Recognize, Respond and Resolve:

A Proactive Approach to Addressing Clinical Performance Concerns

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Objectives

- Recognize red flags or performance patterns that can be early indicators of poor or declining clinical performance.
- Identify approaches to respond to concerns and support early intervention.
- Identify resources to resolve concerns and effectively support skill remediation or performance improvement.

Introductory Concepts

Defining Terms

REMEDIAL

1: intended as a remedy; ***2:*** concerned with the correction of faulty…habits and the raising of a [learner's] general competence ***Merriam-Webster's Dictionary***

REMEDIAL EDUCATION

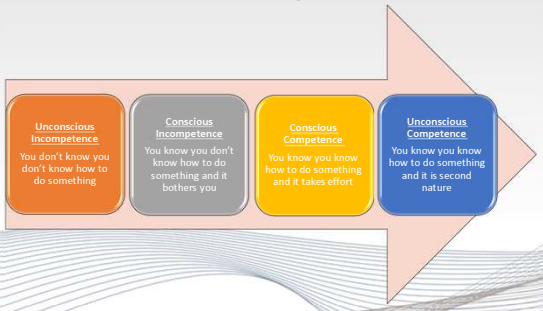
"…to assist students in order to achieve expected competencies in core … skills" ***Wikipedia***

"…is instruction provided to students who need more support in core areas" ***Study.com***

REMEDIAL EDUCATION FOR PHYSICIANS

- Refers to education addressing specific skills or educational needs related to core competencies
- Includes education designed for physicians who have educational needs in specific competencies, have been disciplined, are recovering from impairment, or are returning to practice after an absence

Levels of competence



Dunning-Kruger Effect

- People who are incompetent at something are unable to recognize their incompetence

AND

- Not only do they fail to recognize their incompetence, they're also likely to feel confident that they actually are competent

What is their level of competence?

Unconscious Incompetence → Conscious Incompetence → Conscious Competence → Unconscious Competence

- 15 year-old driver
- 18 year-old drive
- 45 year-old driver
- 87 year-old driver

RECOGNIZE

Indicators of questionable or declining clinical performance

- Patient underwent hiatal hernia repair
- Returned to ER and had another surgery
  - Doctor assured the family that the surgeries were a "success"
- Her condition worsened
- Chief of staff suggested to family that they consider use a different surgeon
- Patient underwent third surgery… ultimately died


Westword

WHAT HOSPITALS DON'T TELL PATIENTS AND THEIR FAMILIES WHEN THINGS GO WRONG

- Privileges at another hospital restricted and then reinstated with limitations
- Under review by the state board
- Multiple malpractice suit settlements
- Physician reached settlement with family
- Hospital sued for negligent credentialing
- Physician ultimately lost privileges and license

How would your hospital respond?

A surgeon who yells at OR doctors, nurses and staff whenever he is notified that a case is coming from the ER

A surgeon who does wrong side surgery, appropriately addresses the mistake; however, his op note does not accurately reflect what happened

A 75 year-old surgeon who continues to see patients even though there have been a number of cases reviewed by the QA committee

Underperforming physicians

What does the literature say?

- U.S. study estimated that 6 – 12% of physicians were dyscompetent[1]
- Canadian study of randomly selected physicians found 15% of FPs and 3% of specialists were practicing with considerable deficiencies[2,3]

1) J Contin Educ Health Prof. 2006 Summer;26(3):173-91
2) Healthcare Policy. 2009;42:141–160
3) CMAJ 1990;143:1193–1199

"The preponderance of evidence suggests that physicians have a limited ability to self-assess..."

- Review of 17 studies where physician self-assessment was compared to objective measures of competence
- Many of the studies reviewed found the worst accuracy in self-assessment among physicians who were the least skilled and those who were the most confident

Accuracy of Physician Self-assessment Compared With Observed Measures of Competence, JAMA, Vol. 296 No. 9, September 6, 2006

Aging physicians

Actively licensed physicians[1]
- 30% are >60 years old
- 52% are >50 years old

Late career physicians are still confident in their skills[2]
- 91% feel they still provide useful services
- 89% feel they can still be competitive

Studies have found skills deteriorate over time
- Adults in their 70s take twice as long to process mental tasks as those in 20s (JCEHP 2010)
- Higher risk mortality and longer patient stay in inpatient care associated with older physicians (AJM 2011)

[1]FSMB Census of Actively Licensed Physicians 2016
[2]CompHealth Survey of Late-Career Physicians; 2017/07 CPHY-20200

Problematic peer communication

Intimidating/unprofessional behavior on medical teams can
- Foster medical errors
- Contribute to poor patient satisfaction
- Lead to preventable adverse outcomes
- Increase the cost of care
- Lead to excessive staff turnover

"Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment."

The Joint Commission, Sentinel Event Alert, July 9, 2008

Patterns are important

- Studies have found that a small number of doctors account for the majority of complaints or claims[1,2,3]
- Those who have more than one claim/complaint are at higher risk of having another over time
  - In an Australia study, doctors named in a third complaint had 38% chance of further complaints in a year and a 57% chance of another complaint within 2 years[2]

[1]Hickson GB, et al. Patient complaints and malpractice risk. JAMA. 2002 Jun 12;287(22):2951–2957
[2]Identification of doctors at risk for recurrent complaints: a nation study of healthcare complaints in Australia. BMJ Qual Saf. published online April 10, 2012
[3]Prevalence and Characteristics of Physicians Prone to Malpractice Claims. 2016 Jan 28; NEJM374:4

Warning signs

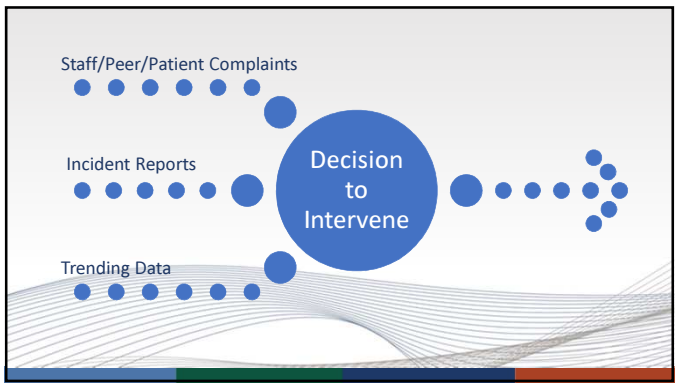
- Outside chart review identifies concerns
- Significant patient harm
- Fitness for duty (following health issue)
- Questions about procedural skills/decisions
- Returning to practice after absence

More warning signs

- On-going patient/staff complaints
- Trending data is outside norms
- Multiple malpractice suits
- Patterns of inadequate treatment
- Inadequate supervision of PAs or residents
- Failure to improve after FPPE
- Aging physician

RESPOND

Don't ignore issues when they arise



2015 NPDB Guidebook

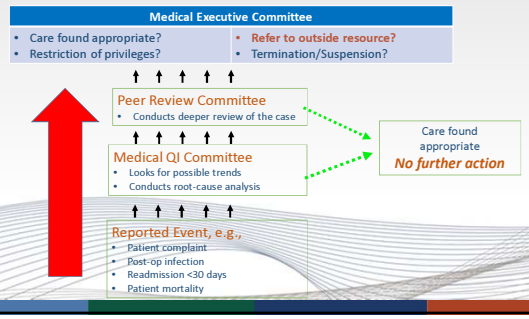
- HCQIA – Actions that "adversely affect" privileges longer than 30 days must be reported
- Key Issues under new NPDB Guidebook:
  - Expanded definition of "adversely affect" requiring NPDB report
  - Expanded definition of "suspension"
  - Expanded definition of "investigation" that requires NPDB report if physician "surrenders" privileges
  - Expanded approach to "surrender" of privileges

Early intervention

- If addressed early and effectively
  - Win-win situation for physician, medical staff and patients
- If overlooked too long
  - Possibility of significant patient harm
  - Damaged relationships on staff
  - Legal consequences for hospital and physician
  - Could reach point that NPDB reporting is required

Ultimately, hospital could lose needed physician from staff and physician could lose career

Internal Review



External Peer Review

- Used to provide objective expert review of one or more cases that have been identified by the facility
- Often used
  - To avoid perceptions of conflict of interest
  - When second opinion or outside expertise is needed
  - When there is a lack of qualified clinicians on staff for specific specialty
  - When new technology is being used
  - When there is a high likelihood of litigation

Physician Health Program

- Provide peer assistance services
- Aid individuals who have health or mental health problems that could affect ability to practice
- Offer assessment, referral, monitoring and support services
- Are non-disciplinary and confidential
- Are available in most states – scope of services provided varies

http://www.fsphp.org/State_Programs.html

Competence Assessment Programs

- Focus on physicians whose clinical competence has been questioned
  - Referred by a regulatory agency
- Conduct comprehensive assessment
  - Relevant to core competencies
- Provide remedial education that identifies specific expected activities and goals

Guidelines for Physician Enhancement Programs
Coalition for Physician Enhancement

External Peer Review vs. Assessment

External Peer Review	Competence Assessment
Purpose: Provide objective evaluation of patient care to determine if standard of care met	Purpose: Evaluate clinical competence and skills, and provide educational recommendations
Process: External expert evaluation of patient charts identified by facility	Process: Objective, comprehensive assessment using multiple test modalities
Usually does not provide recommendations for next steps	*Offers recommendations to help address areas of need identified*

Competence Assessment

Case Study: Questionable Care

- 56 year-old Internist
- New to small community hospital after long career at academic medical center
- Nurses began complaining about care
- Patient death shortly after doctor saw the patient

Case Study: Questionable Care

Assessment Findings

- Acceptable documentation, communication and health/cognitive function
- Knowledge and judgement deficits
  - Struggled with management of complicated cases

Case Study: Rocky References

- 64 year-old ophthalmologist
- Went to work for a large group practice
- Applied for privileges
- Recruiter did not anticipate problems
- Peer references indicated some subtle questions about competence

Case Study: Rocky References

Assessment Findings

- Demonstrated some out of date knowledge
- Problems with clinical thinking and organization
- Failed cognitive function screen

Case Study: Concerning Clinical Care

- Critical care physician in practice with her father
- Concerns
  - Lack of indications for procedures
  - Deficiencies in patient consents
  - Poor communication with nurses
  - Responds defensively and blames others
- Two prior external peer reviews
- New CMO suggests competence assessment

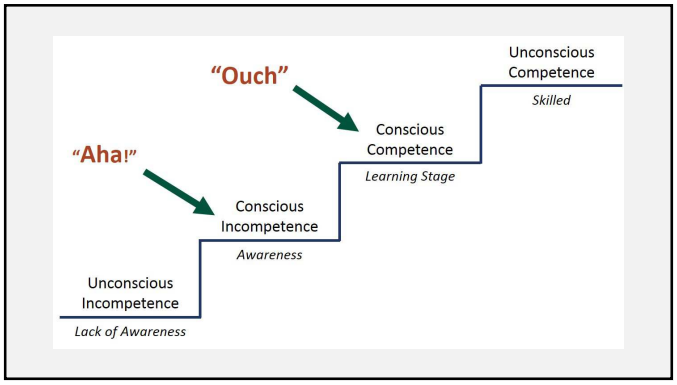
Case Study: Concerning Clinical Care

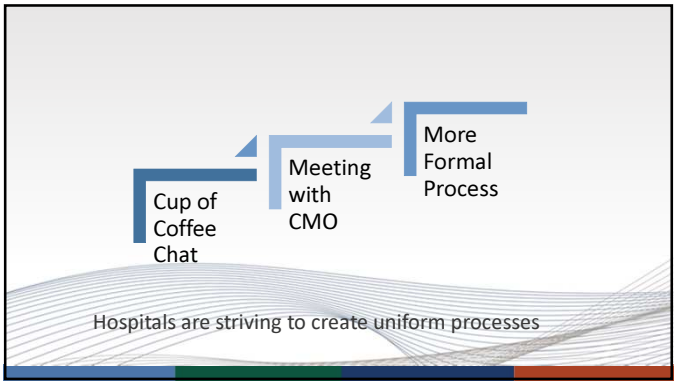
Assessment findings

- Fair knowledge but significant deficits in diagnostic imaging and mechanical ventilation
- Limited ability to reach correct diagnosis and assess acuity
- Marginal documentation
- Poor patient communication

RESOLVE

Create an Effective Intervention





FPPE Process

- Chart reviews
- Observation
- Coaching

FPPE can be used to gather more data or to enhance skills – if improvements are not achieved and sustained, consider external resources

"The first step is a talk with CMO and MSP (together) to bring issue to physician's attention…

If it continues, they refer pretty quickly…

It is a change from prior years where the same issues often dragged on for years with no behavior change."

Medical Staff Director

Intensive Skill-building Seminars

Use principles of effective continuing medical education

- Intensive (2-5 days)
- Limited class size
- Use tools such as
  - Personal Improvement Plans
  - Chart Reviews
  - Feedback or Post-Program Report from Faculty
  - Follow-up or coaching option

Look for practical personalized educational options

Intensive Skill-Building Seminars

- Medical Recordkeeping (follow-up chart reviews)
- Professionalism/ethics/boundaries
- Communication (with peers or with patients)
- Disruptive behavior
- Prescribing controlled drugs
- Specialty courses on specific procedural skills

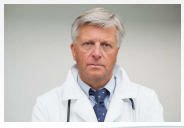
"I was never taught this in medical school"

Case Study: Inter-professional Communication

Professionals who struggle in their communication and interaction with colleagues – Negatively impacting team function and potentially patient outcomes

- Surgeon yells at nurses, doctors, and staff
- Several talks with CMO
  - "It won't happen again…"
- Referred to intensive inter-professional communication seminar

Case Study: Inter-professional Communication



- Learned about personality profiles, emotional intelligence, team dynamics, stress management
- Developed personal improvement plan
- Received a written report from faculty

Doctor shared with CMO that his perspective had changed…
Partners called to say he was easier to work with…
Wife called to thank them!

Case Study: Clinician-Patient Communication

- Displayed nonverbal mannerisms that were off-putting to patients
- Enrolled in clinician-patient communication seminar
- Through practice sessions with actors
  - Received real-time feedback about how his nonverbal behavior affected the relationship
  - Tried a variety of new behaviors

Participant was able to practice and refine his communication skills…
Demonstrated the ability to make more meaningful connections with patients

Case Study: Professionalism

- Young surgeon did wrong site surgery
  - Realized mistake while patient was in recovery
  - Explained situation and obtained patient consent to return to OR
- Operative note indicated that error was identified and fixed *while still in OR*
- QA committee felt note was evasive and misleading

Case Study: Professionalism

- Required to attend professionalism intervention
- Gained clarity about how to make good decisions when faced with competing pressures
  - Realized that stress had impaired her judgment and her ability to focus on the welfare of his patient

"In her final essay, he acknowledged that she had failed the hospital leadership and her colleagues, and developed a plan to change her behavior going forward."
Course Director

Education Intervention
following competence assessment

- Didactic: varies, often a combination
  - CME: on-line, home study, in-person
  - Directed self-study
  - Research using appropriate sources
- Practical (clinical)
  - Shadowing in clinical setting
  - Mini-residency model (hands-on versus shadowing)
  - Practice-based: work with preceptor in home community
    - Can include supervision of care, retrospective chart reviews, regular meetings to discuss care
  - Combination

Case Study: Rocky References

Ophthalmologist applying for privileges… peer references raise questions

Outcome

- Referred to PHP for neuropsychological evaluation
- Determined that he could not practice with safety
- Told to stop practicing immediately

Case Study: Unnecessary Procedures

Internist – recently moved to smaller community

Educational Intervention

- Targeted CME courses
  - Inpatient care; patients with multiple co-morbid conditions
- Met with preceptor weekly for six months
  - Reviewed patient charts, discussed application of knowledge

Outcome

- Physician successfully completed plan
  - Reconnected to medicine and rejuvenated in career
- Hospital satisfied with improvements

Case Study: Concerning Clinical Care

Critical care doctor – in practice with her father

Educational Recommendations

- Intensive educational intervention including
  - Direct observation of specific procedures
  - Preceptorship for 6 months
  - Documentation course
  - Communication course
- Reduce practice volume

Outcome

- Physician refused to comply with recommendations
- Hospital moved forward to suspend privileges

Follow-Up

Follow-up supports long-term success and helps maintain behavior change

- Personal Action Plan
- On-going feedback
- Accountability Partner
- Coaching

Maintaining change can be challenging for anyone…
so supporting behavior change and giving timely feedback is important

Sample Action Plan

Action Plan for Sustained Change

Name: _____ Date contract established: _____

Please record: 1) the development priorities you have identified and your specific objectives, 2) what will be different (bottom of page), 3) action plans and strategies, 4) the involvement of others to support your efforts, 5) your target date(s) for completion, 6) progress to date (to be reviewed with coach)

STEP 1: Development Priority	STEP 3: Action Plans/Strategies	STEP 4: Involvement of others	STEP 5: Target dates	STEP 6: Progress to date
Development Area: Goals: (*SMART) 1. 2.				(To be updated prior to coaching sessions)
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STEP 2: What will be different when I succeed at reaching my goals? Who will notice? What will be different for me?

Consider Proactive Intervention

Don't wait until it's too late!

Resources

FSMB Directory of Physician Assessment and Remedial Education Programs
http://fsmb.org/Media/Default/PDF/USMLE/RemEdProg.pdf.pdf

Coalition for Physician Enhancement
http://cpe.memberlodge.org/organizationalmembers

Questions?

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