# Provider Professionalism: maintaining respect and civility

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# Case 1

Dr. Jones is a high-volume interventional pulmonologist seeing their patient in the pre-operative area before a planned indwelling pleural catheter placement.  The OR schedule is running late and Dr. Jones is frustrated by the delays.

The pre-op nurse notices a lack of site / laterality confirmation on the pre procedure check list and asks Dr. Jones to complete this task.

Dr. Jones rushes over to the patient, marks the L thorax, tosses the pen on the floor and states in an aggressive tone "the site is marked, now get my f***ing patient into the OR"…

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**Thoughts ?  Next Steps ?**

# Case 1

- …shortly after the incident the OR nursing director, PCCM fellowship director, and several other faculty members approach you (the PCCM division chief) and recall many prior incidents of aggression – including inappropriate humor with discriminatory language, bullying of trainees, and sexist comments to office / OR staff

- Understandably, they demand action and want the physician “fired today”…

- When the department chair hears about the incident, they ask you for the documentation regarding the prior professionalism incidents

- Unfortunately, there are no specific records of the prior incidents or of any follow-up conversations / corrective actions….

# Case 2

Dr. Adams is a respected ICU attending physician with a reputation for being an excellent clinician, educator and colleague. On a busy morning in the ICU a stable patient is transferred out urgently to the medical team to make space for an admission.

The medical team resident is asking several clinical questions of the ICU fellow – Dr. Adams walks over and states: “we are running an ICU here, all of this is in the medical record, now please accept the damn patient and move on…”

Dr. Adams has no other professionalism complaints…

# Case 2

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Dr. Adams has no other professionalism complaints…

**Thoughts ?** **Next Steps ?**

# Case 3

Dr. Smith is your ICU director with high clinical standards and expectations for care / quality improvement on the unit. Although Dr. Smith is very knowledgeable and a clear expert, they are often perceived as “condescending” and even “belittling” during patient rounds and in conversations with nursing and RT colleagues; in fact, a new second year resident left after rounds last week in tears following an interaction with Dr. Smith.

As division chief, you meet with Dr. Smith to review the feedback and learn that Dr. Smith received negative resident reviews at their prior job due to similar concerns – but Dr. Smith had dismissed the feedback since residents “know nothing”…

# Declining Civility in the U.S.

- 2023:  American Bar Association Annual Survey
  - 85% of respondents stated civility is worse compared to 10 years ago
  - 53% of respondents attribute this to media / social media
  - 19% of respondents attribute this to elected officials

- U.S. Healthcare Facilities Face a “Pandemic” of Workplace Violence
  - U.S. Bureau of Labor statistics = 63% increase in healthcare worker injury from 2011 – 2018
  - 2021 survey, National Nurses United = 2-fold increase in workplace violence between 2020 - 2021

# Burnout in U.S. Physicians / Providers

- AMA *Organizational Biopsy* and *Joy in Medicine* programs
  - Evaluate 6 domains --
  - Job satisfaction, job stress, burnout
  - Feeling valued, total work time / week, intention to leave practice

- Physician burnout peaked at 62% in 2021

- Burnout rate has steadily decreased –
  - 53% 2022
  - 48% 2023
  - But still… this is high!

# Professionalism is a Patient SAFETY Issue

**Patients under the care of disrespectful physicians:**

**20-30%**
more likely to have a surgical site infection…

**20-40%**
more likely to develop sepsis…

**24-30%**
more likely to die if trauma care is required

**Physicians who model disrespect account for:**

**50-70%**
of an organization's malpractice claims experience and cost

**Disrespectful team members create a ripple effect that impacts, culture, performance and retention:**

**INCREASED**
- Withdrawal
- Anxiety
- Jousting

**DECREASED**
- Creativity
- Learning
- Motivation

Hickson, et al., JAMA, 2002 | Moore, et al., Vanderbilt Law Review, 2006 | Felps, et al., Research & Organizational Behavior, 2006
Hickson, et al., So Med J, 2007 | Cooper, et al., JAMA Surgery 2017 & 2019 | Cooper, et al., Annals of Surgery, 2022

# Managing Disruptive, Unprofessional Behavior

Case 1

- Policy Violator (e.g. discrimination, sexism, sexual harassment)
- Repeat Offender
- Lack of documentation / intervention

- ACTION: urgent, policy violation-focused, near "final written warning"

Case 2

- Regarded clinician and professional
- First offense

- ACTION: urgent, peer / leader conversation

Case 3

- Regarded clinician
- Poor interpersonal / communication skills
- Infrequent, but repeat offender (e.g. pattern of behavior)

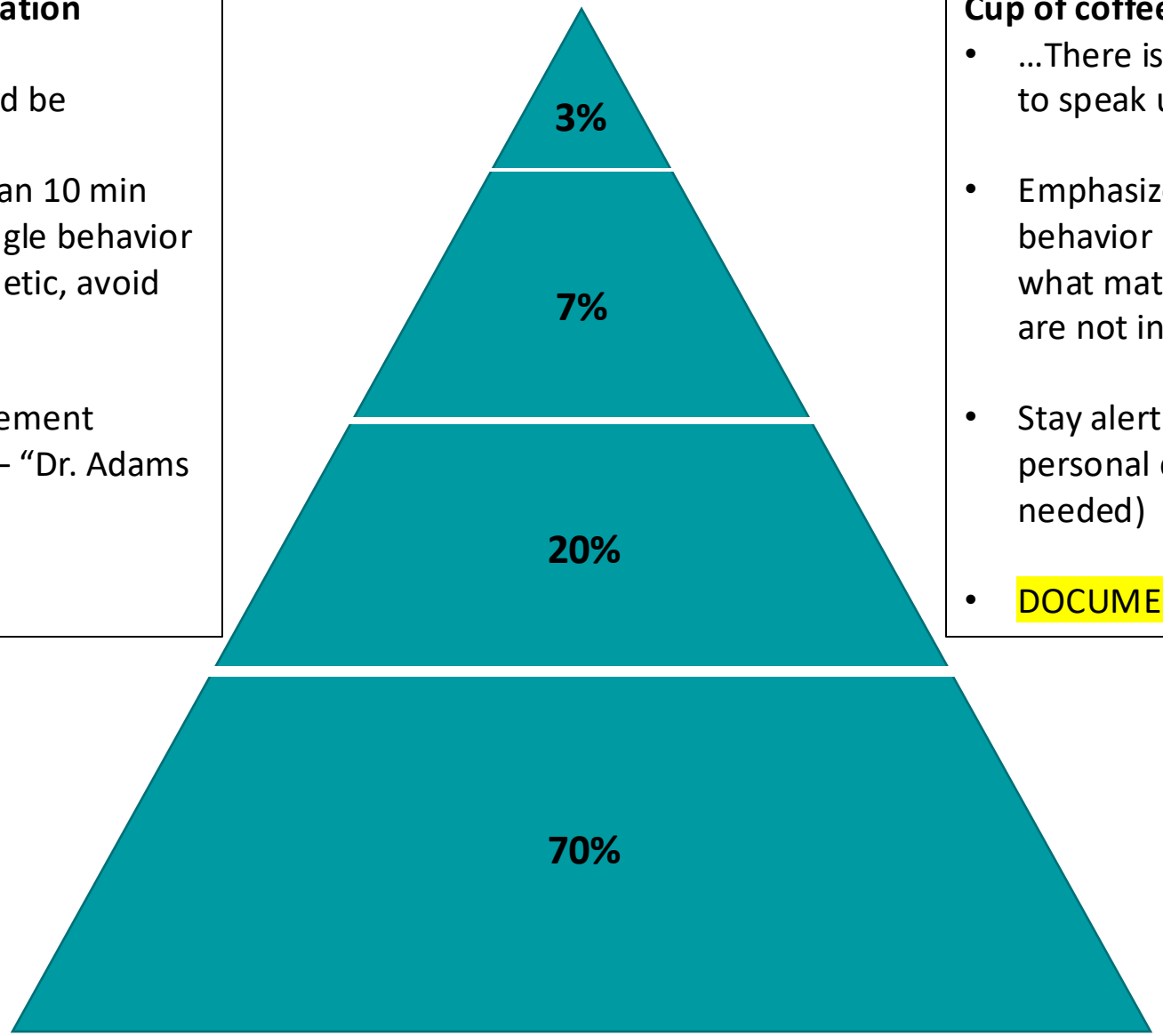
- ACTION: urgent, structured development plan

**Cup of coffee conversation**

- Timely
- 1:1 with peer, could be supervisor
- Brief – no more than 10 min
- Focused on the single behavior
- Listen, be sympathetic, avoid judgement

- OK to acknowledgement mitigating factors – "Dr. Adams in the busy ICU"

- But…




**Cup of coffee conversation**

- …There is never a justification to speak unprofessionally

- Emphasize that PERCEIVED behavior (not intentions) is what matters – e.g. colleagues are not in your mind…

- Stay alert for red flags (e.g. personal crisis and escalate as needed)

- DOCUMENT

Cup of coffee w/ physician

Level 1- Feedback

For first time concerns, non-policy violations

**Remedial Actions**

**Case Level / Severity**

*Adapted from the Vanderbilt model, Dr. Gerald Hickson*

# Sample “Cup of Coffee” Documentation

## Cup of Coffee Conversation – Debrief

Staff / Faculty Subject Name: **Dr. Scott Schissel** (Medicine)

Messenger / Peer name: Dr. Smith (Chair of Medicine)

Conversation date: 7/23/24. Incident date 7/22/24

Brief professionalism lapse (1-2 line summary):

See Safety (rL) report. In short, Dr. Schissel’s patient on B12 needed a continuous albuterol nebulizer. The nurses on B12 were not familiar with administering this medication and “Stopped the line” to receive more input from RN leadership and pharmacy. Dr. Schissel arrived on the unit and expressed his concern regarding the medication delay using aggressive and non-collaborative language / style. This is not the first instance of this type of behavior, as outlined by Dr. Smith.

# Sample “Cup of Coffee” Documentation

**Cup of Coffee Conversation – Debrief**

Conversation Summary:

1. Faculty reception to the conversation: Dr. Schissel receptive to hearing the concerns and feedback but demonstrated only partial ownership / acceptance of his behavior. Dr. Smith emphasized the need for Dr. Schissel to remain professional through conflict and use escalation pathways and the chain of command, as needed.

2. Challenges (e.g. pushback, deflection, dismissal, seeking retribution): ONLY partial ownership of behaviors.

3. Additional comments or key case-specific follow-up: feedback given and received by Dr. Schissel. Ongoing surveillance and follow-up regarding any new disruptive behavior is important.

EMAIL / Safety report:

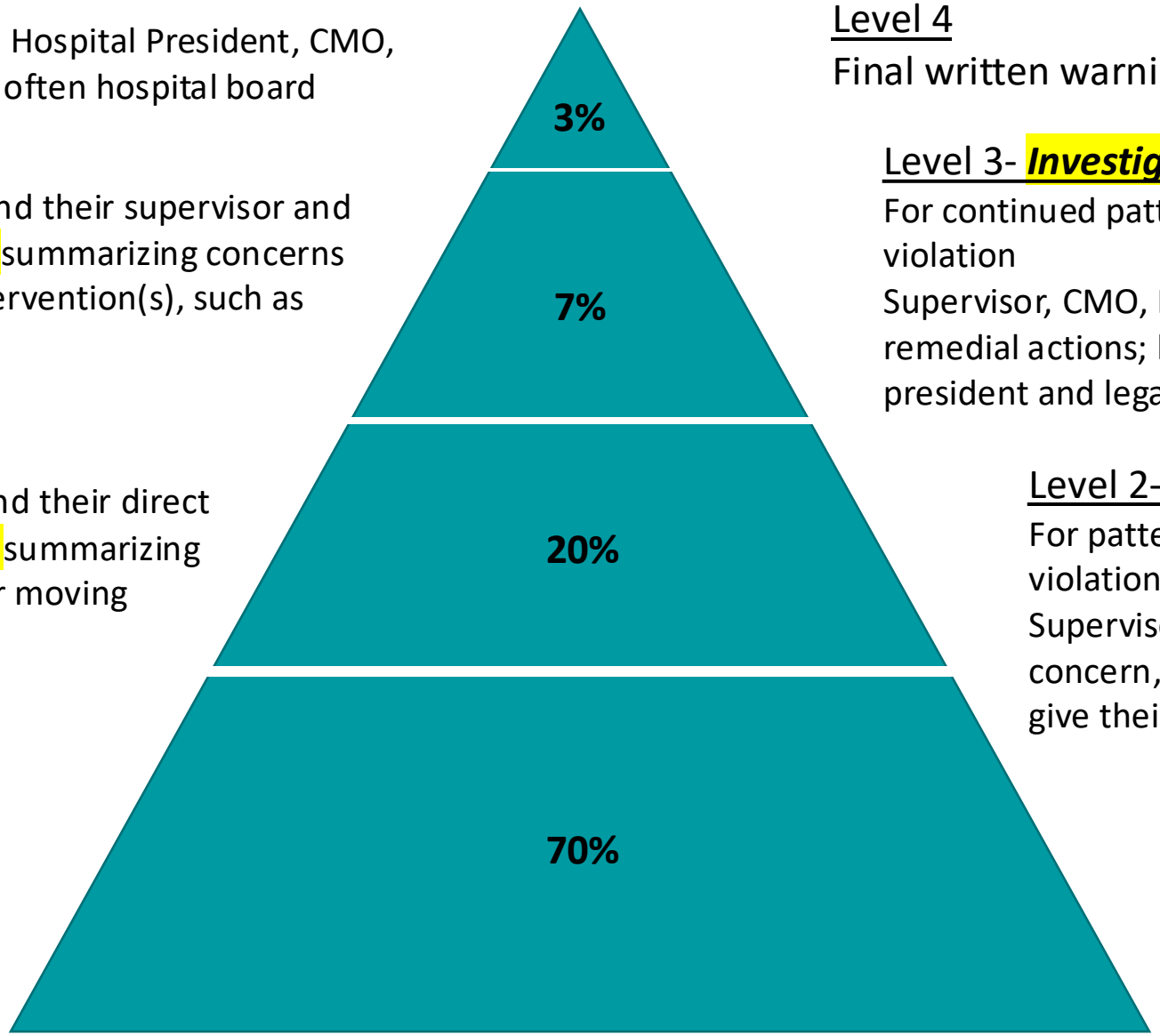
Involvement from legal counsel, Hospital President, CMO, Chair, med staff leadership, and often hospital board

Discussion between physician and their supervisor and dept chair w/ a follow-up letter summarizing concerns and expected behavior with intervention(s), such as mandated coaching

Discussion between physician and their direct supervisor w/ a follow-up letter summarizing concerns and expected behavior moving forward

Cup of coffee w/ physician and their direct supervisor / chair

**Remedial Actions**




Level 4

Final written warning or termination

Level 3- ***Investigation***

For continued pattern of concern and/or policy violation

Supervisor, CMO, HR partner with Chair for remedial actions; hospital president, med staff president and legal counsel should be aware

Level 2- ***Evaluation***

For pattern of concerns and/or policy violation

Supervisor, CMO, HR conduct evaluation of concern, including opportunity for subject to give their perspective

Level 1- ***Feedback***

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# Case 3: follow-up

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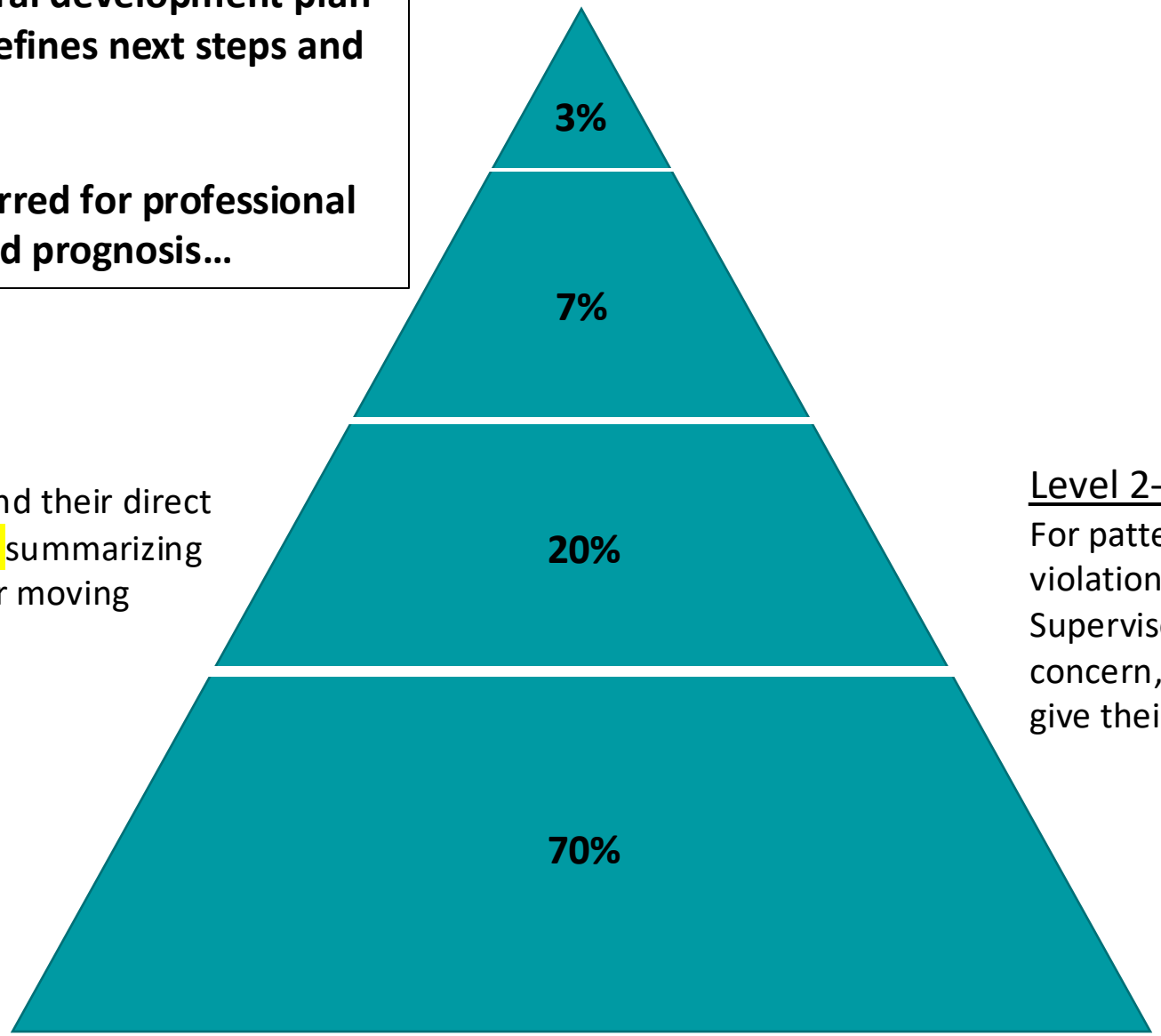
As division chief, you meet with Dr. Smith to review the feedback and learn that Dr. Smith received negative resident reviews at their prior job due to similar concerns – but Dr. Smith had dismissed the feedback since residents “know nothing”…

- **Physician needs a behavioral development plan with a letter that clearly defines next steps and goals**
- **Fortunately they SELF-referred for professional coaching – good insight and prognosis…**




Discussion between physician and their direct supervisor w/ a follow-up letter summarizing concerns and expected behavior moving forward

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# Thank You!

# Questions - Discussion