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IDENTIFYING AND ADDRESSING HEALTH CONCERNS: BEHAVIOURAL CHALLENGES

Dr Charles Swainson, Dr Debbie Cohen,
Dr Mike Kaufmann and Dr Jenny King

Behavioural Challenges

Dr Debbie Cohen

Director of The Individual Support Programme, Cardiff University

Behavioural Challenges

- Engagement
- Insight
- Resistance

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Behaviour Change
Motivational Interviewing

- Ambivalence is common, normal
- Confrontational interviewing – increases resistance
- Shift style - resistance diminishes
- Collaboration, honour autonomy

Rollnick and Miller

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Biopsychosocial Model

Factors	Biological	Personal	Social
Predisposing			
Precipitating			
Perpetuating			

Sharpe M. BMJ 2002;

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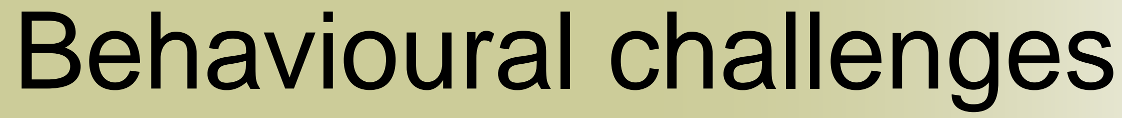
Behavioural Challenges

In Summary

- Rapport and clarity about your role is critical
- Follow a framework to identify concerns
- Refer to appropriate resources



Behavioural challenges

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Behavioural Assessment at NCAS

Dr Jenny King CPsychol AFBPsS

The purpose of behavioural assessment

- Identify any underlying behavioural traits that might be affecting performance
- Diagnose the extent to which the concerns can be explained by personality and behaviour
- Provide a view about any challenges to addressing behavioural concerns
- Offer recommendations about approaches to addressing behavioural factors

What are we assessing?

- Empathy and Sensitivity
- Communication and Influencing
- Personal Organisation and Administrative Skills
- Coping with Pressure
- Leading and Managing Others
- Team working
- Openness, Learning and Self-awareness
- Judgement and Decision making

The behavioural assessment process

Psychometric testing

Behavioural interview

Verbal feedback

Report → Final NCAS report

Measuring personality and its impact on behaviour

These "Big Five" traits influence behaviour at work

- *Neuroticism* – how emotional
- *Extraversion* – how sociable
- *Openness* – how open to experience
- *Agreeableness* – how easy to get on with
- *Conscientiousness* – how organised, focussed and disciplined

We measure them with the NEO-PI

Behaviours that cause trouble at work

Research into manager/leader "derailment" shows that strengths can become overplayed when individuals are under pressure

These strengths then become counter-productive, having adverse effects on the individual, their colleagues and their organisation

We measure these with the Hogan Development Survey (HDS)

How strengths become weaknesses (Hogan and Hogan, 1997)

Strength	Dysfunctional behaviour
Enthusiastic	Volatile
Shrewd	Mistrustful
Independent	Detached
Focussed	Passive-Aggressive
Confident	Arrogant
Charming	Manipulative
Vivacious	Dramatic
Imaginative	Eccentric
Diligent	Perfectionist
Dutiful	Dependent

Preliminary findings (from content analysis of 176 NCAS cases Apr 02-Aug 07)

Patient-focused to the exclusion of wider considerations

Diligent to the point of perfectionism

Avoid confrontation

Poor influencers

Low self-awareness

Receptive to ideas

Resistant to changing their own ways of working

A model for “diagnosis”

Capacity

Learning

Arousal (Motivation)

Distraction

Alienation

What kind of problem is it?

Type of problem	What is it?
Capacity	A fundamental limitation that is unlikely to change
Learning	A deficit of knowledge, skills or experience
Arousal/ Motivation	Boredom ; stress; burn-out; low morale
Distraction	A problem elsewhere causing a problem here (or illness/health problems)
Alienation	Deep rooted anger/mistrust, leading to sabotage

	All	GP	Hospital Dr
Capacity	28	14	14
Learning	156	78	76
Motivation	11	4	7
Distraction	25	9	16
Alienation	25	12	13
Organisation	40	6	33

Findings from 176 NCAS cases Apr 02 to Aug 07

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helping people and organisations thrive

Matching resolution to diagnosis

Factor	What is it?	Resolution
Capacity	A fundamental limitation that is unlikely to change	Change job or role
Learning	A deficit of knowledge, skills or experience	Training (adapted to learning style); feedback (e.g 360°)
Arousal/ Motivation	Boredom ; stress; burn-out; low morale	Coaching, counselling,mentoring; new project or role
Distraction	A problem elsewhere causing a problem here	Set limits; discuss referral to appropriate source of help
Alienation	Deep rooted anger/mistrust leading to sabotage	Move OUT! Or ring-fence OR "negotiated settlement"

What predicts the likelihood of change?

Do they have the "key" personality traits to help them change?

- Are they stable enough?
- Can they persevere?

Do they have insight?

- Are they psychologically minded?
- Can they reflect on their behaviour and learn from their experience?

Do they want/intend to change?

- Have they a history of successful change attempts?
- What will motivate them to change?

What kind of environment will they be working in?

- What support is available?
- What are the contextual factors that may influence their behaviour?

Thank you…!!

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Disruptive behaviour in doctors: a staged, rehabilitative approach

Michael Kaufmann MD

Director, Physician Health Program

Ontario Medical Association

“The age of the cowboy surgeon is over.”

Wayne and Mary Sotile

“The Resilient Physician”

Disruptive behaviour

"A physician with disruptive behaviour is one who cannot, or will not, function well with others to the extent that his or her behaviour, by words or actions, interferes or has the potential to interfere with quality health care delivery."

CPSO Task Force definition

PHP experience

Approx. 7% of referrals due to conduct problems specifically (about 20 per year)

Over 100 cases to date

Many referred with other problem types display disruptive behaviour

88% male

One third surgeons

Ob-gyn, anesthetists approx. 10% each.

Management of problem behaviour

In Ontario, doctors are not hospital employees

- Not usually governed or served by occupational health or human resource policies and services

Codes of Conduct, policies and procedures required for medical staff

Behaviour is not a diagnosis

Response must be prompt, consistent, rational, and

Staged

Context must be considered (personal, occupational)

Removal of privileges (employment) last option

Stage One

Behaviour:

First instance(s)

Minor severity

Infrequent

Anger outburst(s)

Patient/staff complaint

Non-adherence to hospital policies and Code of Conduct

Response:

Document

Investigate, validate

Discuss

Counselling (optional)

Education (optional)

Follow-up

Accountability

Stage Two

Behaviour:

Persisting pattern despite Stage One intervention(s)

Increasing frequency

Increasing severity

Response:

Investigate, validate

Discuss

Assessment to determine cause

Management plan

- Education
- Counselling
- Clinical treatment (if needed)
- Monitoring/Feedback

Assessment of behaviour

Psychiatric

Psychological / psychometric / neuropsych

Substance use / abuse / dependence

Physical

Reports from usual treating clinician(s)

Occupational

- Document review
- Colleagues, co-workers (often on-site)

Spouse and / or other collateral

Behavioural interventions

Individual counselling

Group counselling

Brief educational programs

- Self-awareness
- Emotional management
- Communication and conflict resolution skills
- Leadership skills

Longer education / treatment programs

"360-style" behavioural monitoring

Workplace – based interventions

PHP behavioural monitoring

Incorporates assessment recommendations

Individual contact with PHP monitor / case manager

Mental health professional(s)

Workplace monitors

Workplace mentor

Return to work plan

"360" behavioural monitoring surveys

Failure to progress defined:

- Continuing pattern, single "egregious" incident, deteriorating 360s

Duration usually two years

Contractual with contingencies

P.U.L.S.E. Program | Survey - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Search Favorites

Address http://survey.pdpflorida.com/ Go Links

Please complete the survey below with your honest, anonymous feedback

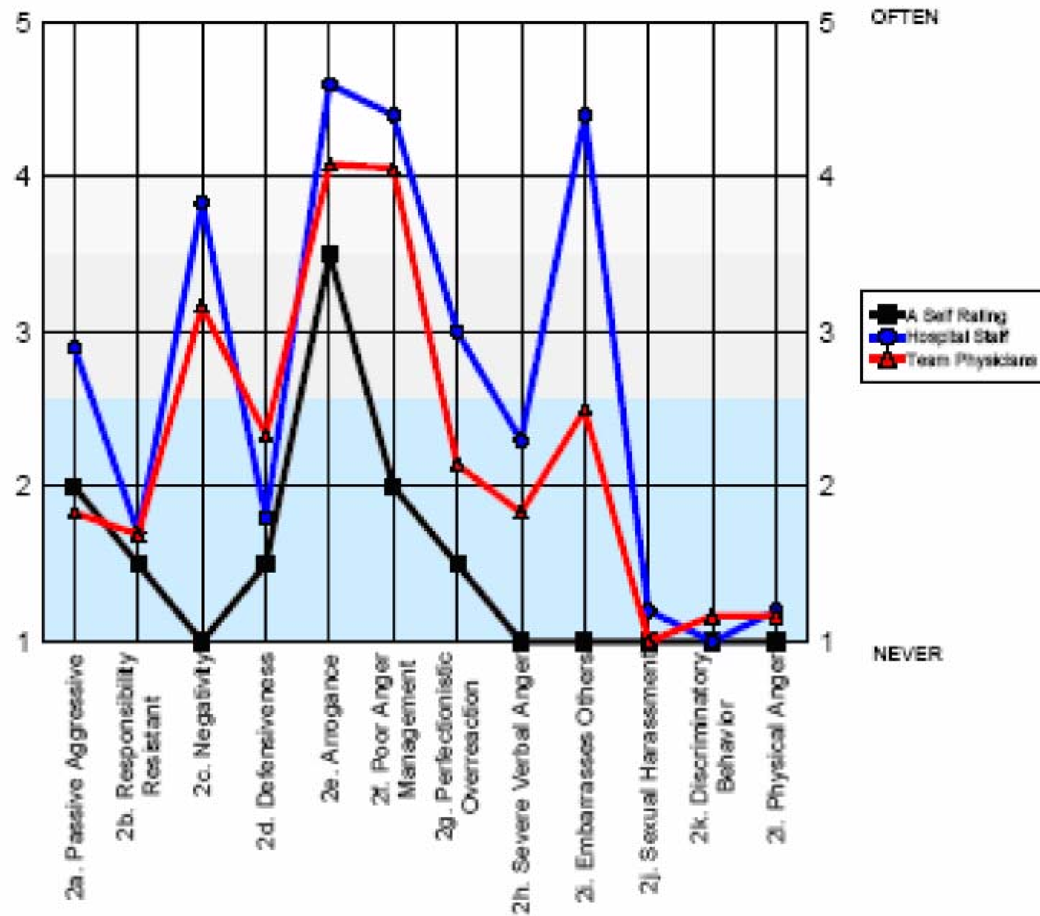
What is the NAME of the Person you are assessing?	**Dirk Disruptive, MD**

Over the last 12 months together, compared to others in the same job or specialty, how often would you say this Person...	Very LOW	Below Average	Average	Above Average	Very HIGH
Treats team members with respect	○	●	○	○	○
Points out mistakes in a respectful and helpful way	●	○	○	○	○
Is open to suggestions	○	○	●	○	○
Adapts to changing policies, procedures, priorities	○	○	○	●	○
Behaves in a way which encourages team members' best work	●	○	○	○	○

Save Next >

Done My Computer

DISRUPTIVE BEHAVIORS (Lower Preferred)



	2a. I	2b. I	2c. I	2d. I	2e. /	2f. F	2g. I	2h. :	2i. E	2j. S	2k. I	2l. F	Total
A Self Rating	2.0	1.5	1.0	1.5	3.5	2.0	1.5	1.0	1.0	1.0	1.0	1.0	1.7
Hospital Staff	2.9	1.7	3.8	1.8	4.6	4.4	3.0	2.3	4.4	1.2	1.0	1.2	2.9
Team Physicians	1.8	1.7	3.2	2.3	4.1	4.1	2.1	1.8	2.5	1.0	1.2	1.2	2.4
Total	2.3	1.7	3.3	2.0	4.3	4.0	2.4	2.0	3.2	1.1	1.1	1.2	2.6

When you see Roadside Radar, what's the first thing you do?

"Feedback Creates Change!"

Stage Three (if all else fails…)

Behaviour:

Continuing pattern of behaviour despite Stage Two interventions

Dangerous behaviour

Criminal behaviour

Response:

Suspension of privileges, employment

Reports to authorities

- Regulatory
- Police

Paradigm change

Old:	New
The doctor is a "jerk"	The doctor / hospital needs help
These doctors are bad	These are usually good doctors
It's all the doctor's fault	Context matters
Be cautious, delay action	Act promptly and decisively
"Fix" the doctor	Consider the entire system
The situation is incorrigible	Use a rational, staged approach
	This is an opportunity for constructive change

Adapted from Kent Neff

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