Problems and Problem Solving: Working with Difficult Folks

10:45 - Noon
Plan

• What is a “difficult learner”?  
  – Two tests  
    • The Definition Test  
    • The Patient-Centeredness Test

• The Model

• Awareness Intervention

• Dr. Medio’s Top 10
Difficult

• **SYNONYMS:**
  *hard, difficult, arduous*

These adjectives mean requiring great physical or mental effort to do, achieve, or master. **Hard is the most general term:** "You write with ease to show your breeding, / But easy writing's curst hard reading" (Richard Brinsley Sheridan). Difficult and hard are interchangeable in many instances. **Difficult, however, is often preferable where the need for skill or ingenuity is implied:** "All poetry is difficult to read, / The sense of it is, anyhow" (Robert Browning). **Arduous applies to burdensome labor or sustained physical or spiritual effort:** "knowledge at which [Isaac] Newton arrived through arduous and circuitous paths" (Thomas Macaulay).
Example – Resident

• **Students say**, “Never helps us out or answers our questions. Always says, “Go look it up – it’s good for you to find your own answers”

• **Residents say**, “Dumps on us. Doesn’t pull fair share of the workload. Always making excuses and last minute requests to get out of work”

• **Staff say**, “Arrogant and egotistical. Thinks they know everything. Treats staff as personal servants. Demanding and yells at staff when gets upset or stressed”

• **Attendings say**, “Smart but takes short-cuts. Hard to depend on. Not always trust-worthy. Takes credit where credit belongs to others on the team.”
Definition

• Difficult in the educational context is:
  – a person who demonstrates behaviors which impedes required progress toward the demonstration of competency
... demonstrates behaviors ...

• Every description of “difficult” must be translated into behaviors if you are to have any hope of producing success

  – What are the specific behaviors that make this resident difficult?
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... impedes required progress ...

- Progress in an educational setting is **not an option**; it is a requirement
  - We enter at one level of the Dreyfus continuum, and we must exit at a higher level on the Dreyfus continuum
Dreyfus Continuum

<table>
<thead>
<tr>
<th>Levels</th>
</tr>
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<tbody>
<tr>
<td>Mastery</td>
</tr>
<tr>
<td>Expert</td>
</tr>
<tr>
<td>Proficiency</td>
</tr>
<tr>
<td>Competent</td>
</tr>
<tr>
<td>Advanced Beginner</td>
</tr>
<tr>
<td>Novice</td>
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</tbody>
</table>
... impedes required progress ...

• Progress in an educational setting is **not an option**; it is a requirement
  – We enter at one level of the Dreyfus continuum, and we must exit at a higher level on the Dreyfus continuum
  – *Where is progress impeded?*
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... competency.

• Begin to create this equation in your education thinking:

COMPETENCY = Patient-Centeredness

• When competency is not present, the patient is the one who experiences difficulty

• What are the competency issues?
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Therefore ...

• Every difficult issue that must be addressed is actually a patient care issue!
  – Can you translate difficult situations you may encounter into their patient care analogs?

• CAUTION!! CAUTION!! CAUTION!!
  – If you cannot CLEARLY translate a difficult situation into a patient care analog, you may be walking on thin ice
  – It may be more about you than about them!
Is it always about professionalism?

• Yes and no.
For the secret to the care of the patient is in caring for the patient.

Francis Peabody, 1927
For the secret to the care of the health care professional is in caring for the patient.
Example?

<table>
<thead>
<tr>
<th>Acceptable Behavior</th>
<th>Unacceptable Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is good for the patient</td>
<td>What isn’t good for the patient</td>
</tr>
</tbody>
</table>
Example?

Acceptable Behavior

What is good for the patient

The primacy of patient needs

Unacceptable Behavior

What isn’t good for the patient

The primacy of physician needs
Acceptable Behavior

What is good for the patient
The primacy of patient needs
Integrity of the profession

Unacceptable Behavior

What isn’t good for the patient
The primacy of physician needs
Disintegration of the profession

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A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors

Gerald B. Hickson, MD, James W. Pichert, PhD, Lynn E. Webb, PhD, and Steven G. Gabbe, MD

Abstract

Vanderbilt University School of Medicine (VUSM) employs several strategies for teaching professionalism. This article, however, reviews VUSM’s alternative, complementary approach: identifying, measuring, and addressing unprofessional behaviors. The key to this alternative approach is a supportive infrastructure that includes VUSM leadership’s commitment to addressing unprofessional/disruptive behaviors, a model to guide intervention, supportive institutional policies, surveillance tools for capturing patients’ and staff members’ allegations, review processes, multilevel training, and resources for addressing disruptive behavior.

Our model for addressing disruptive behavior focuses on four graduated interventions: informal conversations for single incidents, nonpunitive “awareness” interventions when data reveal patterns, leader-developed action plans if patterns persist, and imposition of disciplinary processes if the plans fail. Every physician needs skills for conducting informal interventions with peers; therefore, these are taught throughout VUSM’s curriculum. Physician leaders receive skills training for conducting higher-level interventions. No single strategy fits every situation, so we teach a balance beam approach to understanding and weighing the pros and cons of alternative intervention-related communications. Understanding common excuses, rationalizations, denials, and barriers to change prepares physicians to appropriately, consistently, and professionally address the real issues.

Failing to address unprofessional behavior simply promotes more of it. Besides being the right thing to do, addressing unprofessional behavior can yield improved staff satisfaction and retention, enhanced reputation, professionals who model the curriculum as taught, improved patient safety and risk-management experience, and better, more productive work environments.

Figure 1 The disruptive behavior pyramid for identifying, assessing, and dealing with unprofessional behavior.
## Educational Setting vs. Practice

<table>
<thead>
<tr>
<th>EDUCATIONAL SETTING</th>
<th>PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom</td>
<td>S - subjective</td>
</tr>
<tr>
<td>Collect Data</td>
<td>O - objective</td>
</tr>
<tr>
<td>Analyze and Categorize</td>
<td>A - assessment</td>
</tr>
<tr>
<td>Plan</td>
<td>P - plan</td>
</tr>
</tbody>
</table>

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Symptom

• The observed problem behavior is the symptom - *it is not necessarily the diagnosis*

• Consider the multiple perspectives

  *This session should best be called*

  *The Symptomatic Person*
Collect Data

• All data is subjective - *it is a question of degree*

• The more directly the data is observed, the higher the likelihood of validity

• ACGME Outcomes Project suggests that direct observational data is highly valid and reliable; particularly if seen by multiple people from multiple perspectives
Analyze and Categorize

- Person’s Acknowledged Problems
- Supervisor Recognized Problems
- Systems Issues

_all are likely to be present in every problem learner situation_
Person Acknowledged Problems

- Person has insight
- Person is willing to share
  - from a place of **fear**, the sharing is a defensive behavior
  - from a place of **safety**, the sharing is partnership behavior

- Acknowledging that you have listened to the story is the goal
- Going back to our example, what might be the resident’s story?
Example – Resident

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Teacher Recognized Problems

- Supervisor is aware of the issue and must create awareness for the learner
  - from a place of **fear**, the person will demonstrate defensiveness, often consistent with the problem itself!
  - from a place of **safety**, there will be an acknowledgment, often emotional, of the issue
  - **seeking acknowledgment is the goal when raising supervisor recognized issues**
  - From our example, how would you seek acknowledgement?
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Systems Issues

• No system is perfect
• A sign of a person’s maturity is the degree to which they can deal with issues in spite of the systems issues
  – from a place of fear, the system is blamed for the issue
  – from a place of safety, the system is rationally acknowledged as being less than optimal, but not causative
  – Acknowledging the systems issue and moving past this is the goal
  – Going back to our example, what systems issues might be in play?
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Categorize and Analyze: Summary

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<th>Fear</th>
<th>Safety</th>
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<tbody>
<tr>
<td>Person Acknowledged</td>
<td>Defensive</td>
<td>Partnership</td>
</tr>
<tr>
<td>Supervisor Recognized</td>
<td>Behavior Consistent</td>
<td>Acknowledge Emotional</td>
</tr>
<tr>
<td>Systems Issues</td>
<td>Blame</td>
<td>Acknowledge Rational</td>
</tr>
</tbody>
</table>

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Develop Action Plan

• Plan is problem and person specific
• Must take into account all aspects of the analysis
  – people will quickly disengage if they perceive “person acknowledged” and “systems issues” are a smokescreen
• Specific follow-up expectations and consequences must be stated
• What are the possible ingredients of the action plan for our difficult resident?

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Follow-up Expectations and Consequences

• Expectations, in order to be most effective, should be grounded in the principle of *patient centeredness*

• Consequences should be *real and meaningful*
  – Hunterdon example for quality project, calendar, and electives
March 5, 2002
Dear Managed Care Organization:

Dr. Jones has successfully completed all of the requirements of the family medicine residency program except for the following:

- Did not complete required quality improvement project
- Did not turn in calendar of activities
- Did not fully document elective experiences

If you have any questions, do not hesitate to call,

Hershey S. Bell, MD
Program Director
Franklin Medio, PhD

• 3 distinct conversations: knowledge, skills, behavior/attitudes
  – Good performance in one area does not excuse poor behavior in another area!
  – Each stands on its own merits
• “You’re a doctor!”
• If the conversation went well, you probably didn’t do your job!

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Dr. Medio’s Top Ten Reasons ...

1. “I don’t want to be the bad guy.”
2. “I don’t want to upset him or her.”
3. “I don’t want to make a big deal out of this.”
4. “I don’t want to ruin the person’s career.”
5. “I don’t want to end up in court.”
Dr. Medio’s Top Ten Reasons ...

6. “I am not sure how he or she will react.”
7. “I (or others) may have contributed to the problem.”
8. “I know he or she realizes it was wrong and will not do it again.”
9. “I think its too late in the rotation (or year or program).”
10.“I don’t like confrontation.”
Figure 1 The disruptive behavior pyramid for identifying, assessing, and dealing with unprofessional behavior.
YOUR EXAMPLES
QUESTIONS? ANSWERS? MORE QUESTIONS??