The “problem” junior
picking up and managing problems
during postgraduate training

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Outline

- introduction
  - recent developments
  - terminology and definition

- literature on postgraduate training
  - magnitude
  - nature and etiology

- lessons learned
  - from undergraduate training
  - other frameworks

- take home messages
Recent developments (1)

- Internal quality assurance
- Re-registration demands by patient(organisation)s
- "Shared care", "care" vs "cure", teamwork
- Healthcare management
- Costs
- Internal quality assurance (re)registration
- External quality assurance law
- Work time directive
- Medical professionalism in a changing world
- Knowledge, skills, attitude
- Complexity of care
- Errors, patient safety
- Cardiothoracic surgery Nijmegen
- Patient care
- Philosophy
- Revolution
- Information technology
- Evolution
- Patient care
- Part-time work
- Attitude
- Personal vs professional
- Feminisation
Media attention

**MEDICAL JUSTICE**
**Dr. Hardy Faces 6 Charges of Unprofessional Conduct**

Allergist faces charges over billing
A disciplinary hearing is continuing this week for an allergist doctor charged with several counts of submitting improper bills.

Dr. Larry Wayne Hardy, an allergist, faces six separate charges of unprofessional conduct from the College of Physicians and Surgeons of Saskatchewan.

The charges were laid after Hardy's secretary came forward with information, according to the college.

In one charge, Hardy is accused of billing the province and Veterans Affairs Canada for the same work.

In others, he is alleged to have submitted claims for consultations or assessments when in fact he did not see the patients on the date in question.

He is also charged with making claims for performing allergy tests when he did not do the necessary services.

The cases of dozens of patients are named in the charges.

"The disciplinary hearing began Monday and must still hear from more than 20 witnesses."

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**Doctors Behaving Badly? They Say It Happens All The Time**

by RICHARD KNOX

If results from national survey can be believed, more than 2 in 3 U.S. doctors witness other physicians disrupting patient care or collegial relationships at least once a month.

More than 1 in 10 say they see it every day.

The survey involved 840 doctors, most of them leaders in their own physician communities.

"Disruptive physician behavior is the issue that just won't go away," says Dr. Barry Silbaugh of the American College of Physician Executives, which sponsored the project with the help of a Massachusetts-based group called QuantaMD. "Our profession is still plagued by doctors acting in a way that is disrespectful, unprofessional and toxic to the workplace."

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**Methadone doctor's conduct questioned**

**Jerome Lessard, QMI Agency**

**February 12, 2012, 12:30 AM EST**

BELLEVILLE, ONT. - A doctor who runs a network of methadone clinics across Ontario has been accused of disrespectful and unprofessional conduct.

Concerns have been mounting since the College of Physicians and Surgeons of Ontario issued a notice of hearing against Dr. Michael Varenbut, who opened Ontario Addiction Treatment Centres (OATC), a network of 42 methadone clinics, including the Owen Sound site.
Terminology

- popular media:
  - tyrants, boors, bullies, cruel bastards, destructive narcicists

- scientific literature:
  - difficult resident, troublesome learner, resident in difficulty
    disruptive resident, impaired physician, problem junior,
    problem resident

Definition

- “A learner who demonstrates problem behaviours significant enough to require intervention by program leadership”
  - ABIM, 1999

- “Trainees that do not meet the expectations of the training programme because of problems with knowledge, skills and/or attitude”
  - Steinert, 2008
Unprofessional behaviour

- Guidelines compliance
- Cooperation
- Working climate
- Errors/mistakes
- Adverse outcome
- Complaints
- Malpractice suits

Unprofessional behaviour

- non-compliance immunisation requests
- evaluation forms

- irresponsible behaviour
  - presence hospital/patient-related activities
  - no improvement despite feedback

Low professional behaviour scores
Low ABIM knowledge test scores

Competency-based training (2)

- competency-based training
  - integration of education, training and assessment

- occasionally encounter suboptimal performance

Lit. Neth J Crit Care 2011, 15, 4: van Mook, Bion et al
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  - other frameworks: CME

- **take home messages**
Magnitude

- 3-5% to 15% at some point
  - unsolicited complaints
    - nurse surveys
    - 4-5% of physicians

- labour/delivery unit survey
  - 61% reported disruptive behaviour
  - 50% daily or weekly!
  - most often physicians

- comparable with data from UGT
  - 5.5 – 8%

Magnitude

- residents in internal medicine 6.9%
  - Yao, 2000

- residents in internal medicine
  - point prevalence 3.5%
  - unchanged over decade
  - Dupras, 2012
Nature/etiology

- incorrect diagnostics, diagnosis, treatment
- avoidance of patients/psychological needs, dehumanised care, overinvolvement/boundary violations

etologies
- substance abuse
- psychological issues
- inappropriate handling of narcissism, perfectionism and/or selfishness
- spill over of private problems
- poorly controlled anger (e.g. lack of clinical/administrative support)
- lack of feedback (clinical/administrative inertia)

Top of the iceberg

- professional realm = last area to manifest
- picked up and dealt with correctly and rapidly!
- formal local frameworks/programs for identifying and dealing with problem doctors scarce
- national frameworks exist

Lit. Neth J Crit Care 2011, 15, 4: van Mook, Bion et al
Dialy practice: internal med. (1)

- 83% during inpatient rotations
- reporting
  - 70% faculty
  - 63% supervising residents
  - 53% peers
  - 35% nurses
  - infrequently
    - 8% patient complaints
    - 6% adverse events
    - 6% self

- contributing factors
  - depressions, anxiety and personality disorders 32.6%
  - learning disability 6.6%
  - illness, substance abuse, divorce 5%

Lit. APM 2012 Dupras
Dialy practice: internal med.  

- management
  - 52% informal discussions
  - 38% formal remediation

- actions
  - 27% formal warning
  - 13% academic probation
  - 5% dismissal
  - 15/4% repeat rotation/year

- deficiencies: all competency domains
  - 53% patient care
  - 48% medical knowledge
  - 77% of PD reported multiple deficiencies

Lit. APM 2012 Dupras
Dialy practice: internal med. (1)

- **effect of remediation**
  - 86% successful for knowledge
  - 49% successful for professionalism

- 35% in retrospect warning signs
  - Low scores USMLE, interview etc

- ‘risk factors’
  - Community based, university affiliated hospitals
    - 62% increase in odds
  - Program directors salary < 250.000 USD
    - 2.25 fold increase in odds
  - Experience as PD each year
    - 2.5% decrease in odds

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Lessons from UGT

selection for undergraduate medical training

MMI

personality questionnaires

Lit. Med Teach 2010 van Mook; Med Educ 2007 Knights; Med Educ 2006 Knights
National frameworks/guidelines

- Netherlands
  - Medical Treatment Act (WGBO) 1995
  - Professions Act (WBIG) 1996
  - guidelines functioning doctors KNMG 7-2005
  - law on healthcare complaints 2005
  - guidelines dealing with incidents, errors and complaints 4-2007
  - guidelines disfunctioning trainee TMO 12-2011
  - arbitration committee 2005
    - mediation trainee-trainer
  - guidelines disfunctioning medical specialist 4-2008
  - guidelines health services inspection 3-2010
  - guidelines disfunctioning family physician 4-2011

Lit. Driessen PMO 2011;
A specific model: GMC

Dealing with concerns about a Doctor

Stage One

Referral to the GMC
It is often better for patients to raise their concerns through local complaints procedures in the first instance with the NHS Hospital Trust, Primary Care Trust (or equivalent) or Private Healthcare Body.

Further Investigation
Where a matter raises serious concerns about a doctor’s practice, the GMC will undertake an investigation. This may include an assessment of the doctor’s health or performance, where appropriate. GMC case examiners will then decide what action to take, for example referral to a Fitness to Practise Panel. If the case examiners cannot agree or a warning is offered and the doctor refuses to accept the warning, the case will be referred to the Investigation Committee.

Stage Two

Investigation Committee and Interim Orders
If both case examiners decide that a warning is appropriate, the doctor may exercise his/her right to an oral hearing before the Investigation Committee. If the two case examiners do not agree on the appropriate outcome, the case will be decided by a meeting of the Investigation Committee.

Adjudication
Fitness to Practise Panels comprise the final stage of the GMC’s procedures. All aspects of the doctor’s fitness to practise will be considered and there are no longer separate streams for conduct, health and performance.

- GMC
  - Investigation Committee
    - No action required
    - Warning issued
    - Referral to a FTP Panel
    - Undertakings agreed
    - Referral to the IOP
  - Interim Orders Panel
    - IOP directs interim conditions (restricting practice)
    - IOP directs suspension with immediate effect

- GMC
  - Further Investigation
    - The case examiners may decide to:
      - Take no action
      - Issue a warning
      - Refer to a FTP Panel
      - Agree undertakings
      - Referral to the Interim Orders Panel (IOP)

Private Health Local Procedures
• Internal review
  - No action required
  - Internal/Local action
  - Information exchange
  - Referral to the GMC

NHS Local Procedures
• Internal review
  - No action required
  - Internal/Local action
  - Information exchange
  - Referral to the GMC

GMC
- GMC Procedures
  - Internal review
    - Information exchange
    - Further investigation by the GMC
    - Conviction or decisions from another regulatory body
    - Inappropriate complaints would be closed at this stage
Another specific model: LHV
A more generic model

- Vast majority of doctors: no professionalism issues
- Single ‘unprofessional’ incidents
  - (In)formal intervention
    - Reports on severe unprofessional behaviour, and mandated issues (e.g. law)
- Apparent pattern
  - Awareness intervention
- Pattern persists
  - Authority intervention
- No change
  - Disciplinary intervention

- Strong leadership
- Adequate faculty training and instruction
- Low threshold for reporting lapses

Sanctioning: *compulsion*
Monitoring: *pressing*
Remediating
Documenting
Stimulating/motivating
Reflecting in and on action
Reporting/informing/responding
Signaling
Policy/awareness
Statutory/legal assurance

Lit. Acad Med 2007 Hickson; Med Teacher 2012 van Mook
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Take home messages (1)

- pre-entry selection so far not possible
  - a single tool is unlikely to suffice

- residents in difficulty are not common
  - but neither are they rare

- residents rarely possess self-awareness to identify their own deficiencies
  - assessment, including MSF

- most residents have difficulties in multiple competencies
  - knowledge testing not to be forgotten
• deficiencies in professionalism are relatively common
  ▪ but respond poorly to remediation

• dealing with the resident in difficulty
  ▪ development of local ICU frameworks based on CoBaTrICE guidelines?
    ▪ existing local UG/PG frameworks
    ▪ national UK/NL guidelines
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