Managing Physician Fitness to Practice

A Five-Step System to Address Physician Behavioral Issues
Physician Executive Council Membership at a Glance

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A Persistent Problem

Speaking to CMOs about how they deal with recalcitrant physicians typically provokes vivid responses. The worst offenders—the "scalpel-throwers"—typically jump to mind first. But those outliers just begin to capture the full array of very serious physician issues that physician leaders manage—from substance abuse and mental health issues, to the effects of aging, to passive-aggressive or abrasive communication. All of these issues (and more) put physicians at risk of undermining a culture of safety and pose potentially grave risks to patient care and staff engagement. Some of these physicians may even be unfit for practice.

CMOs often deal with these issues on a one-off basis, operating without clearly defined supports and consequences for at-risk or struggling physicians. Although a haphazard approach will not succeed in managing these issues, a strictly standardized system is not the answer either, as it misses the human element at the core of behavioral issues. Every physician has a unique set of personality traits, experiences, and environments that may impact his or her behavior—managing issues of fitness for practice requires understanding and adapting support systems to these unique drivers. Fortunately there is a sweet spot for hospital organizations to adopt which identifies and addresses physician issues in a fair, systematic way, yet is sufficiently flexible to meet the needs of the affected individual.

We interviewed three physician leaders involved in managing physician fitness issues at their respective institutions to find out what systems were in place: Campbell Medical Center, a 300-bed hospital in the Midwest; Park Nicollet Health Services, a two-hospital health system in St. Louis Park, Minnesota; and Vanderbilt University Medical Center, a four-hospital health system headquartered in Nashville, Tennessee. All of these organizations have successfully built systems to identify issues before they cause serious harm to patients, staff, or physicians, and they support the physician's safe return to practice whenever possible. To help other organizations learn from their experiences, this briefing covers:

• An overview of the three foundational elements critical to success at all of the organizations
• A proposed five-step process for managing behavior issues, with analysis on how the interviewed organizations implement each step

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1) Pseudonym.
Three Foundational Elements for Success

To support the management of physician fitness issues, all of the interviewed organizations have three essential infrastructural elements in place.

First, they have established **organization-wide standards for professional behavior**. These standards apply equally to all physicians and staff, and fit with the values and mission of the organization. Setting clear expectations ensures physicians and staff can be held accountable when their behavior does not meet that standard.

Second, leaders are firmly committed to **systematically addressing physician fitness issues**—even in the face of negative short-term consequences. For example, if the physician with the most patient complaints is also a top revenue-generator for the hospital, he or she must be held to the same behavioral standards and put through the same process as everyone else. Demonstrating this commitment at all levels of leadership—from service-line leaders to C-suite executives—is essential to maintaining a culture of accountability for professional behavior.

Finally, every organization has a committee or **dedicated HR partners that oversee the management of physician fitness issues**. These committees and partners do not necessarily exclusively deal with physician fitness issues—for instance, they may also manage employee behavioral issues. Here is an overview of the approaches at the three profiled institutions:

- **Campbell Medical Center** established a Professional Wellness Committee to educate, evaluate, and support physicians on professional behavior and well-being. This committee is designed to protect the confidentiality of physicians who seek or are referred for support, and it is carefully separated from authoritative bodies like the Credentialing Committee and Medical Executive Committee. This separation is critical to preserve physician confidentiality and trust—physicians know that seeking help from the committee will prompt support, not consequences.

- **Park Nicollet** uses HR Business Partners who are assigned to work alongside clinical-administrative dyads at the service-line level. These partners draw upon the expertise of HR centers of excellence such as Employee Relations and Employee Occupational Health to work closely with service-line leadership throughout the process of identifying issues, guiding physicians to supportive resources, and—as needed—disciplinary action. The advantage to aligning the management structure this way is that the HR Business Partners maintain great familiarity with both the individual incidents and the physicians involved, allowing them to watch for patterns and craft responses to each individual situation.

- **Vanderbilt** established a Center for Patient and Professional Advocacy to support their professional behavior management system.

With these fundamental components in place, organizations then can follow a five-step process to successfully manage physician behavior issues.
Five Steps to Manage Unfit Behavior

**Figure 1: Five Steps to Manage Unfit Behavior**

**Step 1: Culture of Prevention**

Perhaps the most important piece of managing unfit behavior is working to prevent it in the first place. Leaders at all of the represented organizations create a culture where safe, professional behavior is the expectation. This includes educating physicians, staff, and leadership on organization-wide behavioral standards, providing support to encourage healthy behaviors, and providing access to resources and support systems. For instance:

- The Professional Wellness Committee at Campbell Medical Center hosts an annual wellness dinner for new physicians and their spouses. The event is designed to raise awareness of the importance of physical and mental wellness, and to inform physicians of the resources available to them.

- Park Nicollet’s Surgical Services service line holds an annual “Culture of Safety Day,” with the aim of setting expectations for communication and behavior. No elective surgeries are done, and all operating room personnel, physicians, and mid-levels meet offsite for an intensive session of presentations, discussions, and face-to-face interactions. The event was instituted to build a culture in which all physicians and staff are comfortable—and feel responsible for—voicing their concerns related to safety and behavior, and do not fear retaliation.

**Step 2: Pattern Identification**

To identify instances of unfit behavior, organizations do not rely on a single method to catch all occurrences; they cast a wider net by using multiple methods. The goal is to maximize the information available in order to improve the chances of spotting a problem—and determining if it’s indicative of a pattern of behavior. All of the interviewed organizations relied on three primary channels to uncover unfit behavior.

- **Electronic staff reporting systems**: Campbell Medical Center and Park Nicollet instituted electronic reporting systems to register staff complaints. Incidents are formally documented, and those reviewing these records, such as Park Nicollet’s HR Business Partners, can analyze incidents to spot patterns over time. A culture of trust and accountability will encourage
staff to report incidents; when possible, administrators should follow up with the person reporting the incident so they know the organization is responding to their concerns in a constructive way.

- **Reviewing complaint-related data trends:** The Vanderbilt system identifies outlier physicians by reviewing data trends on patient complaints, staff complaints, and adherence to clinical standards. In just about any of the aforementioned data distributions, a small percentage of physicians will be responsible for a high proportion of complaints.

- **Self-reporting:** A very small percentage of physicians will self-report that they are having a problem. Generally speaking, self-reporting does not trigger a formal intervention, but it does provide access to supportive resources. At Campbell, physicians are able to go directly to the chair of the Professional Wellness Committee. Similarly, Vanderbilt offers a Physician Wellness Program to assist both mandated and self-referrals. Importantly, physicians who turn to these resources know they can expect confidentiality—not even their department chair will know they are seeking help.

**Step 3: Causal Analysis**

Once a physician is justifiably suspected of or has demonstrated unfit behavior, the responsible committees or individuals should analyze the root cause of the behavioral issue to identify the proper intervention. This step requires involvement from both the committees and the physician in question, and may also include expert clinical, behavioral, and psychosocial analysis. Importantly, this is not a one-time process: as physicians go through interventions, they may be re-evaluated and new information may come to light that informs the intervention.

- At Campbell Medical Center, clinical leadership and members of the Medical Executive Committee may request a formal evaluation by the Professional Wellness Committee. The committee then conducts an assessment of the physician’s behavior and practice, and returns that report to the requester.

- Clinical leadership at Park Nicollet leverages the expertise of their HR Business Partners to identify the appropriate intervention track based on the type of issue. There are three major categories: quality-of-care problems, disruptive behavior, and loss of competency—each of which has a related intervention described in step four.

- Additionally, the American Medical Association recently voted to develop competency guidelines for elderly physicians. Although the AMA has not specified how regular these assessments should be, the guidelines will include tests of physical and mental health as well as a review of the physician’s cases.

**Step 4: Supportive Intervention**

Once the root cause of the disruptive behavior has been identified, the organizations support physicians through a tailored program, leveraging existing intervention options, to address the underlying issue. The key at this step is to be supportive—not punitive—but firm. Physicians must understand that the behavior is unacceptable, but they must be given the resources they need to resolve the underlying issue.

Vanderbilt has a formalized system for escalating interventions called the [Professionalism Pyramid](#) (see Figure 2).
• A single incident of unprofessional behavior results in a “cup of coffee” intervention. This is a non-directive, non-punitive conversation between the affected physician and a peer. It is usually neither investigated nor documented. The aim is to provide the physician an opportunity to reflect on a specific incident and consider ways to prevent its recurrence.

• A pattern of poor behavior leads to an awareness intervention. A physician trained in delivering non-judgmental messages is paired with the physician for a conversation supported by the relevant data. No causal analysis is conducted at this level. The aim is to make the physician understand how he or she differs from his or her peers—whether due to an excess of patient complaints or consistent failure to comply with a certain protocol. Roughly 80% of physicians will respond positively to this type of peer intervention and take steps to correct the problem.

• Physicians who fail to correct their behavior then receive a guided authority intervention. This stage includes a mental health evaluation, after which physicians are connected to the most appropriate resources for their situation. Potential resources include coaching, anger management classes, personal health care, practice management review, or teamwork skills training. Of those individuals who make it to this step, roughly 60% respond positively to these additional resources.

• If the behavior is not resolved after guided intervention, physicians receive disciplinary intervention, which is further described in the fifth and final step of the process.

References

Figure 2: Vanderbilt’s Professionalism Pyramid
At Park Nicollet, interventions are paired to three issue tracks: quality-of-care problems, disruptive behavior, and loss of competency.

- Issues related to quality of care are referred first to the department chair for assessment and intervention; they may then be referred on to a local peer review committee for further assessment. Issues that are ongoing or are very serious in nature may go to the credentialing committee for further assessment and possible action.

- Problems indicating a possible loss of competency—for example, due to aging or a medical condition—are elevated to the department chair for assessment. The department chair and/or the service line chief will partner with the HR Business Partner and Employee Occupational Health to determine if additional evaluation and/or intervention are required.

- Physicians demonstrating disruptive behavior are initially handled by the department chair and service line chief. These clinical leaders will investigate the situation and work with their Business Partner to leverage best practices and processes for addressing the issue, which could include coaching, written letters of warning, and referrals to resources such as a physician employee assistance program or an internal coach. If a physician were to fail these interventions, he or she would face the possibility of termination.

**Step 5: Consistent Consequences**

When physicians have been given the opportunity to correct their behavior and fail to do so, hospitals are justified in taking disciplinary action—and they must do so. At this stage, all three organizations leverage a similar strategy: referring physicians to the highest administrative bodies in their organization. These include:

- **Credentialing Committees**, which may conduct a Focused Practice Professional Evaluation (FPPE). This six-month process involves a full audit of the physician’s practice. Failure on an FPPE has heavy consequences, including loss of privileges being reported to the National Practitioner’s Database.

- **Employment Committees**, which may review whether the behavior fails the terms of the physician’s contract. Ultimately, physicians who continually fail to correct their behavior may be subject to termination.

- **Legal teams**, particularly when there is potential for a malpractice suit.
Additional Resources

All three organizations profiled in this paper sometimes refer their physicians to resources outside their own organizations for assessment and support. Internal resources have two major limitations that may make external supports preferable. First, a physician may not want others within their own organization to know they are seeking treatment. Second, because doctors may be adept at “gaming” the treatment system in their favor, it’s important for physicians to be treated by professionals with experience working specifically with physicians. These organizations shared some of the support resources they use, including the following:

- **State programs**: Many state medical associations or boards of medicine provide support programs for physicians with mental health or substance abuse issues. For example, the Ohio Physician Health Program provides a structured five-year program that allows physicians to receive assessment and treatment while protecting their medical license. As long as they complete the program, physicians do not have to report their treatment to the Board when they renew their license. A complete list of state programs is maintained by the Federation of State Physician Health Programs.

- **Professional Renewal Center of Kansas (PRCK)**: A team of psychiatrists and internists conduct a multi-day assessment of physicians’ needs, then offer tailored treatment programs. PRCK also gives a CME course called “The Program for Distressed Physicians” with the aim of teaching new behavioral skills to physicians exhibiting disruptive behaviors.

- **VITAL WorkLife’s Physician Employee Assistance Program**: This service provides both proactive support to help physicians maintain a healthy work-life balance, as well as support services for those experiencing a problem. The program provides a broad range of services, from retirement planning to help for a sick family member. The Physician EAP teams include psychologists, peer coaches, and a variety of other professionals whose services can be matched to the needs of individual physicians.

- **Vanderbilt Center for Patient and Professional Advocacy (CPPA)**: In addition to supporting Vanderbilt’s internal management system, the CPPA also partners with organizations across the country to help them implement similar programs. The program provides partner sites with data tools, training, and effective processes for identifying and managing physician behavioral challenges. CPPA also maintains a list of nationwide programs accepting referrals for physicians with behavioral challenges, which includes the Vanderbilt Center for Professional Health and the Vanderbilt Comprehensive Assessment Center for Professionals. For more information about available services, contact the CPPA.