conversation is an informal talk where a trained peer sits down with the physician to discuss the behavior, ask for the physician’s point of view, and state behavior expectations. The key is to intervene early, because if no one intervenes, the behavior can become a pattern.

There are exceptions—claims of discrimination, allegations of sexual boundary violations, substance abuse, or other impairments affecting ability to practice safely immediately go to a higher level of intervention.

Going to a higher level

A much smaller group of physicians, about 2% to 3%, have a pattern of disruptive behavior that is a threat to quality and safety and needs to be addressed at a higher level on the pyramid, Dr. Hickson notes.
These interventions require improvement and evaluation plans with accountability by the physician.

Finally, if there is no change in behavior despite these interventions, the top-level intervention entails disciplinary action, including restriction or termination of privileges.

Dr Hickson says the Vanderbilt center has used the model to oversee 1,000-plus physician interventions.

“We believe this behavior can respond to an organized approach, but the organization’s leadership has to be willing to respond,” he says. Leaders have to be willing not to blink when faced with bad behavior by a powerful physician. Some back away when they realize what’s necessary, he says.

Some physicians object

Some physicians criticized the Joint Commission’s alert on disruptive behavior, saying a code of conduct could be used to remove physicians who disagree with the administration or aren’t seen as “team players.”

“I think there are legitimate concerns,” Dr Hickson acknowledges. “But why is the Joint Commission saying medicine needs to do something about this? Part of it may be a failure by physicians at the local level to address these issues.”

Vanderbilt is careful to take its process into organizations where the medical staff will own it, he notes.

“These processes need to be driven by the medical profession. Members of the profession need to take steps to address inappropriate behavior, whether it’s cussing, throwing things, being chronically late, or not answering calls.”

If it’s true, as some physicians charge, that tools like a code of conduct can be misused, “then shouldn’t we as a profession be out in front in making sure these tools are used properly?” he asks. ✤

Information on Vanderbilt’s Center for Patient and Professional Advocacy is at

www.mc.vanderbilt.edu/centers/cppa.