Professionals’ Influence and the Malpractice Problem*: Promoting Accountability in a Culture of Safety

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“Failure free operation over time...effective, efficient, timely, patient-centered, equitable”

Requires:

- Vision/goals/core values
- Leadership/authority (modeled)
- A safety culture
  - Willingness to report and address
    - Psychological safety
    - Trust

Professionals commit to:
  Technical and cognitive competence
Professionals also commit to:
  Clear and effective communication
  Being available
  Modeling respect
  “Self awareness”

Professionalism promotes teamwork

Professionalism demands self and group regulation

Case: “Let’s Go”

• Ms. X: G1 at 39 weeks, and arrives in L&D at 8 am
• Reports regular contractions every 3-5 min for last 2 hr...on exam 2-3 cm/80%/-1...admitted in term labor
• 10 am: 3cm/90%/-1.
• 1 pm: no change...AROM...Dr. OB orders pitocin augmentation.
• 3 pm: 4-5 cm/90%/0
• 5 pm: no further change.
Case: “Let’s Go”

• Dr OB expresses concern about progress, says, “Ms. X, it looks like we’ll need to do a C-Section.”
• Ms. X says okay.
• Nursing professional takes Dr. OB aside, asks whether immediate C-Section is necessary... “could we put in an IUPC (to determine labor adequacy)?”
• Dr. OB: “Looks like FTP. Let’s go ahead with Section.”
• How might your team member (Nurse __) respond?
• From Reason’s “Unsafe Acts” algorithm (1997):
  – Did the team member intend to cause harm?
  – Did the team member come to work impaired?
  – Did the team member knowingly and unreasonably increase risk?
  – Would another team member (you) in the same situation act in a similar manner?

How prepared are you?

Do you have a reliable plan?
What are behaviors that undermine a culture of safety? And what can we do about them?
Definition of Behaviors That Undermine a Culture of Safety

- Prevent or interfere with an individual’s or group’s work, or ability to achieve intended outcomes (e.g. ignoring questions, not returning phone calls re pt care, publicly criticizing team/institution)

- Create, or have potential to create intimidating, hostile, offensive, or unsafe work environment (e.g. verbal abuse, harassment, words reasonably interpreted as intimidating)

- Threaten safety: aggressive or violent physical actions

- Violate VUMC policies, including conflicts of interest and compliance

It’s About Safety

Excepts from Vanderbilt University and Medical Center Policy #HR-027, 2010
Perhaps Even More Common:

Failure to:

– Practice hand hygiene
– Complete handoffs/documentation
– Observe time outs
– Answer pages
– Practice EBM (CAUTI, CLABSI, VAP, etc.)
– Refrain from jousting
– Adhere to safety/quality guidelines
– Others?
What barriers exist?
Why Might a Medical Professional Behave in Ways that Undermine A Culture of Safety?

1.
2.
3.
4.
5.
6.
7.
8.
Consequences of Unsafe Behavior: Patient Perspective

- Lawsuits
- Infections/Errors
- Non adherence/noncompliance
- Drop out
- Costs
- Bad-mouthing the hospital/practice to others (tip of the iceberg)

Consequences of Unsafe Behavior: Healthcare Professional Perspective

- Harassment suits
- Lack of retention
- Burnout
- Costs
- Jousting
- Bad-mouthing the organization in the community

(tip of the iceberg)

Infections/Errors

Failure to Address Behaviors that Undermine a Culture of Safety

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)... affects quality and pt safety (Lewicki & Bunker, 1995; Wageman, 2000)

• Withdrawal (Schroeder et al, 2003; Pearson & Porath, 2005)

Regression Analysis: Preoperative Risk, Patient Complaints, and NSQIP Overall Surgical Adverse Events*

* Analysis controls for # cases sampled, significant interaction, p < 0.01
## The Balance Beam

<table>
<thead>
<tr>
<th>Competing priorities</th>
<th>Staff satisfaction and retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sure how lack tools, training</td>
<td>Reputation</td>
</tr>
<tr>
<td>Leaders “blink”</td>
<td>Patient safety, clinical outcomes</td>
</tr>
<tr>
<td>“Can’t change…”</td>
<td>Liability, risk mgmt costs</td>
</tr>
<tr>
<td>Fear of antagonizing</td>
<td></td>
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</tbody>
</table>

| Do nothing | Do something |

Guiding Principles for Action

• **Justice** — Fairness for all
• **No conflict of interest**
• **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 2\(^{nd}\) goal

1. Leadership commitment (will not blink)
2. Goals, a credo, and supportive policies
3. Surveillance tools to capture observations/data
4. Processes for reviewing observations/data
5. Model to guide graduated interventions
6. Multi-level professional/leader training
7. Resources to address unnecessary variation
8. Resources to help affected staff and patients

Infrastructure for Promoting PA

• Leadership commitment
  – Hold all team members accountable for modeling...
  – Enforce code of conduct consistently and equitably
  – Recognize professionalism in action
  – Employ appropriate measures designed to reduce unprofessional behaviors.
  – Focus on behavior and performance.

Behaviors that undermine a culture of safety. SEA #40. The Joint Commission, July 2008.
Infrastructure for Promoting PA

- Goals, credo, supportive policies
  - Code of conduct ... defines acceptable and inappropriate behaviors.
  - Implement policies that address “Zero tolerance” for most egregious...
  - Protect those who report or cooperate
  - Locally defined performance standards...measures...

Behaviors that undermine a culture of safety. SEA #40. The Joint Commission, July 2008.
Policies will not work if behaviors that undermine a culture of safety go unobserved, unreported and unaddressed
What Are “Surveillance Tools”?

• Risk Event Reporting System
  – “Dr. __ entered the room without foaming in...proceeded to touch area with purulent drainage...I offered a pair of gloves...took them and dropped them in the trash.”

• Patient Relations Department
  – Record patient/family concerns: “I asked Dr. XX to explain their plan. Dr. XX said, ‘I drew a picture. If you don't get it, you just don't get it.’”

• Compliance hotline; Equal Opportunity, Affirmative Action, and Disability Services (EAD)

Promoting Professionalism Pyramid

No Δ

Level 3 "Disciplinary"
Intervention

Level 2 “Guided"
Intervention by Authority

Level 1 "Awareness"
Intervention

"Informal" Cup
of Coffee
Intervention

Pattern persists

Apparent pattern

Single “unprofessional"
incidents (merit?)

Egregious

Mandated

Mandated
Reviews

Vast majority of professionals - no issues - provide feedback on progress

Pichert et al, 2011.
Hickson & Pichert, 2012.
Hickson et al, 2012.
Pichert et al, 2013.
Talbot et al, 2013.
Hickson & Moore, in press.

Adapted from Hickson, Pichert, Webb, Gabbe. Acad Med. 2007. ©2013 Vanderbilt Center for Patient and Professional Advocacy
But does any of this work?
Med Mal Research Background 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
- Some physicians attract more suits
- High risk today = high risk tomorrow

“Dr. OB was dismissive, said I was okay... said, 'Ms. XX, go home and find something else to worry about...upset me and I cried..’”

“Dr OB and nurse told me I was faking this labor and discharged me 40 min ago...now I’m having contractions 45 secs apart, 1 min long...”

“Dr. OB’s nurse left answering machine message, ‘Contact our office immediately, you have abnormal results.’ Everyone heard...”
Academic vs. Community Medical Center Physicians

9-14% of Physicians associated with 50% of concerns

35-50% are associated with NO concerns

## 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>
</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 (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></td>
<td>100%</td>
<td></td>
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* In multiples of lowest risk group

• Letter with standings, assurances prior to & at meeting

• Risk Score Graph

• Complaint Type Summary

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**Risk Score Graph**

- All Physicians - National PARS® Data
- Orthopedic Surgeons - National PARS® Data
- Threshold for Assessment and Review **

**Threshold for Assessment and Review**: Risk Score of 144 is within top 0.5% of All Physicians and #4 of 950 Orthopedic Surgeons in the National PARS® Database

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**National PARS® Risk Score Comparisons**

Audit Period: June 16, 2009 through June 15, 2013
### Does it work? PARS® National Progress Report

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total # of high-complaint physicians</td>
<td>970</td>
</tr>
<tr>
<td>Departed after initial intervention</td>
<td>76</td>
</tr>
<tr>
<td>First follow-up in 2013 or 2014</td>
<td>120</td>
</tr>
<tr>
<td><strong>Total with follow-up results</strong></td>
<td>774</td>
</tr>
</tbody>
</table>

**Results for those with follow-up data:**

- Successfully completed intervention process: 428 (55%)
- Good – Anticipate ending visits in 2013/2014: 128 (17%)
- Some improvement – Still need tracking: 42 (5%)
- **Subtotal**: 598 (77%)
- Unimproved/worse: 124 (16%)
- Departed unimproved: 52 (7%)

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**NSQIP and Pt Complaints**

**Question:** Do Patient Complaints moderate the relationship between Preoperative Risk Factors and Surgical Outcomes?

<table>
<thead>
<tr>
<th>Preop Risk Factors</th>
<th>PARS® Categories</th>
<th>Surgical Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA Class</td>
<td>Care &amp; Treatment</td>
<td>Intraoperative</td>
</tr>
<tr>
<td>Priority Status</td>
<td>Communication</td>
<td>Wound</td>
</tr>
<tr>
<td>Wound Class</td>
<td>Concern for Pt/Family</td>
<td>Urinary</td>
</tr>
<tr>
<td></td>
<td>Accessibility</td>
<td>CNS</td>
</tr>
<tr>
<td></td>
<td>Billing w/C&amp;T concern</td>
<td>Respiratory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>
Clear and Effective Communication
• “Dr. __ did a very poor job of communicating. He raced through an explanation of what we should expect, then left without giving us a chance to get clarification.”

Respectful
• “I said I had questions. Dr.__ looked up and asked, ‘Are you illiterate?’ I said, “No.” Dr.__ responded, ‘Oh, I just gave you a pamphlet that explains it. Since you didn’t get it, I thought maybe you could not read.’”
Regression Analysis: Preoperative Risk, Patient Complaints, and NSQIP Overall Surgical Adverse Events*

* Analysis controls for # cases sampled, significant interaction, p < 0.01
Back to the opening scenario:

“Listen, NURSE, I am Dr. OB. I know what I’m doing... she’s ready. Let’s go. NOW.”
Nurse: “Called Dr __ re change in pt status...came 25 min later, looked at pt, publicly yelled at me, ‘you lied...pt okay...don’t call again’...felt threatened.

Nurse: “Dr OB wiped head w/ arms...had contact w/ pt...I asked Dr _ to re-gown, use new gloves ... replied: ‘at other hospitals... not required to wear cap, gowns [so] I guess I’ll stay in trouble here.’”

“Dr. __ was making personal calls (appt for massage) ...had pts...needed orders...I asked Dr. __’s help: ‘they can wait...,’ families overheard”
Distribution of Staff Professionalism Reports about Physicians – 3 years

- VUMC Professionalism Total Reports

- Physicians with > or = 4 Reports (n=21)

These 21 (0.75%) of all VUMC Professionals (n=2800) were associated with 26% of Reports about Behavior/Conduct.
5 Codes Account for 60% of Concerns

Oct 2007 – April 2013

% of All Staff Professionalism Concerns

- Rude, insensitive: 25%
- Problems with Treatment: 15%
- Angry, yelled: 10%
- Blame or criticize: 8%
- Didn’t listen, ignored: 6%
Distribution of Physicians and Staff Professionalism Reports

- Professionalism Reports
  - Physicians with > 3 Reports (n=27)

These 27 (1%) of all VUMC Professionals (n=2800) were associated with 27% of Reports about Behavior/Conduct.

Percent of Physicians - Thru September 2013

Total Number of Reports

[Graph showing distribution of reports and highlighting 27 physicians with >3 reports associated with 27% of reports about behavior/conduct.]

Confidential and privileged information under the provisions set forth in T.C.A. §§ 63-1-150 and 68-11-272; not be disclosed to unauthorized persons.
Staff Professionalism Concerns: Who Observed the Event?

21% observed by patients & families

- Reporter Only: 37%
- Reporter + Staff: 42%
- Reporter + Staff + Patient: 15%
- Reporter + Patient: 6%
Your role as a group/team leader

• Know what represents behaviors/performance that undermine a culture of safety
• Have a plan and a supportive infrastructure
• Address (act, report) behaviors/performance that undermine a culture of safety early and consistently

Comments and Questions
Now or Later
www.mc.vanderbilt.edu/cppa