2016 APD Annual Meeting

ETHICAL CHALLENGES OF BEING A DEPARTMENT CHAIR

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THE DOCTOR IS IN

RELEVANT RELATIONSHIP WITH INDUSTRY: None
Conflicts of Interest?

- Retired founding Chair, UCONN’s Derm Dept
- Chairs have less power than you think!
- Altho I am interested in ethics, I am **NOT** more ethical than you!
- Ethics is fun!
Why do they call it Chair?
What I would like to have done as Chair…

- Require all community derms to send their dermpath & Mohs to UCONN
- Require everyone to teach
- Require sending interesting patients to GR
- Require mentoring of students & derm residents
- Require annual tithing by affiliated private practitioners in the community & all graduates
- Pay all faculty more money
- Succeed in promoting & rewarding all my faculty
I want to.... But....
Responsibilities & Expectations of Dept Chairs

• Establish vision for dept
• Develop faculty consensus
• Meet with faculty to understand their individual needs
• Balance individual needs with those of organization
• Develop a strategic plan for dept
• Help dept adapt to a changing health care environment
• Lead as well as manage
• Role model: work ethic, behavior
Responsibilities & Expectations of Dept Chairs

• Recruit faculty & a diverse workforce
• Retain faculty
• Develop careers by mentoring
• Engage faculty at every level
• Help create a sense of identity & ownership with aggressive goals & a shared vision
Dept Chair Responsibilities & Expectations

- Manage business of pt care including Medicaid
- Manage business of research as NIH funds dry up
- Manage business of clinical trials while working with university IRBs
- Attend university committee mtgs (good citizen) while also funding most of your own salary

All to be accomplished in an ethical, fair, balanced, sensitive & politic way

Chairman Woof
The Ethics Of Being a Good Chair = Balancing Act
Chairperson’s Ethical Balancing Act

- Best interests of Institution Vs Derm Dept Vs Faculty Vs Residency Vs Individual
- Academic mission Vs Financial realities
- RVU issues → Borderline behavior Vs Physician burnout &/or professional dissatisfaction, esp if infrastructure poor & inefficient
Chairperson

**Terminology**

- **Autonomy**: pt’s right to refuse or choose Rx
- **Beneficence**: pt’s best interests come 1st
- **Non-maleficence**: do no harm
- **Justice**: fairness in healthcare distribution
- **Dignity**: for the pt & practitioner
- **Truthfulness**
- **PATERNALISM / Maternalism**
- **PROFESSIONALISM**: desirable attitudes, behaviors, & characteristics for medical profession; difficult to define
Why are we talking about this

- **Technological advances**: telecomm, e-tech, social network, digital photo, EMR, telederm
- **Financial pressures**: clinically, research funds
- **Consumerism & Business of medicine**
- **Academic pressures**: publish or perish, promotion
- **Bureaucratic pressures**: HIPAA, MACRA, MIPS
- **COIs**: financial & professional; pharma rules
- **Human Nature**: boundary violations, physician impairment, greed, ignorance, incompetence, personality disorders, multiculturism, ethical insensitivity, etc.
Consensus Ethical Issues of a Chair


JGK, Bruce Thiers, Dirk Elson, Mark Lebwohl:

1. Money Issues
2. Creating Proper Environment
3. Managing impaired docs
4. Dealing with community docs: Town & Gown
5. Issues all derms are dealing w/ like HIPAA issues & pre-authorizations:
   - Lack of treating physician control over pt care
   - Stretching the truth on pre-auth forms

1. Ethics of Financial Issues

- How to take care of the uninsured & underinsured pts while still running the practice in the black
  
  

- How to appropriately compensate faculty who engage in non-revenue-generating activity: uninsured pt clinics, teaching, research
  
  – Where does the compensation come from: other faculty members' collections? University?

- Equitable pay-for-performance for all faculty members. Should everyone earn the same % of revenues & pay the same dept/univ tax? Equal pay for equal work?
Money, RVUs, Time, Thoroughness, Quality?

• RVU + pressure to see more patients → are we able to spend time needed to properly take care of our patients?

• Impact on Merit-Based Incentive Payment System (MIPS)?
$, RVUs, Time, Thoroughness, Quality

• Ex. Faculty & residents should offer a total mucocutaneous exam screening to every new pt to fulfill our obligation to dx early melanoma & NMSC

– Pts generally scheduled at ~10 min intervals

– Physicians complain that there is not enough time for a FBSE & so deal w/ CC issue & ask pts to return

• When pressure to generate RVUs either leads to fraudulent or shady billing or neg impact pt care

→ become an ethical issue

• Chairs are where the fiscal buck stops!
Ethics of Money
(= Oxymoron?)

• Cost-sharing among faculty or should each pay their own costs (e.g., some want more & better trained nurses while others satisfied with MAs)?
• What to do w/ research faculty who lose grant support?
• How to deal w/ faculty using Univ resources for private purposes or consulting?
• How to deal with faculty away for academic reasons more than they are at the univ & not making their RVUs/salary?
2. Ethics of Dept Environment

• Govt + University regs limit our ability to be creative & flexible (as extending courtesy for some visits & change clinic hrs to fit needs of faculty)
• Disconnect between desire to keep faculty fully informed yet not sharing every short-term problem that on surface look catastrophic but your “wisdom” tells you will pass w/o incident
• How to fairly & ethically deal with dissension among faculty/staff & personal issues (mentoring)?
• Should univ clinics be staffed w/ PE’s or only docs?
• Ethical issues of hospital based derm clinics?
3. Managing Impaired or Disruptive Physicians

- What to do with residents/med/ students/faculty with mental health issues or are incompetent?
- How to deal with bigoted or abusive faculty?
- How to deal with combative faculty member?
- How to deal with a senior faculty member losing their abilities?
4. Community: Town & Gown Ethics

- Should community referrals for Mohs & dermpath be tied to faculty appts?
- Dealing with consults from outside docs’ pts
- Dealing w/ Loyalty Factor – train folks who go into community & compete with univ that trained them!
- Dept donations from graduates & community
TOWN & GOWN Vs. IVORY TOWER

CASE 1: 2nd opinion potential to undermine comm. doc-pat relationship

• Pt comes to univ clinic for 2nd opinion
• Pt says he feels he has been mismanaged by community private practice dermatologist
• Pt has come to the Chair b/c of their reputation & thinks that only the Chair can make him better
• How do you proceed?

Ivory Tower Scenario

- Professionalism: Rx pts & colleagues w/ respect
- Consultant’s role: provide honest opinion & render advice to help pt
  - Try to strengthen (NOT undermine) existing doctor-patient relationship
- Pts often frustrated → blame their physician for their disease severity or unresponsiveness
  - Poor outcome rarely $2^0$ to gross negligence or incompetence
  - Usually $2^0$ to severe disease or non-compliance
Ivory Tower Scenario

- Consultant often succeeds bc pt finally uses medication as prescribed
- Consulting MD plays important role when pt not responding to Rx
- **WARNING**: Beware seductive & manipulative pts
- Pt who speaks badly about his last derm is likely to say the same about his new one
- Flattery: typically a means to an end → need to distinguish respect from manipulation
- Univ consultants must make referring MD feel safe
Ivory Tower Ethical Bottom Line

- Consultant: diligent about reviewing past Rx & suggest appropriate next steps
- Never undermine an existing therapeutic relationship
- Simply acknowledging pt’s condition is challenging often sufficient to validate efforts of other physicians
- Goal: provide expert care while setting reasonable expectations re: outcome & maintaining professional relationships w/in community
  - Safe environment for & towards private docs
Community Town & Gown
CASE 2: Demand volunteer faculty to help support dept & residency?

• Recently Chair notes that a community derm w/ a faculty appt in your dept (but does a minimal amt of teaching) no longer sends his bx specimens to univ DP lab
• Does Chair have authority to speak to him & ask him to support Univ DP lab to ensure education for residents as a quid pro quo for academic title?
• Do you have the authority?
  – Perhaps
• Need to
  – educate community derms on need of DP & Mohs for residency
  – provide excellent service to outside docs
• Should you ethically use threat of loss of academic title to pressure a contributor to continue to send specimens to Univ DP lab?
  – No
• Ethically appropriate to expect community derms to contribute to dept
Ethical Questions Raised

How has someone who does minimal teaching maintained an academic title in your dept?

- Clinical faculty appts should reflect genuine ongoing commitment to educational goals of Univ.
- Those w/ adjunctive faculty appt should play active role in education w/in dept. How?
  - Resident lectures, role models, mentoring
  - Supervision of resident clinics at the univ hosp, VA hosp, or indigent clinic, participate in dept free skin ca screenings
  - Grand round participation
  - Resident rotations at an outside unique practice
  - Collaboration on studies or academic writing
  - Contribute pts to clinical trials
Academic Titles

- Service to Univ may take many forms: committee work, quality resident lectures, pt education seminars, or advocacy for dept w/in community, etc.
  - Referrals to Mohs & DP Lab included
- Real & substantive time commitment assoc’d w/ academic title
- Titles should not be bestowed arbitrarily nor used for coercion
- Community derms supporting dept is vital!
Question for Chair

- Why long term contributor no longer sends specimens to Univ DP lab?
- Quality of services by Univ lab: respected faculty providing excellent service
  - Community derms should want level of expertise offered by Univ DP lab
- Has level of service declined, fee structure become prohibitive, or has the contributor entered into a client billing agreement with another lab to generate profit?
  - Another ethical problem that is rampant!
Bottom Line

- I do not have the answer!
- Why community docs are not loyal to the university dept?
  – Greed?
- As physicians, our decisions should always be made in the best interests of pts & community
- Academic depts need to come up with ethical ways to generate loyalty & attract business to Univ DP lab & Mohs
Case 3: Environment: Mentorship & Fair Promotions

- A gifted, well-liked member of your faculty has not achieved the steps required for promotion
- Individual = key member of faculty & dept would suffer academically & financially if he left
- Several faculty have suggested he challenge the institution’s promotion rules
- Some suggested to dept chair that an exception is warranted for this individual …
- How should the dept chair respond?
• Want to promote teamwork & sense of being appreciated
• Some faculty do vital work for dept but that work may not viewed by institution as of value for promotion
• Faculty members may leave & depts suffer bc of failure to achieve tenure or promotion
• Institutions have changed promotion rules: recognize importance of diverse faculty & role of clinician educators but requirements remain rigorous & success requires planning
• Promotion committee: balanced between clinicians & researchers + work under Univ rules
• Require recommendation from chair but deliberations are independent → focus on work & service of individual + reputation (local, national, int’l)
• Risk to univ if individual challenges the system
• **Chair has no authority to grant an exception except to appeal decision to Dean**
• Professional support structures & friendships unravel once promotion decisions are challenged
• Result in shifting alliances → feelings of betrayal on all sides → poses great threat to dept & organization
• Key to success is fairness, consistency, & integrity of process

Faculty work attitudes, satisfaction & behavior strongly influenced by perception of fairness of promotion process & fairness of outcome

Procedural justice critical to reactions to decision, esp when outcome is not in favor of faculty member

People can accept outcome if perceive process fair

• Our case: pressure to allow one individual to challenge system initially may not seem risky as other faculty were supportive
• But voiced support shifts & opinions change when next promotion decision approaches
• Integrity of & trust in process must persist
• Ability of some to circumvent system → adverse effect on morale → damages professionalism, respect for institutional rules & sense of personal virtue

• **How did individual make it this far w/o achieving milestones required for tenure?**

• Chair plays active role in mentoring & monitoring progress to avoid crisis

• Focus on success of each individual candidate → critical to success of dept
Ethical Bottom Line

- Best solution: ensure this situation never occurs
- Univ promotion policies: understood by faculty
- Policies: reviewed for fairness + everyone understands steps required to achieve promotion
- Progress should be monitored & support provided when someone deviates off track
- Dept chair should foster common vision → members of faculty support one another to achieve personal & dept goals
Case 4: Managing Impairment: Dealing with Performance Issues

• A faculty member has demonstrated some errors in clinical judgement
• You discuss your concerns with him, but he becomes angry & resigns
• You have recently learned that he plans to join a well-respected group private practice in your community
• Is there an ethical obligation to notify senior member of group re: concerns?

Grant-Kels JM, Kels BD. J Amer Acad Dermatol 2011;65:833-835.
• Dept chairs: highly respected & their opinions carry weight
  – Accompanying obligation: never abuse this influence!
• Are concerns valid & do not represent a clash of personalities?
• Same principals apply to any physician who becomes aware of potentially dangerous practices by a colleague
• Code of ethics requires physician to:
  – tell the truth
  – prevent harm
  – manage limits of one’s competence
  – address inappropriate behavior of others

• Whose responsibility is it to manage a physician’s competence if they no longer work w/in dept?

• Physicians who share pts have greater insight into QOC delivered by colleagues than gleaned from exam or imparted by CME course attendance

Professionalism: Pt Interests 1st

• Medical societies position statements:
  – fundamental principles of “primacy of patient welfare”
  – professional responsibilities of “commitment to professional competence”
  – “commitment to improving quality of care”
  – “commitment to professional responsibilities”

• Dictates we participate in:
  “the process of self-regulation, including remediation & discipline of members who have failed to meet professional standards.”

“AMA’ s Code of Medical Ethics” on line Section 9 “Opinions on Professional Rights & Responsibilities”, section 9.031

“Reporting Impaired, Incompetent, or Unethical Colleagues: Initial reports of incompetence should be made to the appropriate clinical authority who would be empowered to assess the potential impact on patient welfare and to facilitate remedial action.”

• Hosp peer review body should be notified where appropriate
• Incompetence that poses immed threat to health & safety of pts should be reported directly to state licensing board
• Incompetence by physicians w/o hosp affiliation should be reported to local or state medical society &/or state licensing or disciplinary board

Bottom Line

• If there is **unequivocal** evidence that colleague is impaired or practicing medicine below SOC → ethically obligated to address it
• Must be confident that infractions are real before unjustifiably sullying reputation of colleague
• Evidence of repeated infractions should be required
• Multiple sources to corroborate data to clarify that the accusation is not based upon personality conflicts nor motivated by efforts aimed at retaliation &/or a wish to impose constraints that might be construed as restraint of free trade
Bottom Line

• Chair should address concerns w/ departing faculty
• If they are not willing to address issues thru additional education or appropriate alterations in behavior → chair should consider reporting concerns
• When any physician becomes aware of colleague practicing in unsafe manner → seek help
• State & specialty society committees available to work with, assist, & remediate impaired physician
• Accused physician must be treated respectfully & be given opportunity to defend their reputation
Personal Note
Ethical Conundrums of Chair

• Chair = Parent = Caring
• Words carry weight
• A successful chairperson cares more about their faculty than they do about themselves
• Consistency
• No favoritism
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• Perception of fairness & ethical climate has strong influence on employee satisfaction
• Good chair fosters a common vision, w/ all members of dept working together to achieve critical goals
• Each member of dept should feel they are an integral part of quest