“Over the top” or “over the hill”
New frontiers in Physician well being.

Disruptive behavior
The Aging workforce

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I have nothing to disclose
How do we avoid situations like this?
First we must change the culture

No longer tolerate bad behavior as a reflection of dedication and advocacy for patients

Changing the culture

- Redefine the “Great Doctor”
- Clarify expectations inherent in “Professionalism”
- Develop a culture of zero tolerance
It Starts Early

Unprofessional Behavior in Medical School is Associated with Subsequent Disciplinary Action by a State Medical Board

Papadakis M et al
Academic Med. 2004;79:244-249.

“Failure to address unprofessional behavior promotes more of it”

UCSF SOM graduates disciplined by the CA Medical Board (1990–2000)

• 68 Cases (graduated 1943 to 1988)
• 198 Matched Controls
• Outcome variable: state board disciplinary action
• Predictor variables:
  • gender
  • undergrad GPA
  • MCAT score
  • Med School grades,
  • NBME part 1 scores
  • professionalism severity score 1 or 2
Factors associated with CA Board disciplinary action

<table>
<thead>
<tr>
<th>Predictor*</th>
<th>OR</th>
<th>Confidence Interval 95%</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>Men</td>
<td>1.51</td>
<td>0.65-3.51</td>
<td>0.34</td>
</tr>
<tr>
<td>Undergraduate GPA</td>
<td>0.57</td>
<td>0.25-1.28</td>
<td>0.17</td>
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<tr>
<td>MCAT lowest quartile</td>
<td>1.01</td>
<td>0.50-2.05</td>
<td>0.98</td>
</tr>
<tr>
<td>Failed &gt;1 course</td>
<td>1.30</td>
<td>0.59-2.87</td>
<td>0.52</td>
</tr>
<tr>
<td>*Professionalism severity Score of 2</td>
<td>2.15</td>
<td>1.15-4.02</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Negative excerpts describing unprofessional behavior in course evaluation forms, deans letters, and administrative correspondence.*

Disciplinary Action by Medical Boards and Prior Behavior in Medical School

Maxine A. Papadakis, M.D., Arianne Teherani, Ph.D., Mary A. Banach, Ph.D., M.P.H., Timothy R. Knecht, M.B.A., Susan L. Rattner, M.D., David T. Stern, M.D., Ph.D., J. Jon Veloski, M.S., and Carol S. Hodgson, Ph.D.

235 graduates, 469 controls
University of Michigan, Jefferson Medical College, UCSF

- Annual rate of disciplinary action among practicing US physicians is 0.3%
- Students who exhibit unprofessional behavior in medical school are 3x more likely than their colleagues to be disciplined after they become practicing physicians
- Those irresponsible in attention to patient care or attendance are 8x more likely
What is Disruptive Behavior?

• AMA Code of Medical Ethics:
  “Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care.”

• The Joint Commission:
  “Behaviors that undermine a culture of Safety”

Overt as well as passive

• Verbal outbursts
• Throwing items or making physical threats
• Intimidating, bullying, or demeaning co-workers or patients
• Failing to return phone calls or pages
• Condescending language or intonations
• Refusal to answer questions
• Failure to adhere to “bundle” protocols*

*TJC Sentinel Event Alert July 9, 2008
Types of Disruptive Behavior in the OR

- Yelling/Raising voice: 79
- Abusive language: 72
- Berating in front of peers: 62
- Condescension: 61
- Insults: 55
- Abusive Anger: 52
- Berating in front of patients: 36
- Berating in private: 34
- Physical abuse: 27
- Other: 4

Rosenstein & O’Daniel  J Am Coll Surgery 2006

Who’s to blame?

Longstanding tolerance of inappropriate behavior:

“He’s always acted this way; it’s just how he is”
Impact and Implications of Disruptive Behavior in the Perioperative Arena

Rosenstein AH and O'Daniel J
Am Coll Surg 2006; 203. 96-105

Surgeons aren’t the only ones . . .
Six drivers of disruptive behavior

- 1. Substance abuse, psychological issues
- 2. Narcissism, perfectionism, or selfishness
- 3. Chronic or acute family stressors
- 4. Poorly controlled anger may have a # of contributors
  - Poor clinical administrative systems support
  - Poor practice management skills
- 5. Bad behavior gets desired results
- 6. Inertia – the behavior becomes normal for the individual

Consequences

- Poor adherence to practice guideline
- Loss of patients
- Inability to hire and retain nurses
- Low staff morale and high turnover
- Malpractice suits
- Medical errors and adverse outcomes

Hickson, GB et al Academic Medicine, Vol 82 No 11 November 2007
Patient Complaints and Adverse Surgical Outcomes

Catron TF et al, American Journal of Medical Quality 1-8 May 24, 2015

• **Hypothesis**: Does unprofessional or disruptive behavior independently threaten patient safety?

• **Retrospective study**, single academic medical center
  10,536 procedures, 66 General and vascular surgeons

• **Unsolicited patient complaints** unrelated to care & treatment
  Dr. --- was so mean and rude to my nurse in front of all of us*

• **Adverse surgical outcomes**: American College of Surgeons
  National Quality Improvement Program data.

As complexity and risk of procedure increases, so does the potential effect of unprofessional behavior on teamwork

Communication and accessibility

Single measure of relative perioperative risk: ASA classification (1-5), wound classification (4 levels contamination) and Emergency status
Why is bad behavior tolerated?

- **Competence**: may be highly respected in his or her specialty
- **Fear of retaliation**: often hold a more powerful position
- **Law suits**: threat of legal action against those involved in imposing disciplinary action
- **Money**: often they are the most financially productive for the institution

American College of Physician Executives
Physician Behavior Survey

Almost 40% surveyed agreed that:

“*physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue*”

Disruptive Physician Behavior
Owen MacDonald, Group Publisher, Quantia MD
May 15, 2011
Overcoming Barriers

Moral and ethical duty to protect patients

TJC: Sentinel Event Alert
“Behaviors that undermine a culture of safety”.

Effective January 1, 2009
Hospitals and credentialing bodies are required to develop:
1. a code of conduct
2. a process for managing disruptive behaviors

Set a standard and stick to it

• Draft a Professional Conduct Policy to:
  • Convey expectations
  • Demonstrate the commitment of leadership to uphold the ideals of professionalism
  • Provide pathways of action
  • Establish clear guidelines on how and when to begin disciplinary action
    • Suspension or termination of clinical privileges
    • Reports to licensure bodies
Model: four graduated interventions

1. *Single incident*: Informal conversation
2. *Pattern emerges*: non-punitive awareness intervention
3. *Persistent pattern*: leader developed action
4. *Failure to improve*: disciplinary action
Suspension of privileges:

• Most often involves the appointment of an Ad Hoc committee to investigate

• Can be immediate, Summary suspension: patient safety demands immediate action
  • the individual is entitled to a Fair Hearing
  • Investigative and/or administrative leave: in general subject keeps benefits and pay

Along the way: Ask why?

• Recognize the effects of stress and fatigue in our colleagues
• Consider the contribution of physical or mental illnesses
• Impairment resulting from ETOH, drugs, mood disorder, competence.
Physician Well Being Committee
A Medical Staff Committee
Mandated by TJC – January 2001

- **Purpose:** to facilitate rehabilitation rather than disciplinary action
- **Goal:** to maintain professional privileges
- Peer review committee protected from discovery under evidence codes 1156, 1157
- Medical leave resulting from intervention is not reportable to government agencies*
- Requires adherence to mandatory state and federal reporting practices

“How old would you be if you didn’t know how old you was?”

Satchel Page
AMA definition of an impaired physician

• one who is “unable to practice medicine with reasonable skill and safety ... because of physical or mental illness, including *deterioration through the aging process* or loss of motor skill, or excessive use or abuse of drugs including alcohol.”
Chesley Sullenberger was 58 when he landed US Airways Flt 1549 in the Hudson River

Experience vs. age related decline in function

Commercial pilots vs. Anesthesia Providers

*Pilots*
- Must retire at age 65
- Require physical and mental exams q 6 months starting at age 40

*Anesthesia*
- Recertification required by specialty boards q 7-10 years
- MOCA more comprehensive than multiple choice board exam
- Does not address the specifics of practitioner’s practice
- Grandfather clause excuses older practitioners (<2000)

Should we require regular cognitive and physical screening for anesthesia practitioners over 65? 70?
FAQs

• The workforce is aging
• 20% of nations physicians > 65 years

U.S. Anesthesiologists
Average Age > 49 years

U.S. CRNA's
Average Age = 46.6 years

Why not retire?

• Needs of the workforce
• Position in society
• Lifelong identity
• Financial strain
Cognitive impairment with age is a current area of interest in our specialty

“Indeed, there is little reason to believe that the prevalence in elective THJR subjects should differ from the population at large…”


What about ourselves?
The bad news

• 80% anesthesiologists > 45 yrs have abnormal audiograms
• 40% anesthesiologists > 65 yrs are unable to detect one or more of the standard equipment alarms

Wallace, MS. Hearing acuity of anesthesiologists and alarm detection Anesthesiology 1994; 81:13-28
What about ourselves?  
The bad news

• Decline in perceptual acuity can mimic cognitive function
• The variance in IQ tests among persons over 73 correlates with differences in sensory acuity
• Loss of visual acuity in young adults decreases function on cognitive tasks
• When contrast of visual stimulation is increased in Alzheimer’s patients, cognitive function improves

Can experience counteract the effects of aging?

• Educators place emphasis on experience
  • nonanalytic processing remains stable
  • analytic processing declines with age

Diagnostic accuracy

• Positive relationship between age and preliminary diagnostic accuracy
• Conflicting data - analytic confirmation skills are not as sharp

The Aging Practitioner

- Rate of disciplinary action for physicians
  
  Years out of school: 10y: 1.3 %  40y: 6.6%

- Operative mortality in complex procedures
  
  Increases with surgeon’s age >60 (really?)

- Decreased proficiency with simulated cricothyroidotomy – age and yrs from residency

Physicians’ ability to self-assess

  Little, no, or inverse relationship to external observed measures of competence

  - Khaliq et al. American Journal of Medicine vol 118 #7 July 2005
  - Waljee et al. Annals of Surgery vol 244, #3 Sept 2006
  - Siu et al. Anesthesia and Analgesia vol 111 #4 Oct 2010
  - Davis et al. JAMA vol 296 #9 Sept 2006

Association between Anesthesiologist Age and Litigation

Tessler et al Anesthesiology 2012; 116:574-9

Higher frequency of litigation and a greater severity of injury in patients treated by anesthesiologists > 65y
Systematic Review: the Relationship between clinical Experience and Quality of Health Care

• Medline review: 1960-2004
  # 62 Studies that included:
  - years since graduation or physician age
  - empirical results or Quality of Care Outcome

# 32 (52%) reported decreasing performance with increasing years in practice for all outcomes assessed

Outcomes assessed

1. Knowledge (12 studies) 100% negative association
2. Adherence to standards of practice for diagnosis, screening or prevention (24 studies) 63% negative correlation
3. Adherence to standards of Treatment (19 studies) 74% negative correlation
4. Outcomes (7 studies): focus single study
   - 39,007 pt with AMI
   - 4,546 cardiologist and internist
   - 0.5% increase in mortality for every year since graduation

Medicare files 465,000 patients, 1 of 8 operations, 1998-1999

- Age not be a primary factor in outcome
- It is a relatively weak predictor of operative mortality in aggregate

- Instead: procedure volumes

- As we age and pare down our practice, admit we are limiting future practice

Cardiovascular procedures

Surgeon age and operative mortality in the United States
Annals of Surgery Vol 244 #3 Sept 2006
Cancer resections

Adjusted to volume
The Challenge: identifying the inflection points for any given individual

Cognitive function: the good news
Increased variability with age

• On average cognitive performance declines with age
• Variability among individuals increases with age
• Many older individuals perform at levels equal or above younger colleagues
Framework for clinical assessment

Miller, GE
Academic Med
vol 65 #9 1990

Framework for clinical assessment

Specialty Board Exams
Framework for clinical assessment

[Diagram with levels: DOES (Action), SHOWS HOW (Performance), KNOWS HOW (Competence), KNOWS (Knowledge)]

Specialty Board Exams
Oral Exams
Simulation
Oral Exams
Specialty Board Exams
Late career practitioners: Constructive Proactive Approach

- Don’t wait until ad hoc investigation is required
- Draft policies and procedures that address aging practitioners in a constructive way
- Choose an age at which medical staff will be more closely monitored:
  - Design a detailed capacity-to-practice review
  - Assess cognitive function: MicroCog™
  - History and Physical exam
  - 360 evaluations
  - Allow for co-management or restricted privileges
  - A restricted or no-call schedule
  - Decrease reappointment period
Sept 2010: anonymous survey all academic anesthesia department chairs

129 queried → 51% responded

19 questions including demographics and specific policy related issues

21% had no policy regarding the employment of older anesthesiologists

% of Departments with a policy regarding the employment of older anesthesiologists

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Mandatory retirement age</td>
<td>6%</td>
</tr>
<tr>
<td>Limit hours older staff may work</td>
<td>8%</td>
</tr>
<tr>
<td>Direct older staff to non-clinical roles</td>
<td>17%</td>
</tr>
<tr>
<td>Older staff assigned only to PREOP clinic</td>
<td>17%</td>
</tr>
<tr>
<td>Utilize part time older staff for backup clinic</td>
<td>21%</td>
</tr>
<tr>
<td>Transition older staff to part time</td>
<td>23%</td>
</tr>
<tr>
<td>Assign less complex cases for older staff</td>
<td>53%</td>
</tr>
</tbody>
</table>

Dept. of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women’s Hospital, Harvard Medical School, Boston, MA
More than half of departments surveyed do not stop or limit call at any age

<table>
<thead>
<tr>
<th>Age excused from call</th>
<th>&gt;60</th>
<th>&gt;70</th>
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<tbody>
<tr>
<td>Night call</td>
<td>29%</td>
<td>41%</td>
</tr>
<tr>
<td>Late call</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>Weekend call</td>
<td>15%</td>
<td>32%</td>
</tr>
</tbody>
</table>

1990 Americans with Disabilities Act

- The right of QUALIFIED individuals with disabilities to obtain REASONABLE accommodations that will allow them to perform the essential functions of their jobs.

Reasonable:
- adjustment of hours
- allowing physicians not to take call

May represent an unreasonable accommodation depending on the size and scope of the practice.
Professionalism in Medicine: Take responsibility

National Survey of 3,054 practicing physicians
96% agreed that physicians should report impaired or incompetent colleagues to relevant authorities

45% who had encountered such colleagues had not reported them

24% disagreed that periodic recertification was desirable

*Ann Intern Med* 2007; 147; 795-802
1662 respondents / 3167 mailed questionnaires

Time to go?
Maybe not!