Nip It in the Bud

Strategies for Addressing Disruptive Behavior in Healthcare
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Traci has been a nurse for more than 28 years, with a focus on quality, risk, and patient safety in the past 15 years. Her clinical experience includes CCU, PCU, endoscopy, and perioperative care.

Before joining MedPro Group, Traci was a hospital risk manager for a large tertiary academic medical center in Washington, DC. Her responsibilities included day-to-day operations of the department, where she reviewed and analyzed event reports, conducted investigations, participated in disclosure conversations, performed root cause analysis of events, tracked action plan compliance, and provided claims reports to the corporate branch. Traci also served as an adjunct clinical educator for a nursing program in eastern North Carolina.

Additionally, Traci is a TeamSTEPPS® master trainer; she helps healthcare leaders, providers, and staff use communication and teamwork strategies to improve working relationships, enhance patient safety, and reduce the risk of errors.

Traci earned a master of science degree in patient safety leadership from the University of Illinois Chicago and a bachelor’s degree in nursing from East Carolina University. Traci is currently enrolled in a master of science in nursing program with a concentration in acute care leadership at East Carolina University. She is a member of the American Society for Health Care Risk Management, National Association for Healthcare Quality, and National Patient Safety Foundation.
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Today’s faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at MedPro Group have reported that they have no relevant financial relationships with any commercial interests.
At the conclusion of this program, participants should be able to:

- Identify three different types of disruptive behavior
- Describe the potential effects that disruptive behavior can have on patient care and professional practice
- Recognize behaviors in themselves, peers, and/or staff that might be considered disruptive behavior
- Implement effective strategies to address disruptive behaviors when encountered in the workplace
Inappropriate behavior “means any conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as ‘disruptive behavior’”

Disruptive behavior “means any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or nonverbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised”

**Behaviors**

**Appropriate**
- Encourages clear communication
- Is part of team problem solving
- Offers respectful and constructive criticism

**Inappropriate**
- Belittles or berates others
- Makes inappropriate comments to staff
- Refuses to communicate

**Disruptive**
- Exhibits through violence and intimidation and is not self-corrected
## Disruptive behaviors

<table>
<thead>
<tr>
<th>Passive</th>
<th>Passive aggressive</th>
<th>Aggressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Incomplete charting</td>
<td>- Excessive sarcasm</td>
<td>- Anger outbursts</td>
</tr>
<tr>
<td>- Avoidance</td>
<td>- Implied threats</td>
<td>- Raised voice</td>
</tr>
<tr>
<td>- Failure to answer calls</td>
<td>- Inappropriate jokes</td>
<td>- Demeaning</td>
</tr>
<tr>
<td>- Frequent absences</td>
<td>- Refusal to complete tasks</td>
<td>- Intimidation</td>
</tr>
<tr>
<td>- Chronic tardiness</td>
<td>- Condescending language/tone</td>
<td>- Public criticism</td>
</tr>
<tr>
<td>- Getting behind</td>
<td></td>
<td>- Physical aggression</td>
</tr>
<tr>
<td>- Refusing to help</td>
<td></td>
<td>- Physical violence</td>
</tr>
</tbody>
</table>

Disrespect is the most common disruptive behavior

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Case studies
Case study: improper management of anesthesia patient

- 74-year-old fell from a ladder sustaining multiple fractures
- Admitted to intensive care unit from the emergency department
- Surgical reduction of his elbow 6 days post fall
- Surgical time was more than 4 hours
- Patient coded in the postanesthesia care unit and died several days later

<table>
<thead>
<tr>
<th>Contributing factors</th>
<th>Patient monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical judgment</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Altered documentation (contributed to difficult defense)</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication among providers</td>
</tr>
<tr>
<td>Behavior-related</td>
<td>Inappropriate behavior</td>
</tr>
</tbody>
</table>
Case study: improper management of anesthesia patient

- 37-year-old scheduled for staging arthroscopy with high tibial osteotomy at a surgery center
- Uneventful intra-articular femoral sciatic block completed
- General anesthesia was administered intra-articular
- Tourniquet was used on right thigh and vital signs changed following deflation
- Code was called, advanced cardiovascular life support was followed, and patient was transported to a nearby hospital

Contributing factors:

- Clinical judgment
- Technical skill
- Clinical environment
- Behavior
- Patient monitoring
- Improperly used equipment
- Workflow/workload
- Inappropriate behavior/boundaries
Case study: improper management of surgical patient

- 60-year-old patient with bilateral knee replacement
- Bilateral ischemia of both legs
- Delay in response
- Emergency vascular surgery
- Left above the knee amputation and amputation of right foot

<table>
<thead>
<tr>
<th>Contributing factors</th>
<th>Patient assessment issues; selection and management of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical judgment</td>
<td>Staff issues; policy/protocol</td>
</tr>
<tr>
<td>Administrative</td>
<td>Communication among providers</td>
</tr>
<tr>
<td>Communication</td>
<td>Inappropriate behavior/boundaries</td>
</tr>
<tr>
<td>Behavior</td>
<td></td>
</tr>
</tbody>
</table>
Prevalence and magnitude

American College of Physician Executives and QuantiaMD® survey results

- 70% indicated physician disruptive behavior occurs monthly in their organizations
  - 59% using degrading comments
  - 54% not cooperating with other providers
  - 55% not following established protocols
- 26% engaged in disruptive behavior at least one time
- 50% changed physicians or left the practice
- 90% believe disruptive behavior affects patient care (always, sometimes)
- Identified needs: confronting disruptive physicians, enacting strategies for disciplining disruptive physicians, improving culture and communication

Two most common contributors: (1) workload and (2) learned behaviors

Prevalence and magnitude (continued)

- The best estimate is 3%-5% of physicians present with disruptive behavior
- In a physician executive survey:
  - 70% stated these disruptive behaviors are from the same physicians
  - These behaviors are most common between a nurse or allied healthcare staff member and the physician
  - 80% stated disruptive behavior is under-reported due to fear of retaliation
- The perception of physicians versus nurses
- Inconsistency in resolving behavior

Contributing factors to disruptive behavior

- Psychiatric conditions (symptoms, disorders)
  - Depression
  - Bipolar disorders
- Personality disorders
  - Narcissism
  - Paranoia
  - Passive-aggressive
  - Borderline/mixed
- Occasional incident
  - Substance abuse
## Triggers contributing to disruptive behavior

<table>
<thead>
<tr>
<th>Intrapersonal – Affects job performance</th>
<th>Interpersonal – Relationship between two or more people</th>
<th>Organizational – Inhibits interaction at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of competency or fatigue</td>
<td>• Lack of leadership</td>
<td>• Systems</td>
</tr>
<tr>
<td></td>
<td>• Questioning providers about patient care</td>
<td>• Processes</td>
</tr>
<tr>
<td></td>
<td>• Staff diversity</td>
<td>• Culture</td>
</tr>
</tbody>
</table>

Impact of disruptive behavior

According to The Joint Commission, disruptive behavior:

• Fosters medical errors
• Decreases patient satisfaction
• Increases preventable adverse events
• Increases the cost of care
• Drives away clinicians and others on the healthcare team

Medical errors

- 42% More mistakes in diagnosis
- Performance reduced when exposed to disruptive behavior
- 11% - 14% Higher risk of surgical and medical complications
- 31.7% If more than 4 behavioral reports, had higher complication risk

Decreases in patient satisfaction

<table>
<thead>
<tr>
<th>Predicted risk category</th>
<th># (%) of physicians</th>
<th>Relative expense</th>
<th>% of total expense</th>
<th>Score (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (high)</td>
<td>51 (8)</td>
<td>73</td>
<td>50%</td>
<td>&gt; 50</td>
</tr>
<tr>
<td>4</td>
<td>52 (8)</td>
<td>42</td>
<td>29%</td>
<td>41-50</td>
</tr>
<tr>
<td>3</td>
<td>76 (12)</td>
<td>4</td>
<td>4%</td>
<td>21-40</td>
</tr>
<tr>
<td>2</td>
<td>147 (23)</td>
<td>6</td>
<td>13%</td>
<td>1-20</td>
</tr>
<tr>
<td>1 (low)</td>
<td>318 (49)</td>
<td>1</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>644 (100)</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Increase in malpractice claims

About 8% of physicians are sued annually

Odds of being sued at least once in one’s career based on behavior

- Does not consider suggestions – 5.99
- Snaps at others when frustrated – 5.92
- Does not pay attention – 4.97
- Does not inform others of treatment plan – 4.86
- Talks down to others – 4.28
Factor/odds ratio

- policy/protocol not followed: 2.45
- inadequate patient assessment: 1.85
- insufficient documentation: 1.76
- selection and management of therapy: 1.60
- staff issues: 1.60
- communication among providers: 1.44
- failure to obtain a consult or referral: 1.43
- technical performance: 1.43
- patient monitoring: 1.14
- patient factors: 0.64
- third-party involved: 0.47

CRICO. (2020). The power to predict: Leveraging medical malpractice data to reduce patient harm and financial loss. Retrieved from https://www.rm.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict
Predicting indemnity

These three factors will significantly impact financial outcomes.
Indemnity payments, many in excess of $1M, are expected in nearly half of these cases.

<table>
<thead>
<tr>
<th>Factor Involved</th>
<th>Indemnity Ranges PERCENT OF CASES</th>
<th>closed with pay:</th>
<th>closed without pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>policy/protocol</td>
<td>1% 5% 58%</td>
<td>$3M+</td>
<td>zero indemnity</td>
</tr>
<tr>
<td>insufficient documentation</td>
<td>1% 4% 50%</td>
<td>$1M–3M</td>
<td></td>
</tr>
<tr>
<td>patient assessment</td>
<td>1% 5% 41%</td>
<td>&lt;$1M</td>
<td></td>
</tr>
<tr>
<td>none of the above</td>
<td>&lt;1% 22%</td>
<td></td>
<td></td>
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</tbody>
</table>

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Policy and protocol

![Policy/Protocol Failure Types](image)

- **policy/protocol not followed**: 68%
  - Average Indemnity: $353K
- **need for policy/protocol**: 34%
  - Average Indemnity: $390K
**Patient assessment**

![Assessment Failure Types](image)

<table>
<thead>
<tr>
<th>Assessment Failure Types</th>
<th>CASES</th>
<th>AVG INDEMNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>response to signs/symptoms</td>
<td>53%</td>
<td>$568K</td>
</tr>
<tr>
<td>narrow diagnostic focus</td>
<td>36%</td>
<td>$546K</td>
</tr>
<tr>
<td>diagnostic test ordering</td>
<td>33%</td>
<td>$536K</td>
</tr>
<tr>
<td>history and physical</td>
<td>27%</td>
<td>$532K</td>
</tr>
<tr>
<td>test interpretation</td>
<td>17%</td>
<td>$610K</td>
</tr>
<tr>
<td>other</td>
<td>7%</td>
<td>$550K</td>
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CRICO. (2020). The power to predict: Leveraging medical malpractice data to reduce patient harm and financial loss. Retrieved from [https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict](https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict)
Preventable adverse events

Would not question an order

Physical violence from physicians

A victim may not contact an abuser, even when a clinical call is warranted

Increases cost of care and financial implications

Nurse retention
- 60% quit within 6 months
- Direct costs: $60,000-$100,000

Adverse events
- 1 in 10 patients are harmed
- Average adverse drug event cost: $2,000-$5,800
- Average added costs for healthcare associated infections: $20,000-$38,000

Medical malpractice and state fines
- Average medical error based claim: $521,560
- Fines per hospital: $25,000-$100,000
- $55 billion in medical liability system

10% of total healthcare costs on insurance & defensive medicine

Potential indicators of disruptive behavior

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<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>Frequent job changes</td>
</tr>
<tr>
<td>Employed in jobs inappropriate for their qualifications</td>
</tr>
<tr>
<td>Reluctant to provide references or permission to contact</td>
</tr>
<tr>
<td>History of either voluntary or involuntary relinquishment of licensure or medical staff membership</td>
</tr>
<tr>
<td>History of limitation, reduction, or loss of clinical privileges</td>
</tr>
<tr>
<td>Excessive claims resulting in final judgments against them</td>
</tr>
<tr>
<td>History of investigations or disciplinary actions</td>
</tr>
<tr>
<td>Poor performance evaluations</td>
</tr>
</tbody>
</table>
Empowering to report

Peer messengers share behavior reports directly with recipients

- Vanderbilt: coworker observation reporting system (CORS) to report unsafe conduct and behaviors known to undermine team
- 3% of medical staff (physicians and advanced practice professionals) had pattern of CORS reports
- 71% of recipients with CORS patterns following peer messenger feedback were not named in any subsequent CORS reports (1-year follow-up period)

Peer messenger feedback is helpful in encouraging behavior self-regulation
Promoting professionalism pyramid

Co-worker Observation Reporting System™ (CORS) national data sample

Organizational risk strategies

- Policy and procedures (code of conduct)
- Medical executive committee and leadership support
- Early intervention and monitoring
- Staff education and team training
- Handoff procedures, e.g., situation, background, assessment, recommendation (SBAR)
- Culture of safety surveys
Risk strategies for physicians and other providers

- Chain of command/referral
  - Physician: cancel appointments until charts complete
  - Physician performance: monthly review meetings
  - Compliance: partnership agreement (financial incentives)
  - Compliance: policy and procedures
  - Staff and physician education policy and procedures
Summary

Disruptive behavior threatens patients, teams, and organizations

- Culture of fear and intimidation
- Low staff morale
- Staff turnover
- Erodes collaboration
- Erodes communication
- Patient safety and harm
- Litigation
Resources

Directory of Physician Assessment and Remedial Education Programs (Federation of State Medical Boards):
https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf

MedPro Group: www.medpro.com

Anger management programs

Employee/physician assistance programs

Wellness programs

Professional associations

State medical boards
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