The Impact of Disruptive Behavior on Patient Care and Practice, and Strategies to Mitigate Risks
Today’s moderator is Rachel Rosen, RN, MSN, Senior Clinical Risk Management Consultant, Medical Protective (Rachel.Rosen@medpro.com)

Rachel has more than 20 years of experience in patient safety, quality, and risk management — both as an internal leader and as an external consultant.

Her healthcare industry customers have included multi-hospital systems, large acute hospitals, long-term acute care facilities, critical access hospitals, healthcare services, and managed care organizations.

Rachel has extensive experience in standards preparation and compliance, strategic organizational improvement planning and implementation, quality measurement, patient satisfaction, and medical staff quality and peer review.

Rachel is a graduate of Ball State University with a bachelor of science degree in nursing, and she earned a master of science degree in nursing administration from Indiana University. Rachel is a member of the American Society for Healthcare Risk Management and the Indiana Society for Healthcare Risk Management.
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Objectives

At the conclusion of this program, you should be able to:

1. Identify three different types of disruptive behavior.
2. Describe the potential effects that disruptive behavior can have on patient care and professional practice.
3. Recognize behaviors in themselves, peers, and/or staff that might be considered disruptive behavior.
4. Implement effective strategies to address disruptive behaviors when encountered in the workplace.
Today’s Program

Today’s speaker is Joyce Bruce, RN, MSN, JD, CPHRM, Senior Patient Safety & Risk Consultant, MedPro Group (Joyce.Bruce@medpro.com)

Joyce provides comprehensive services to healthcare systems, hospitals, and clinics in the Midwest. She has more than 20 years of experience in the healthcare industry working in clinical practice, hospital administration, law, and consulting.

Joyce’s extensive clinical leadership includes experience as director of nursing in tertiary and pediatric facilities. In these roles, she led the development of quality programs, delivery of care models, and clinical care paths, including creation of data collection systems. In addition to her healthcare background and expertise, Joyce’s legal experience includes insurance defense, criminal defense, and healthcare law.

Joyce is a graduate of Indiana University with a bachelor of science degree in nursing and a master of science degree in nursing administration. Joyce earned her juris doctorate from Indiana University–Indianapolis. She is a member of the Indiana Bar, Ohio Bar, American Society for Healthcare Risk Management, the American Association of Nurse Attorneys, and Ohio Society for Healthcare Risk Management. She is also a certified professional in healthcare risk management.
Today’s speaker is Dorie Rosauer, RN, MBA, Senior Patient Safety & Risk Consultant, MedPro Group (Doral.Rosauer@medpro.com)

Dorie has more than 30 years of experience in the healthcare industry and has achieved an understanding of the challenges and opportunities facing both clinicians and hospitals. Throughout her career, Dorie has worked as a staff nurse, nurse manager, and nursing supervisor.

Additionally, Dorie has managed the day-to-day organizational operations of quality, risk management, infection control, safety, self-insured retentions, and physician professional liability. During her recent years as a risk management consultant, Dorie’s focus has been on identification and implementation of cutting-edge, proactive, risk-reduction strategies.

Dorie is licensed as a registered nurse in Illinois and earned her MBA from St. Ambrose University, Davenport, Iowa. She is a member of the American Society for Healthcare Risk Management and the Wisconsin Society for Healthcare Risk Management. Dorie is past president of the Illinois Society of Healthcare Risk Management.
“Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.”

AMA Opinion 9.045 - Physicians with Disruptive Behavior
Registration Polling Results

- I have personally experienced
- I have intervened
- My practice/organization has a policy
- I feel supported by management
- I have been afraid to speak up
- I have observed a poor patient outcome
- My practice has experienced a reduction

Answer options:
- Yes
- No
- N/A
Types of Disruptive Behaviors

- Disrespectful
- Aggressive
- Passive
- Passive aggressive (subversive)
- Emotional — verbal
- Physical
Common Themes

- Comments that undermine a patient's trust in other caregivers or the hospital.
- Comments that undermine a caregiver's self-confidence in caring for patients.
- Failure to adequately address safety concerns or patient care needs expressed by another caregiver.
- Intimidating behavior that suppresses input by other members of the healthcare team.
- Deliberate failure to adhere to organizational policies without adequate evidence to support the alternative chosen.

Retaliation against any member of the healthcare team who has reported an instance of violation of the code of conduct or who has participated in the investigation of such an incident, regardless of the perceived veracity of the report.
Disruptive Behavior and Clinical Outcomes

Survey of disruptive behavior in nurse–physician relationships

% of respondents who knew of an adverse event that occurred as a result of disruptive behavior 17%

% of above respondents who thought the event could be prevented 78%

Negative impact:
Stress, frustration, concentration, team collaboration, information transfer, communication, nurse-physician relationships
Impact on Patient Safety

**Institute for Safe Medication Practices Survey**

% of respondents who felt pressured to dispense or administer a drug despite serious and unresolved safety concerns  
49%

% of respondents who have kept quiet rather than question a known intimidator  
40%

**Coping methods:**

Avoiding the abuser, even if this means failing to call when warranted and avoiding making suggestions that might improve care.
Case #1 – Physician Anger

Doctor answering phone in dark on-call room.

“This better be good, I just got to sleep. Why can’t he take care of it?! 

Wait a minute...stop talking! Is it a car accident or a C-section? So who did the C-section?

You mentioned something in your babbling about blood pressure. Does the patient have an IV?

You don’t know?! Why don’t you know?!

You idiots call me all the time. Just get me the information and call me back!”
Case #1: The Issues

- Negative effect on others
- Behaviors shaped quickly
- Lack of respect
- Information not relayed
- Sleep deprivation, stress
- Chain of command not followed
- Risk of poor outcomes
Case #1: The Findings

A national survey of 1,627 physician executives helped characterize issues regarding disruptive doctors.

- 36% said most behavior problems stem from conflicts between physicians and staff members, including nurses.
- 43% said the behavior problems were not linked to alcohol or substance abuse.
- 50% said problems are reported only when a doctor is completely out of line and a serious violation occurs.
- 83% said problems with physician behavior involve disrespect.
- 95% said their organizations have met with a disruptive physician in the last 2 years to discuss behavioral problems.
Case #1: Strategies

- Policy and procedures
- Medical executive committee and leadership support
- Early intervention and immediate action when behavior occurs
- Staff education and team training
- Handoff procedures, e.g., SBAR
- Culture of safety surveys
Office nurse finds physician snoozing in office.

‘Where have you been?! We’ve been looking for you? Dr. Johnson had to take your 11 a.m. patient and your 12 p.m. patient! What’s going on?”

Disheveled physician gets up, unsteady on his feet, trying to find his stethoscope, attempting to get back to work. “What’s the rest of the day look like?”

Office nurse backs away from the physician after she smells alcohol on his breath and says, “I think the rest of your day is at home. You need to go home right now!”
Case #2: The Issues

- Patient safety risks
- Workarounds by staff to accommodate disruptive behavior
- Poor documentation
- Poor staff morale
- Practice reputation
Case #2: The Findings

- Studies indicate that between 8% and 12% of physicians will develop a substance use disorder at some point during their lives.
- Impairments may also include:
  - Chronic sleep deprivation
  - Physical illness
  - Mental illness
  - Declining competencies

Case #2: Strategies

Address patient care needs and safety first.

Coordinate an immediate intervention.

Require “for cause” testing based on both corporate agreement and office handbook.

Identify resources (e.g., state medical society, other referral agencies, and employee assistance program).

Monitor and follow up.

Establish partnership/operating agreements.
Case #3 – Physician Inappropriate Behavior

Office staff member talking with inappropriate behavior by one of the physicians in the practice.

“I’m sorry to bother you but it’s gotten out of control. At first, I felt he was looking at me. Now every other day there’s a new dirty joke.

I can’t get a chart with him trying to give me a massage. I’ve been trying to be polite. I dread coming to work in the morning. I have been doing research online and everything he does matches sexual harassment from what I read.

I really need this job. I don’t think I’m being overly sensitive. I think he’s being inappropriate. Frankly I can’t take it anymore. I wanted to talk with you before I went any further. I really don’t know what to do.”
Case #3: The Issues

• Sexual harassment
• Hostile work environment
• Fear of job loss
• Patient safety compromised — communication/hand off issues
Case #3: The Findings

Reluctance to report disruptive behavior

- Intimidation, fear of being reported as a troublemaker
- Concern for job
- Fear of conflict
- Concern for confidentiality
- Lack of confidence in system to follow through
- Lack of information regarding where to get help
Case #3: Strategies

1. Educate staff and physicians about policy/procedure: zero tolerance, no retribution.
2. Investigate all allegations.
3. Take immediate action according to policy/procedure, with feedback to staff involved.
Case #4 – Physician Process Breakdown

Office staff member on the phone in an office.

“I’m looking for it right now (chart). This is ridiculous. You should see this office. It’s a complete disaster!

Yes, he’s here today but I haven’t seen him since this morning. I mentioned that you called and he completely bit my head off!

I guess I can call the patient and make up something like the labs didn’t come in and that’s why he hasn’t called.

I know he’s having problems at home ... he doesn’t call, he doesn’t finish his orders. He won’t let us help. Things are completely falling apart...”
Case #4: The Issues

- Assessment of situation — first issue or there’s always some excuse
- Burden on the practice, staff
- Inefficiencies in the office
- Chaotic environment erodes patients’ confidence in physician and practice
The Pennsylvania Patient Safety Authority analyzed 177 safety event reports between May 2007 and October 2009 that listed disruptive behavior as a potential cause of patient harm. The reported data showed the following:

- 41% due to conflict between physicians
- 17% due to clinicians not following procedures
- 10% due to lack of response, or delays
- 12% listed as “other”
- 20% not attributed to a specific behavior
Case #4: Strategies

- Compliance with polices/procedures as part of partnership agreement (financial incentives)
- Monthly meetings with the physician to review performance
- Cancelling of patients until charts complete
- Chain of command/referral
The Situation

• “Precipitating” events start outburst in OR, which ends in equipment room
  o Shouting match
  o Foul language
  o Posturing/slamming down utensil, hand, etc.

• Disparity in size/vocals/authority/power
The Outcome

- "Victim" walks out and does not return; takes medical leave
- Sues surgeon (assault)
- Sues corporation (negligent hiring/intentional infliction)
- Sues hospital (hostile work environment/breach of contract)
Lessons Learned: The Problem That Kept on Giving

Entity:

- EEOC/hostile work environment
- Interference with a business relationship
- Patient and care issues/complaints
- Negligent credentialing
- Breach of contract
- Opening of "protected peer review" documents for state agency
Lessons Learned: The Problem That Kept on Giving

Disruptive surgeon:

• Assault
• Intentional infliction of emotional distress
• Peer review action
• Privileges/bylaws action
The Final Result

• Personal liability exposure
• Hospital lawsuit ensued
• Practice declared bankruptcy
• Relationship with hospital ended
• Surgeon left practice, no longer in clinical practice
Lessons Learned

- Deal with quickly
- Each and every time
- Don't forget the “victim”
- Have policies/procedures in place
Summary

1. Disruptive behavior threatens the safety and well-being of patients, staff, teams, and organizations.

2. Historically, disruptive behavior has not been addressed, but that is no longer the case.

3. Effective strategies include practice policies and procedures that address disruptive behaviors, physician and staff education, and commitments from all members of the team to consistently engage in respectful behaviors.
Resources

- Professional associations
- Anger management programs
- Employee assistance programs/wellness programs
- State medical boards
What questions do you have?

Thank You!
THANK YOU for your participation!

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