

Patient Safety Tip of the Week

July 7, 2015 Medical Staff Risk Issues

We haven't done many columns on pure medical staff issues. But several recent articles have appeared that illustrate medical staff issues impacting patient safety. Disruptive physicians, aging physicians, low-volume physicians, and too-early adopters all bring issues that impact patient safety and create problems for staff morale, patient satisfaction, and hospital image.

The disruptive physician

The **disruptive physician**, of course, is typically the most difficult medical staff problem. You all know them. They bully and intimidate staff. They cut corners. They violate rules. They show up late for cases. They throw things. But when you try to take corrective action no one will testify against them. When confronted about their behavior they almost always blame someone else as having been incompetent or doing something wrong.

A very interesting viewpoint on the disruptive physician was recently published ([Gewertz 2015](#)). Gewertz begins by describing bad behaviors of physicians. Then he describes an episode where he, himself, flies off the handle when the attendant at his local gym tells him he cannot use his cell phone. (I chuckled when I read this because the previous day I, too, had reacted similarly when a store had double-billed me for a small electronic part and was unable to immediately reverse the error.) Gewertz's point is that we all have the capability of reacting boorishly at times. But the disruptive physician is not a one-time offender. Despite counseling and anger management techniques the behaviors continue. Gewertz's suggested solution is two-fold: (1) ratchet up the peer pressure and (2) treat each instance the same way you would treat a serious adverse event. He suggests that the event should be reviewed in a confidential interdisciplinary session where the nature and consequences of the interaction(s) would be discussed openly. So you are really **treating this as a "near miss"** and looking to prevent such events from leading to real adverse events in the future. He is really linking the bad behavior to threats to patient safety. Indeed, as most medical directors will attest to, sooner or later the disruptive physician is involved in an incident with an untoward patient outcome. And very often those who might have been able to intervene and prevent the incident failed to do so, whereas they would have intervened with physicians not exhibiting disruptive traits and behaviors. Gewertz's suggested process gets the problem out in the open and he hopes it would increase peer pressure to stop the disruptive behaviors and also dampen the support, overt or otherwise, that some other medical staff members provide for the disruptive physician.

Since the Joint Commission's [Sentinel Event Alert #40 "Behaviors That Undermine a Culture of Safety"](#), issued in 2008, most hospitals have taken steps to identify egregious behaviors and deal with them appropriately.

But just as bad as the disruptive physician are those described by Lucian Leape in what he considers to be the number one problem in patient safety today: we have a **culture of disrespect** (see our July 2012 What's New in the Patient Safety World column "[A Culture of Disrespect](#)"). Leape's 2-part series on the culture of disrespect ([Leape 2012a](#), [Leape 2012b](#)) and the video "[Lucian Leape on Key Lessons in Patient Safety](#)" describe disrespectful behavior in 6 categories. The first category is the disruptive physician as already noted. But the other categories demonstrate disrespect in more subtle ways.

The second category in part 1 of the Leape papers ([Leape 2012a](#)) is **humiliating or demeaning treatment of nurses, residents and students**. (This is also one of situations where people begin to "learn" disrespectful behaviors and perpetuate the problem.) A third category is **passive-aggressive behavior**, characterized by negative attitudes, criticizing authority, blaming others, etc. The fourth category, **passive disrespect**, differs from passive-aggressive behavior in that the latter is often done with anger and intent to cause psychological harm whereas passive disrespect is not malevolent or rooted in anger. Passive disrespect is much more common. It includes things like chronically being late for meetings, responding slowly to calls, not dictating charts in a timely fashion, and generally being poor team players. Resistance to good practices like hand hygiene, timeouts and use of checklists are common examples. The fifth category is **dismissive treatment of patients**. They include behavior like interrupting the patient while the patient is trying to explain symptoms, talking "about" the patient on rounds rather than "to" the patient, etc. The last category, **systemic disrespect**, includes all the system nuances that are disrespectful of patients, physicians, nurses, and all other personnel. Making patients "wait" has become an ingrained fact of life. Productivity and time pressures abound for providers of all disciplines. And minor forms are common: failure to address patients or staff appropriately, lack of "please" and "thank you", etc. Leape et al. go on to describe the consequences of these behaviors and the many endogenous and exogenous factors involved in producing disrespectful behaviors.

In part 2 ([Leape 2012b](#)) the authors discuss **what we must do to create a culture of respect**. Modeling respectful conduct and leadership are critical and this must be begun in medical school or other professional schools. In addition, they recommend that part of the evaluation process for all staff (including physicians) should include an assessment of respectful behavior (perhaps in a "**360 degree**" review where personnel at all levels have input into the assessment). Adopting a **code of conduct** is another first step. But the most important piece is responding appropriately and in a timely fashion when disrespectful behavior occurs. Developing a **learning environment** (eg. where everyone has equal input into root cause analyses, etc.) is another key to creating a culture of respect.

In our March 29, 2011 Patient Safety Tip of the Week "[The Silent Treatment: A Dose of Reality](#)" we noted a study ([DesRoches 2010](#)) which showed many physicians fail to report or confront their colleagues who are either impaired or incompetent. A third of

physicians who knew that a colleague was incompetent or impaired failed to report that physician. The most common reasons cited were belief that someone else would take care of reporting, belief that nothing would happen as a result of reporting, and fear of retribution. The same applies to addressing the disruptive physician. In that column we also highlighted the 2007 American College of Physician Executives (ACPE) Quality of Care Survey ([Steiger 2007](#)) which revealed numerous examples of failure of the system as a whole to deal with incompetent, impaired or disruptive physicians.

Turning a blind eye or deaf ear to such problems just continues to make the working environment worse for all parties involved. We've seen numerous occasions where staff had previously stepped forward to report such behaviors, only to be ignored or, worse yet, suffer retribution for their actions. So the organization as a whole needs to ensure a supportive environment is present so that staff do not feel uncomfortable in confronting such individuals or in addressing such threats to patient safety. You can have all the policies and procedures in the world but if your culture is not conducive to eliminating these hazards we will never move patient safety to that next level. You've often heard the phrase "culture trumps _____" (fill in the blank with words like policy, procedure, strategy, tactics, vision, etc). In fact, "**Culture trumps...Everything!**"

Patient complaints

The physician with **patient complaints** is often a related issue. A new study developed an algorithm to predict physician risk of formal patient complaints using routinely collected administrative data ([Spittal 2015](#)). The **PRONE (Predicted Risk Of New Event) score** is based upon 4 variables: (1) physician specialty (2) physician gender (3) number of previous complaints (4) time since last complaint. While most patient complaints (60%) were related to clinical issues, about a fifth were related to communication issues (13% related to physician attitude or manner). The algorithm led to a possible total score of 22. Those with scores of 0-2 had a 14% risk of a complaint in the next 2 years, whereas those with scores of 15-17 had an 88% risk of a complaint in the next 2 years. The authors suggest the PRONE score could be used to flag physicians needing deeper review. They also suggest one might "tier" interventions based upon the PRONE score. This is interesting and likely to be especially of interest to risk managers. But review of patient complaint patterns should be part of the credentialing process for all healthcare providers.

In our July 2013 What's New in the Patient Safety World column "["Bad Apples" Back In?"](#)" we noted a study by Bismark et al. ([Bismark 2013](#)) which found that 3% of Australia's medical workforce accounted for 49% of all complaints by patients and 1% accounted for 25% of the complaints. Moreover, there was a striking dose-response relationship, i.e. the more complaints about a physician the higher the likelihood that there would be yet further complaints. A doctor with a third complaint had a 38% chance of a further complaint within a year and 57% chance of another complaint within 2 years. For one with a fifth complaint, the chance of another complaint within 1 and 2 years, respectively, was 59% and 79%. The authors point out that we are often too late to

respond to physicians who have attracted multiple complaints and that we should really look at complaints as sentinel events. The hope is that early response may result in changes in physician behaviors. An accompanying editorial ([Paterson 2013](#)) noted that patient complaints are the “canaries in the coal mine” that should alert us to deeper problems and should not be ignored. Another accompanying editorial ([Gallagher 2013](#)) focuses on the need to end our silence and speak up and tell our colleagues about ways they can improve their care and communicate better. They argue we need to do a much better job acting locally (at the departmental, medical staff, academic unit, and clinical unit levels) to address these behaviors before they need to go to higher levels. They also note the need to develop better metrics for incorporating measures of patient satisfaction. And yet a third accompanying editorial ([Shojania 2013](#)) argues there is a systems problem and that we need to focus our resources on identifying such individuals and dealing with them. They also note that, in some cases, there may be multiple system problems that lead to a physician attracting multiple complaints (eg. understaffing in a clinical area).

We, of course, would point out that **staff complaints about physicians** are just as important as patient complaints. Sometimes the patient complaints go elsewhere (eg. to state health departments, professional disciplinary bodies, medical societies, etc.) and you may not be aware of these for some time. Staff complaints are more often available to you immediately. It would be interesting to see how the PRONE score algorithm would work using staff complaints rather than patient complaints.

The aging physician

The other big problem is **the aging physician**. This is often even more difficult a problem to deal with than the disruptive physician. This physician is usually a very well liked and respected physician who has practiced at the hospital and community for many years. But now his skill levels and perhaps cognitive capabilities have begun to decline. But he/she may not be aware of this decline and everyone is afraid to confront him/her about it. Most of his/her patients still love him/her and the board members are his/her friends or have long interacted with him/her in community activities.

In a few cases he/she wants to continue practicing because they need the income. More commonly they want to continue practicing because they love what they are doing and that is their whole life. They feel obligated to their patients and communities. Some don't have outside interests and would not know how to exist without coming to the hospital.

In the “old days” these physicians would hang out in the medical staff lounge and be asked to serve as “assistant surgeons” (they didn't have to actually be surgeons) on surgical cases. But third party payors have now largely eliminated fees for assistant surgeons in all but a few select surgical procedures. So that route for staying active in the hospital has disappeared.

You begin to hear whispers amongst staff about their concerns regarding this physician. They all know that sooner or later he/she is going to do something that might result in patient harm. But they are not willing to come forward with specific examples.

There is a good chance your hospital bylaws have not included any verbiage about physician age since they don't want to appear discriminatory. And it is extremely difficult to specify an age at which some sort of mandatory evaluation should be done. There are many physicians well in their 70's who practice just fine and some in their 50's whose skills have already deteriorated. At a recent AMA meeting the **AMA voted to approve a report saying it is time to have a system for assessing the competence of older physicians** but there was considerable sentiment expressed that screening physicians at a certain age "is inappropriate and smacks of ageism" ([Frellick 2015](#)). However, the AMA has not yet developed criteria or processes for such assessments.

Some times it is a specific physical skill or attribute that declines. We recall one physician who most staff thought was "blind as a bat" who would every year find an ophthalmologist who would certify that his vision was good enough for him to perform surgery.

Having access to truly **independent evaluations** is **critical**. Physicians on your own hospital staff are often uncomfortable evaluating a medical staff colleague, knowing that their assessment may result in that physician losing privileges. Equally important in our litigious society is the threat of a lawsuit by a physician who might lose his/her privileges. We've seen instances where such physicians have sued for restraint of trade when a colleague in the same specialty has made an adverse determination about a physician. Because of that latter threat it is often impossible to get such an assessment within the same city or geographic region.

NPR recently did a short segment on a program for evaluating aging surgeons ([Whitehead 2015](#)). They highlighted the [Aging Surgeon Program](#) at Sinai Hospital/LifeBridge Health in Baltimore and Stanford's [Late Career Practitioner Policy](#). It's pointed out that there is a dearth of literature to demonstrate that patient outcomes are any worse for older physicians than younger ones.

There, of course, is precedent in other professions where the safety for others is involved (eg. airline pilots, air traffic controllers, firefighters, etc.) for either mandatory retirement or mandatory competency screening at certain ages.

So while you are waiting for the AMA to come forward with some specific guidelines (it could be a long wait!) you should probably develop general criteria, irrespective of age, that would trigger some sort of independent competency evaluation for your physicians and consider developing an arrangement with one of the programs like the [Aging Surgeon Program](#).

Physicians returning to the workforce

Physicians **returning to practice** after a gap during which they did not practice is another issue. There are numerous reasons a physician may have had a gap in practice. The gap may have been to raise a family. Or it might have been due to illness. A few years ago we saw a period when the stock market crash depleted retirement resources for many retired physicians, who then sought to re-enter practice. Ensuring that such physicians re-entering practice are competent and up-to-date is therefore very important. In New York State we had a program at Albany Medical College for preparing physicians to reenter practice. A list of physician re-entry programs is also available at PhysicianReentry.org. And the AMA has physician re-entry resources ([AMA Physician Re-Entry](#)). A recent article in the southern California press ([Gorman 2015](#)) noted physician re-entry programs at Texas A&M Health Science Center and Cedars-Sinai Medical Center and an online program in San Diego that includes several months of course work followed by a written exam and evaluation during mock visits with actors playing the role of patients.

Risks associated with low-volume physicians and hospitals

For many years we have known that there is a relationship between less-than-desirable outcomes and certain procedures performed by surgeons or hospitals who are “low-volume” (i.e. they have performed a relatively low number of such procedures). The list of procedures subject to the low-volume effect keeps growing. Yet low-volume surgeons and low-volume hospitals persist at doing these cases.

Three recent articles in US News & World Report made the issue much more apparent to the general public. The first ([Sternberg 2015a](#)) highlighted the significant differences in mortality rates for Medicare patients undergoing certain procedures in hospitals in the lowest quintile of volume (for that procedure) compared to the highest volume quintile over the 3-year period 2010 to 2012. For example, at the low-volume hospitals the mortality rate for knee replacements was double that of the high-volume ones and for hip replacement surgery the mortality rate was 77% higher in the low-volume hospitals. Readmission rates for both procedures were also about 25% higher in the low-volume hospitals.

The second article ([Sternberg 2015b](#)) noted that 3 healthcare systems (Dartmouth-Hitchcock, Johns Hopkins, and University of Michigan) have adopted (or will shortly) voluntary limitations of low-volume surgery. The recommended minimum number of procedures per year for 10 procedures are list in a third article ([Sternberg 2015c](#)). For example, for knee replacement the recommended annual minimums are 25 per surgeon and 50 per hospital. For hip replacement the recommended annual minimums are also 25 per surgeon and 50 per hospital.

Quite frankly, we don't think some of these recommendations are rigorous enough. We wouldn't even consider having a hip replacement from a surgeon who has only done 25 cases per year or a hospital only doing 50 per year.

This issue is a dilemma particularly for rural hospitals. Rural hospitals look to surgical procedures as potential revenue sources, particularly since profit margins are low or negative on the nonsurgical patients they provide care for. The communities and hospital boards also like the idea of providing services locally so patients don't have to travel long distances for these services. We've cautioned such hospitals against setting up programs that cannot be reasonably supported by the volumes coming from their "catchment" area, keeping in mind that many of the potential patients in their geographic area are going to go elsewhere for the surgery anyway. Sometimes the counter argument is using a surgeon who has substantial volume of the procedure at another hospital who will now do surgery at both (or more) hospitals. That is not enough. There is far more to surgery than the surgeon. The rest of the surgical team and those providing the postoperative care must also have extensive experience with the procedure. That is why the newly proposed voluntary standards include case numbers for both surgeons and hospitals.

The "too early adopter"

One of the subthemes related to low-volume surgeons is the "**too-early adopter**". This is the physician (often entrepreneurial) who is pushing for a new piece of equipment or pursuing privileges to do a new procedure that has only been done in a few places. Often there is also a hidden conflict of interest (love how those device manufacturers know just who to approach to get their foot in the door!). This is the physician who threatens to "take my business" to your hospital's competitors if you don't let him/her do this new procedure at your hospital. Over the last decade we saw hospital after hospital purchase robotic surgical systems based on such threats. They'll usually also get a patient or two to contact the hospital administration to angrily ask "why aren't you letting Dr. X do this procedure?"

A recent viewpoint identified this issue as a potential safety "blind spot" ([Pradarelli 2015](#)). That article discusses a court case in which a patient sued multiple parties after suffering complications of a robotic-assisted prostatectomy performed by a surgeon who had performed a very low number of such procedures. While the plaintiff failed to prove that the device manufacturer was responsible for damages, the case reiterates that credentialing and privileging are responsibilities of the hospital and medical staff. And you need to be especially aware that new devices have a way of popping up in places like the OR with little advance notice to relevant parties. It is extremely important that your organization have in place policies and procedures that specify if and when a "vendor" may be present in an OR (or other patient care area). If you do allow them access you need to clarify what they may do and you also need to ensure they meet all the other criteria you require for anyone else going into the OR (eg. infection control training, health status screening, etc.) and that the patient is informed of and agrees to their presence. Similarly, when booking surgical or procedural cases you need to make sure

staff are on the lookout for “red flags” when unfamiliar pieces of equipment are included or when vendor presence is requested.

Your organization needs to carefully review privilege requests for “new” procedures and determine what the appropriate training requirements are for such. And don’t rely on device manufacturers for the training recommendations. Back in the ‘90’s when laparoscopic surgery was just being developed we saw all sorts of surgeons get a few days of training on pigs by device vendors and then a few proctored cases on real patients followed by issuance of a certificate declaring their competence in the procedure. We all recall that there was then a significant “learning curve” during which patient complication rates were quite high. Better to look at training recommendations from specialty societies, though even these may have some conflicts of interest. But it is pretty clear that your organization is at risk if one of your surgeons has adverse patient outcomes during surgeries that he/she has had little experience with. And don’t forget that you need to consider what training is necessary for the rest of your surgical teams when new procedures are introduced.

Dealing with medical staff issues is always very political and often generates lots of controversy. But those issues that impact on patient safety need to be addressed and with the increased attention in both the media and the medical literature now is a good time to get started.

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