Nip It in the Bud

Strategies for Addressing Disruptive Behavior in Healthcare

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Speaker Bio

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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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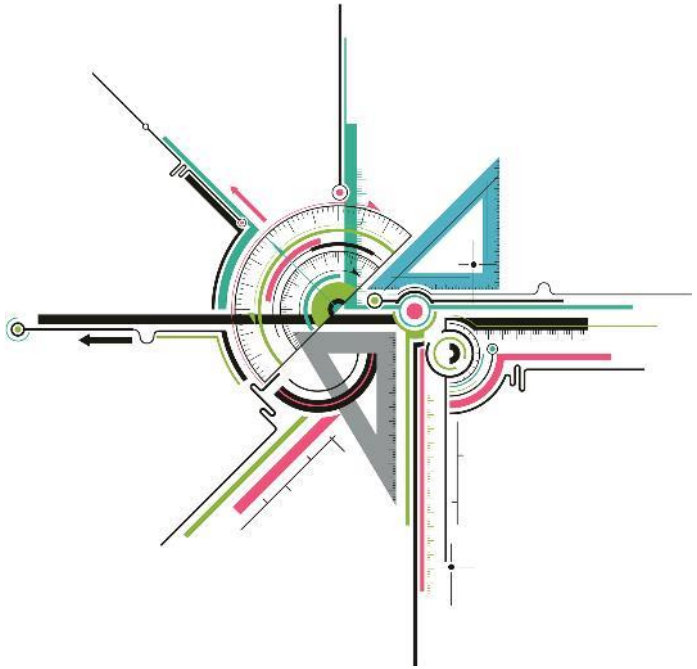
Objectives

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



Definition

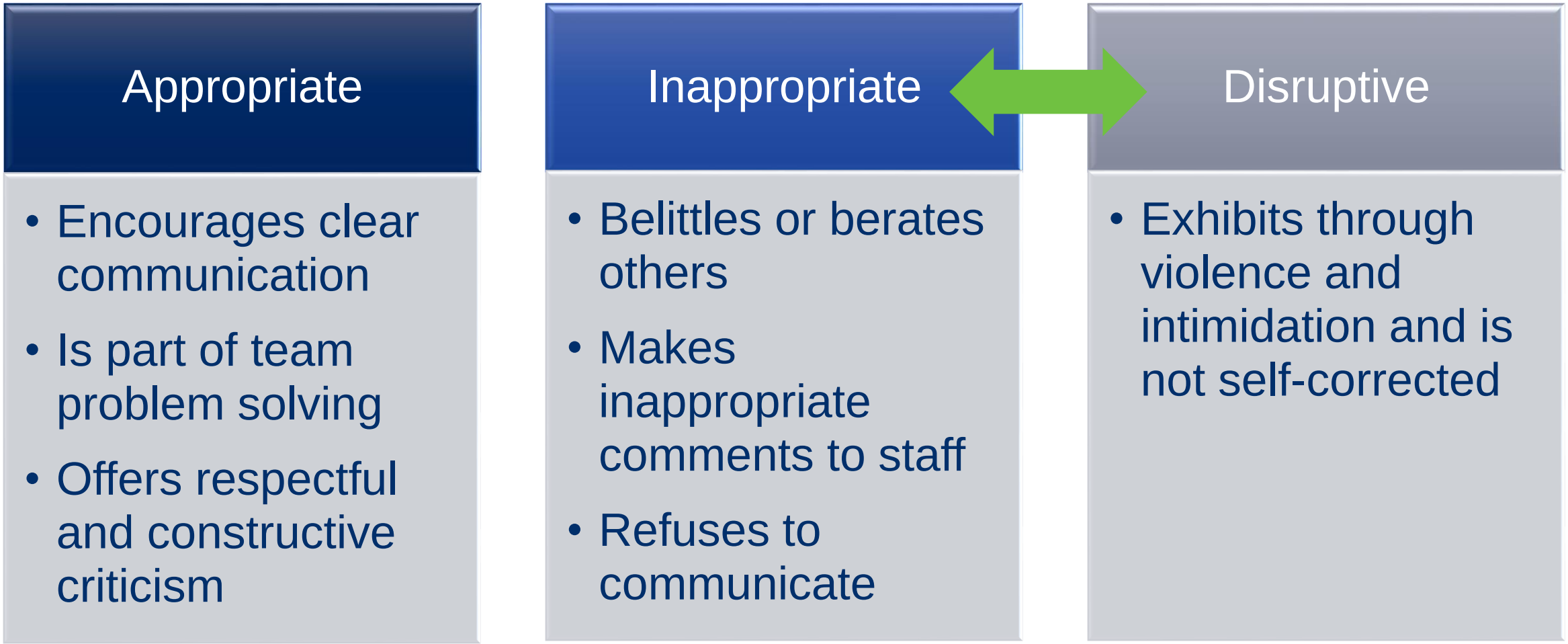
American Medical Association defines disruptive behavior

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”

American Medical Association. (2009). AMA Opinion 9.045 - Physicians with disruptive behavior. Retrieved from https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i09-ceja-physicians-disruptive-behavior.pdf

Behaviors



American Medical Association. (2009). AMA Opinion 9.045 - Physicians with disruptive behavior. Retrieved from https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i09-ceja-physicians-disruptive-behavior.pdf

Disruptive behaviors

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

Disrespect is the most common disruptive behavior

American Medical Association. (2009). AMA Opinion 9.045 - Physicians with disruptive behavior. Retrieved from https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i09-ceja-physicians-disruptive-behavior.pdf

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

Contributing factors

Clinical judgment	Patient monitoring
Documentation	Altered documentation (contributed to difficult defense)
Communication	Communication among providers
Behavior-related	Inappropriate behavior

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	Patient monitoring
Technical skill	Improperly used equipment
Clinical environment	Workflow/workload
Behavior	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

Contributing factors

Clinical judgment	Patient assessment issues; selection and management of therapy
Administrative	Staff issues; policy/protocol
Communication	Communication among providers
Behavior	Inappropriate behavior/boundaries

Prevalence and magnitude

American College of Physician Executives and QuantiaMD® survey results

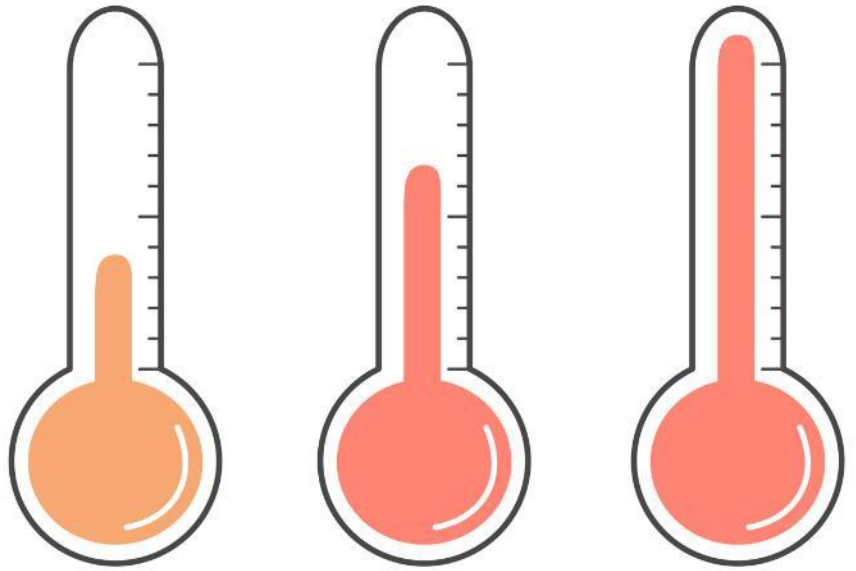
- 70% indicated physician disruptive behavior occurs monthly in their organizations
  - 59% using degrading comments
  - 54% not cooperating with other providers
  - 55% not following established protocols
- 26% engaged in disruptive behavior at least one time
- 50% changed physicians or left the practice
- 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

MacDonald, O. (2011, May 15). Disruptive physician behavior. QuantiaMD. Retrieved from https://www.kff.org/wp-content/uploads/sites/2/2013/03/quantiamd_whitepaper_acpe_15may2011.pdf

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

Intrapersonal – Affects job performance	Interpersonal – Relationship between two or more people	Organizational – Inhibits interaction at work
• Lack of competency or fatigue	• Lack of leadership • Questioning providers about patient care • Staff diversity	• Systems • Processes • Culture

Bae, S.H., Dang, D., Karlowicz, K.A., & Kim, M.T. (2020). Triggers contributing to health care clinicians' disruptive behaviors. *Journal of Patient Safety, 16*(3), 1. https://doi.org/10.1097/pts.0000000000000288

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

Rehder, K. J., et al. (2020). Associations between a new disruptive behaviors scale and teamwork, patient safety, work-life balance, burnout, and depression. *The Joint Commission Journal on Quality and Patient Safety, 46*(1), 18-26. https://doi.org/10.1016/j.jcjq.2019.09.004

Medical errors

42% More mistakes in diagnosis

↓ Performance reduced when exposed to disruptive behavior

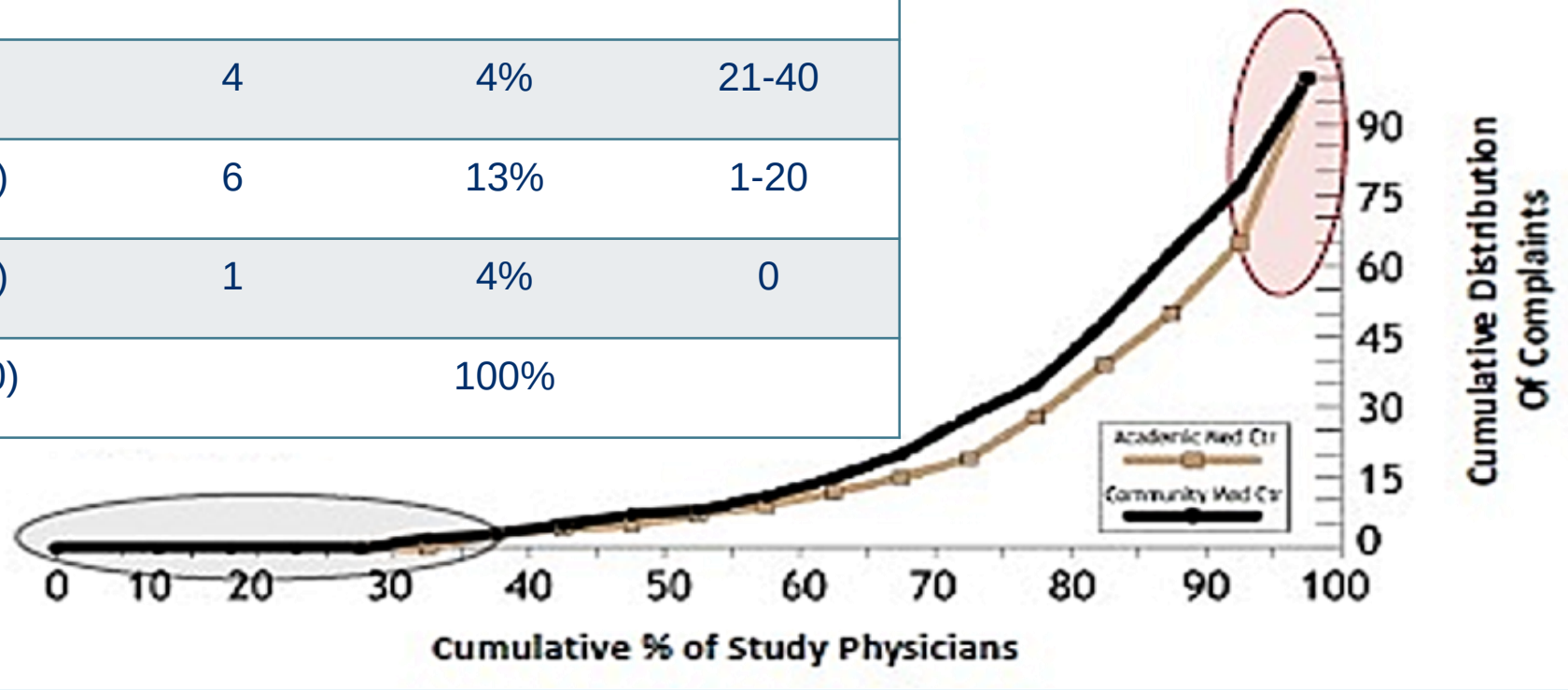
11% - 14% Higher risk of surgical and medical complications

31.7% If more than 4 behavioral reports, had higher complication risk

Hicks, S., & Stavropoulou, C. (2020). The effect of health care professional disruptive behavior on patient care. *Journal of Patient Safety*. Epub Jan 5; Schmidt, H.G., et al. (2016). Do patients' disruptive behaviors influence the accuracy of a doctor's diagnosis? A randomized experiment: Table 1. *BMJ Quality & Safety, 26*(1), 19-23. https://doi.org/10.1136/bmjqs-2015-004109

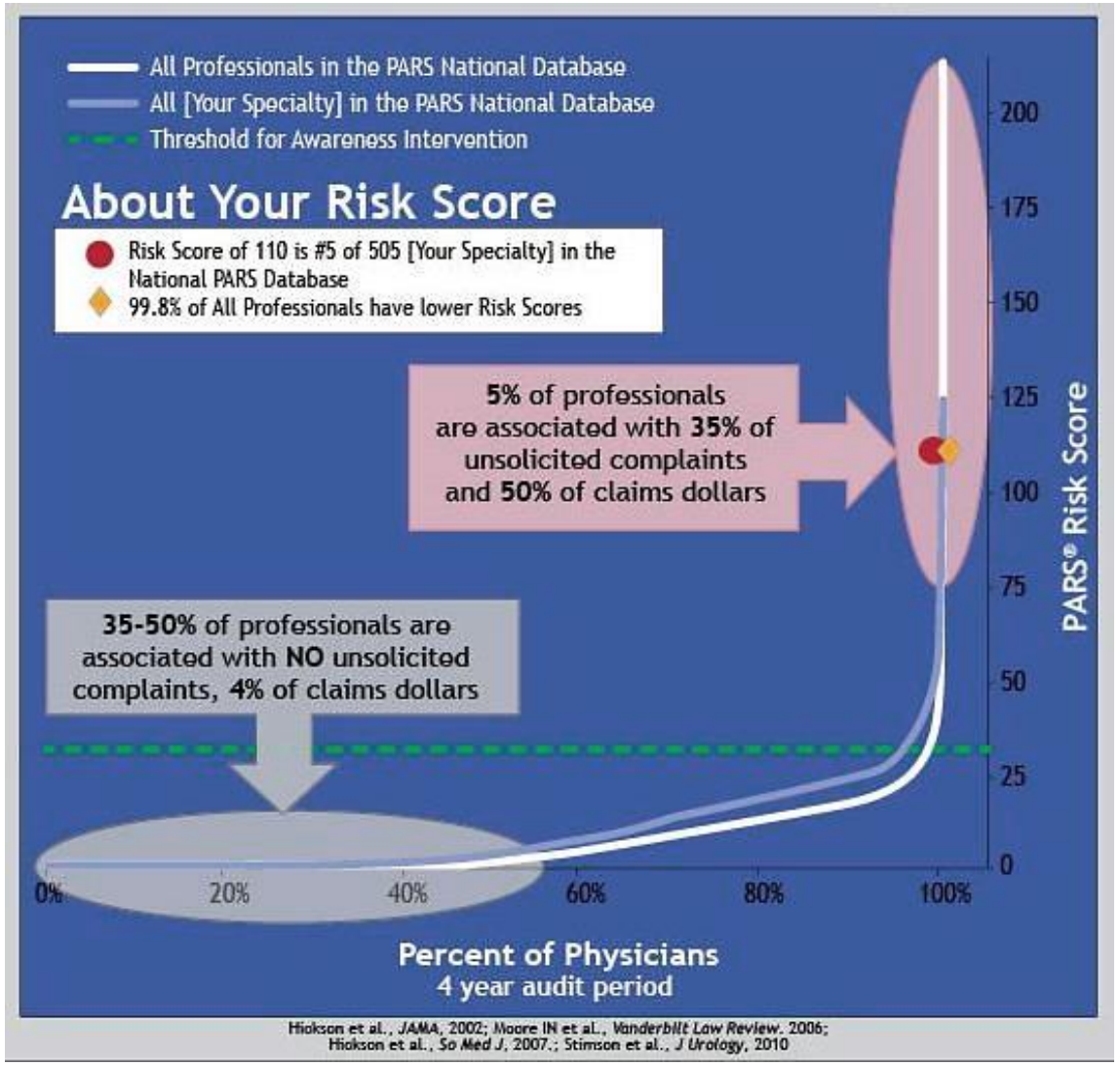
Decreases in patient satisfaction

Predicted risk category	# (%) of physicians	Relative expense	% of total expense	Score (range)
5 (high)	51 (8)	73	50%	> 50
4	52 (8)	42	29%	41-50
3	76 (12)	4	4%	21-40
2	147 (23)	6	13%	1-20
1 (low)	318 (49)	1	4%	0
Total	644 (100)		100%	



Hickson, G.B., et al. (2007). Patient complaints and malpractice risk in a regional healthcare center. *Southern Medical Journal, 100*(8), 791-796. https://doi.org/10.1097/smj.0b013e318063bd75; Moore, I., Pichert, J., Hickson, G., & Federspiel, C. (2006). Rethinking peer review: Detecting and addressing medical malpractice claims risk. *Vanderbilt Law Review, 59*(1175); Hickson, G.B., et al. (2002) . Patient complaints and malpractice risk. *JAMA, 287*(22), 2951-2957.

Patient Advocacy Reporting System® (PARS ®) national data sample



Hickson, G.B., et al. (2007). Patient complaints and malpractice risk in a regional healthcare center. *Southern Medical Journal, 100*(8), 791-796. https://doi.org/10.1097/smj.0b013e318063bd75; Moore, I., Pichert, J., Hickson, G., & Federspiel, C. (2006). Rethinking peer review: Detecting and addressing medical malpractice claims risk. *Vanderbilt Law Review, 59*(1175); Hickson, G.B., et al. (2002). Patient complaints and malpractice risk. *JAMA, 287*(22), 2951-2957; Vanderbilt Center for Patient and Professional Advocacy. The Patient Advocacy Reporting System® (PARS®) Program. Retrieved from https://www.vumc.org/patient-professional-advocacy/pars-program

Increase in malpractice claims

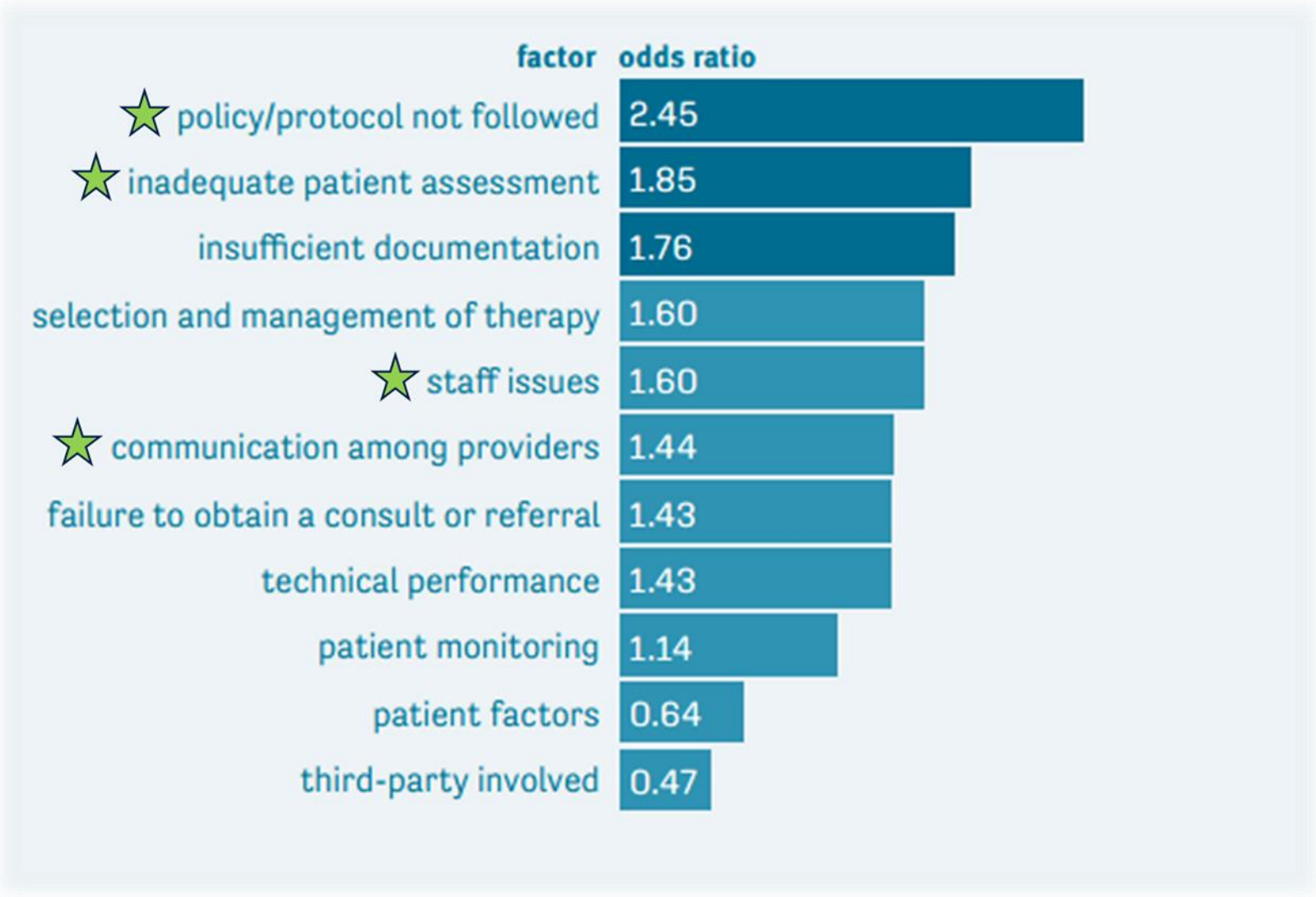
About 8% of physicians are sued annually

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

Lagoo, J., et al. (2019). Multisource evaluation of surgeon behavior is associated with malpractice claims. *Annals of Surgery, 270*(1), 84-90. https://doi.org/10.1097/sla.0000000000002742

Factor/odds ratio

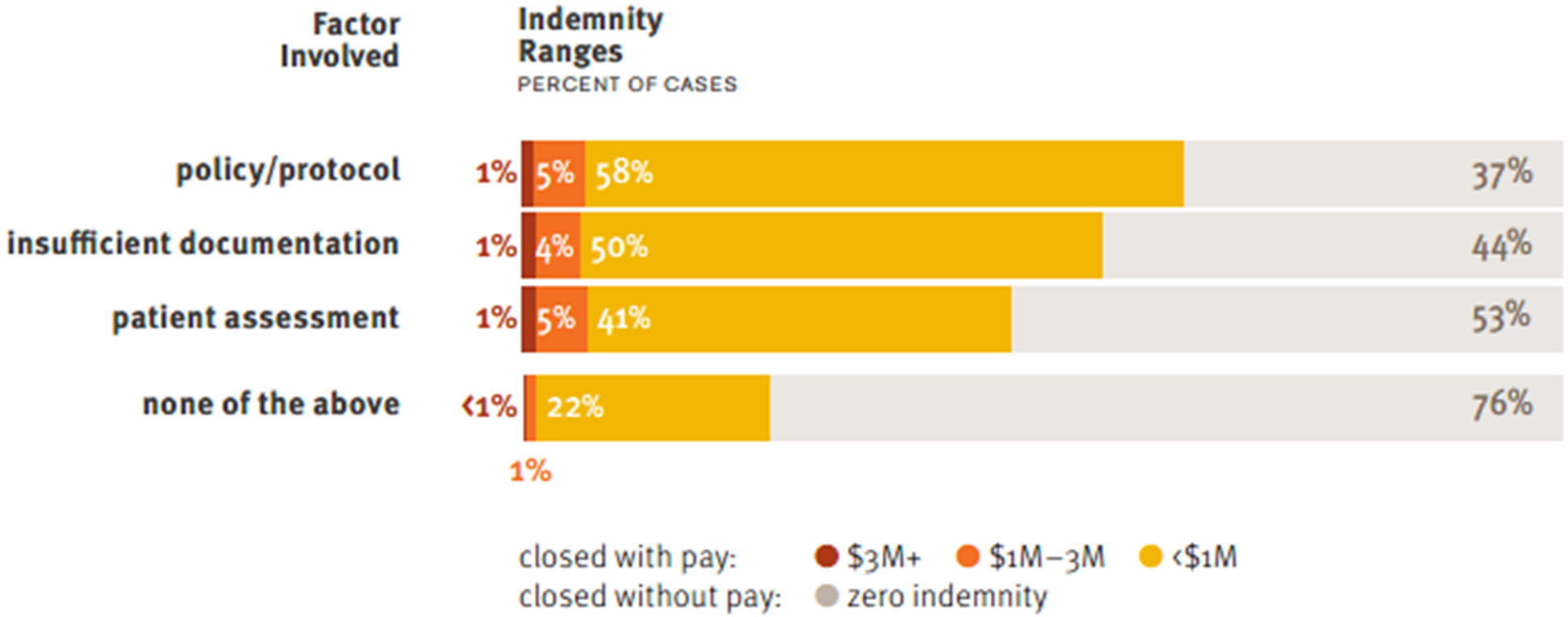


CRICO. (2020). The power to predict: Leveraging medical malpractice data to reduce patient harm and financial loss. Retrieved from https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict

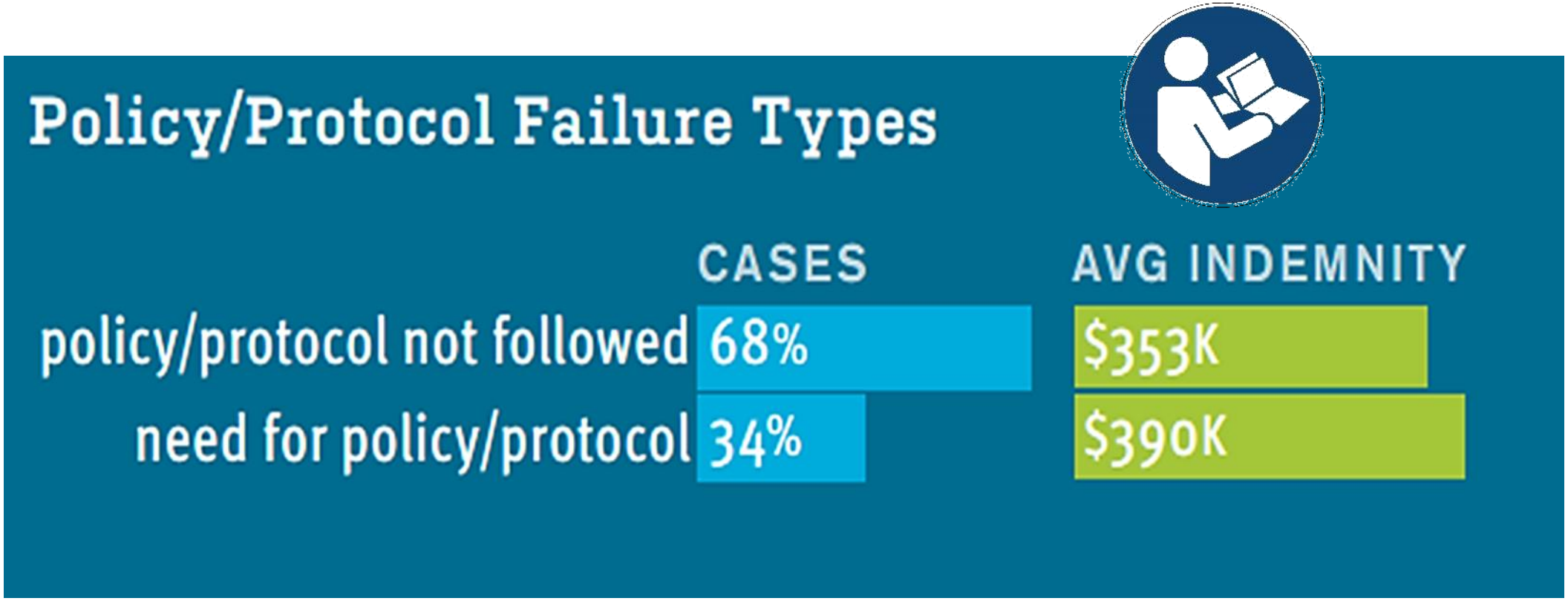
Predicting indemnity

These three factors will significantly impact financial outcomes.

Indemnity payments, many in excess of $1M, are expected in nearly half of these cases.



Policy and protocol



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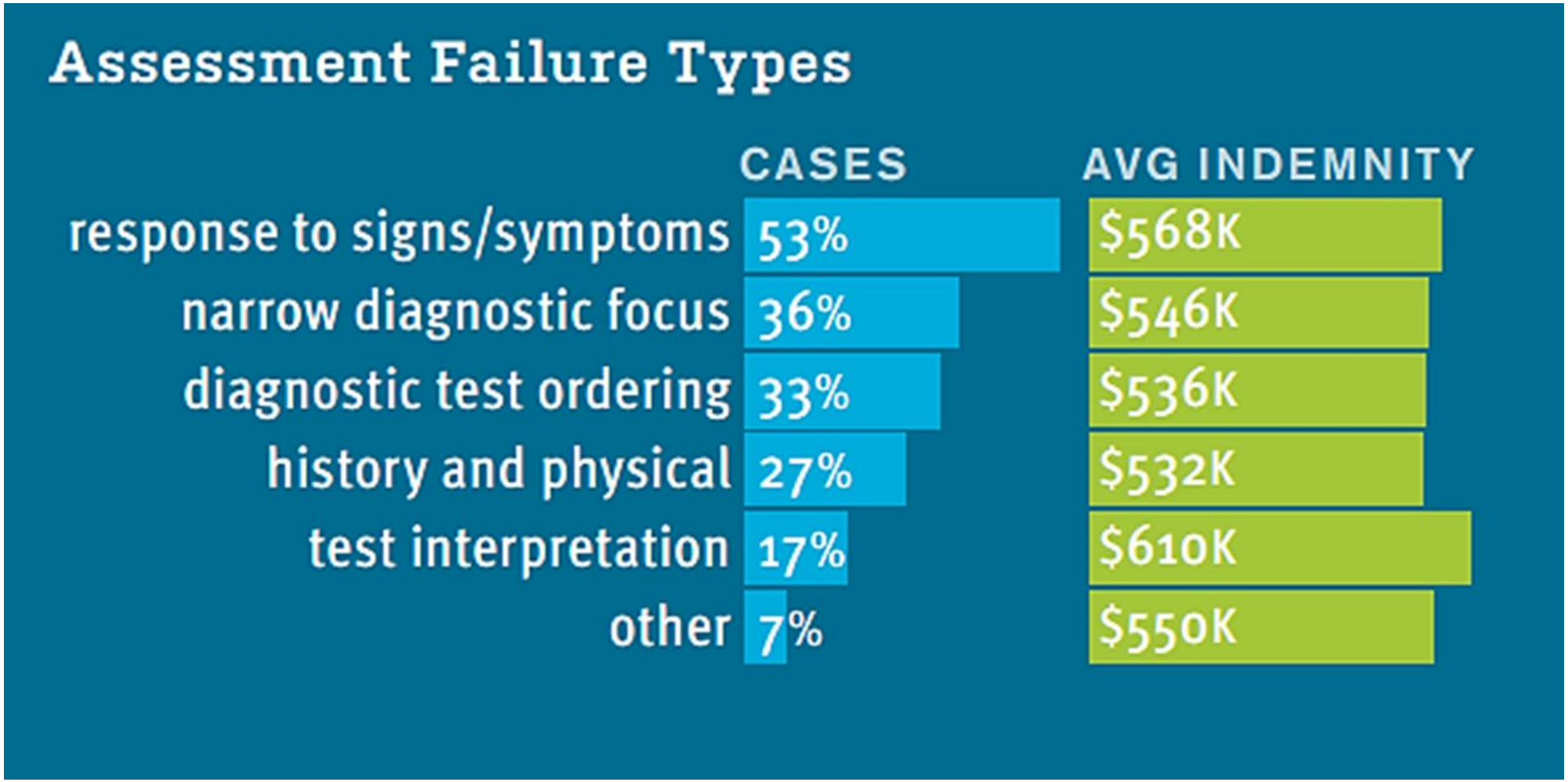
Patient assessment



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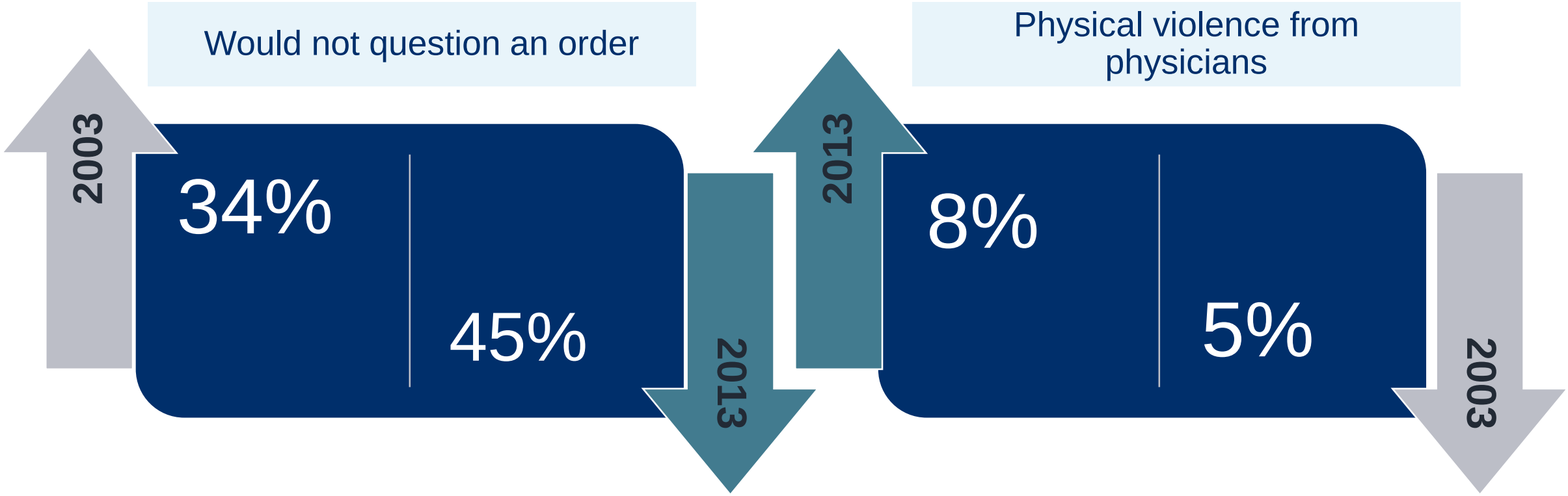
Preventable adverse events



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

Malone, B. (2016). Intimidating behavior among healthcare workers is still jeopardizing medication safety. *Nephrology Nursing Journal, 43*(2).

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

Rosenstein, A.H. (2010). Measuring and managing the economic impact of disruptive behaviors in the hospital. *Journal of Healthcare Risk Management, 30*(2), 20-26. https://doi.org/10.1002/jhrm.20049; Mello, M.M., Chandra, A., Gawande, A.A., & Studdert, D.M. (2010). National costs of the medical liability system. *Health Affairs, 29*(9), 1569-1577. https://doi.org/10.1377/hlthaff.2009.0807

Potential indicators of disruptive behavior

- Frequent job changes
- Employed in jobs inappropriate for their qualifications
- Reluctant to provide references or permission to contact
- History of either voluntary or involuntary relinquishment of licensure or medical staff membership
- History of limitation, reduction, or loss of clinical privileges
- Excessive claims resulting in final judgments against them
- History of investigations or disciplinary actions
- Poor performance evaluations

Empowering to report

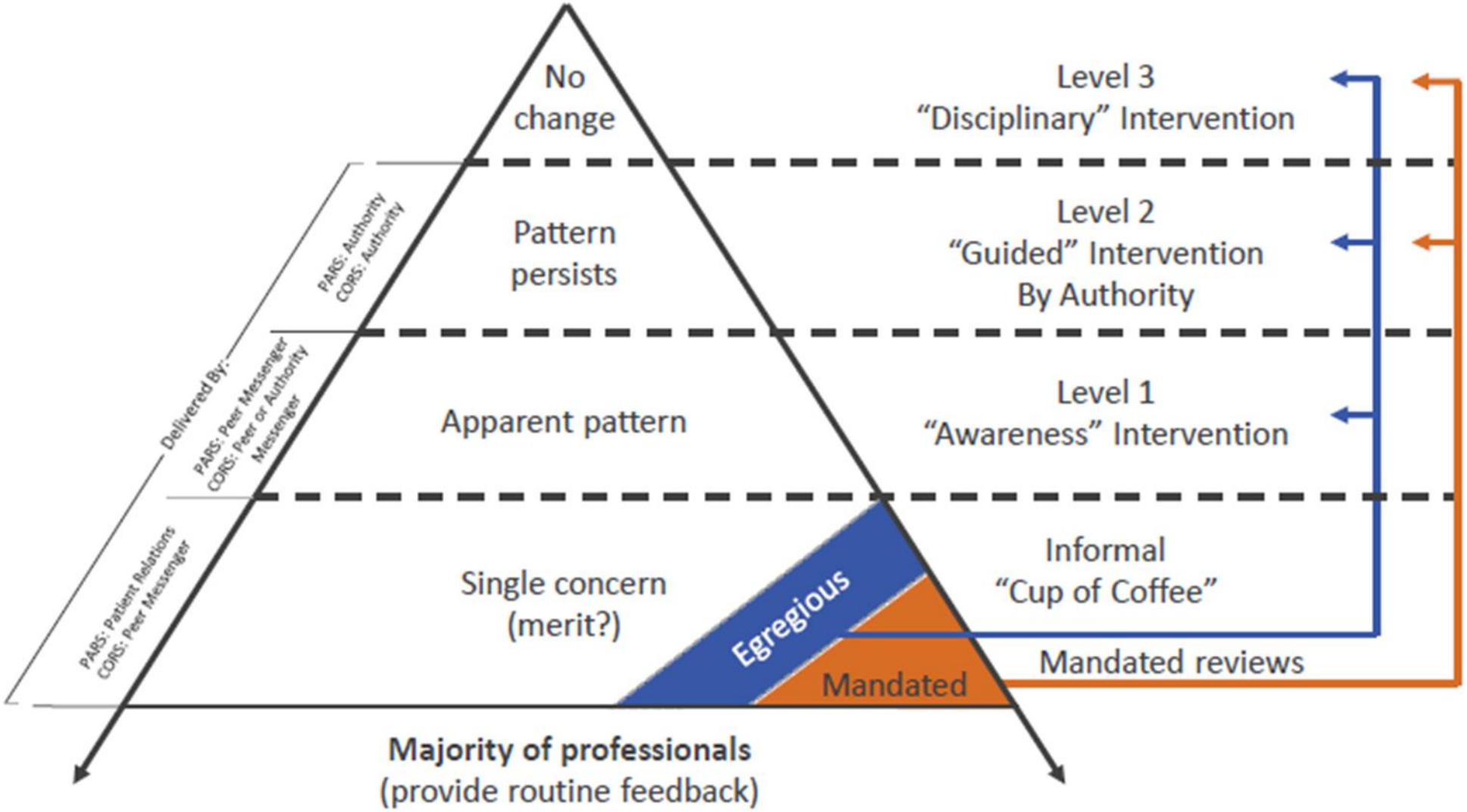
Peer messengers share behavior reports directly with recipients

- 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

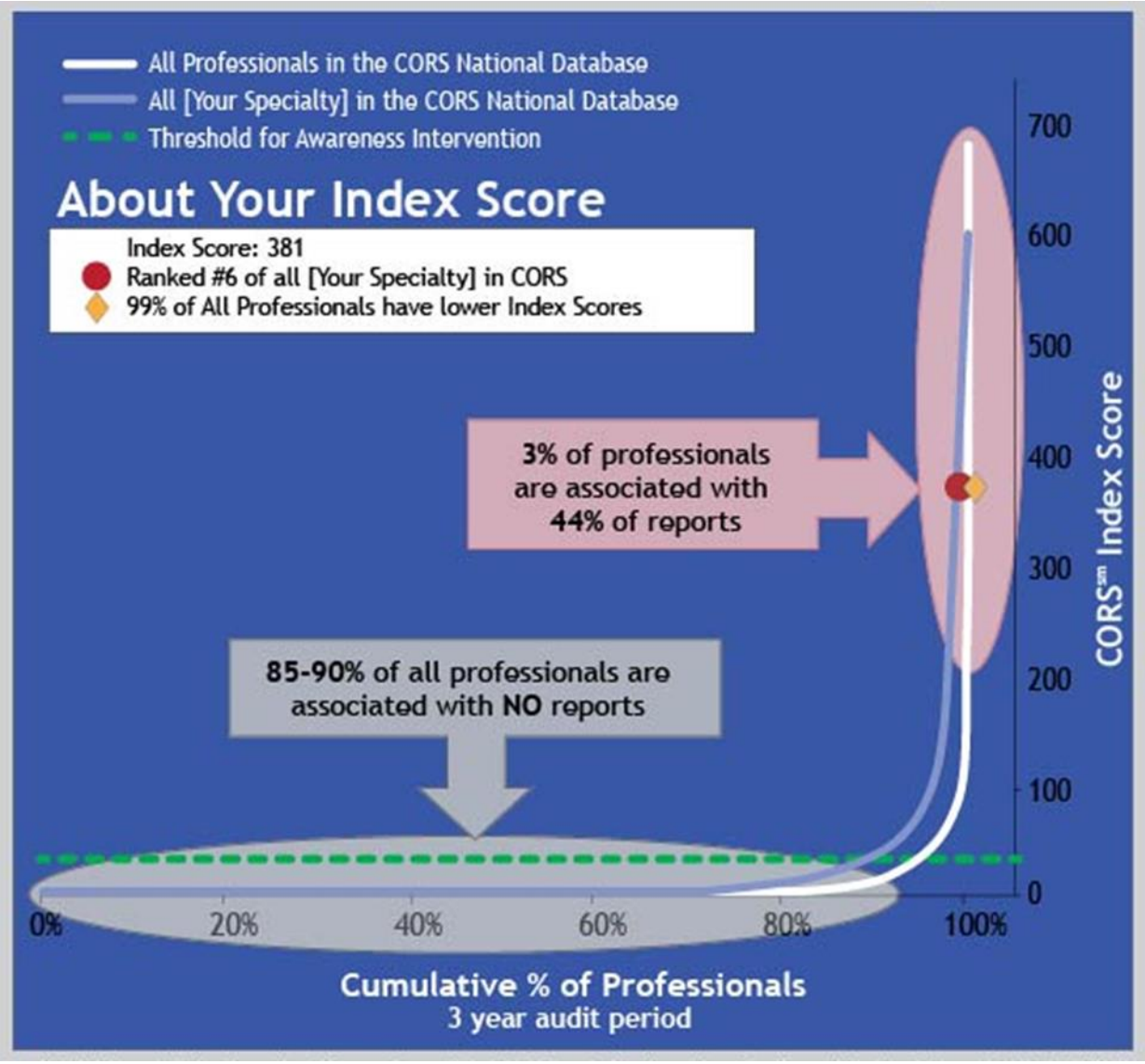
Webb, L.E., et al. (2016). Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *The Joint Commission Journal on Quality and Patient Safety, 42*(4):149-164. https://doi.org/10.1016/s1553-7250(16)42019-2. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27025575

Promoting professionalism pyramid



Hickson, G.B., Pichert, J.W., Webb, L.E., & Gabbe, S.G. (2007). A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. *Academic Medicine, 82*(11), 1040-1048. https://doi.org/10.1097/acm.0b013e31815761ee

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



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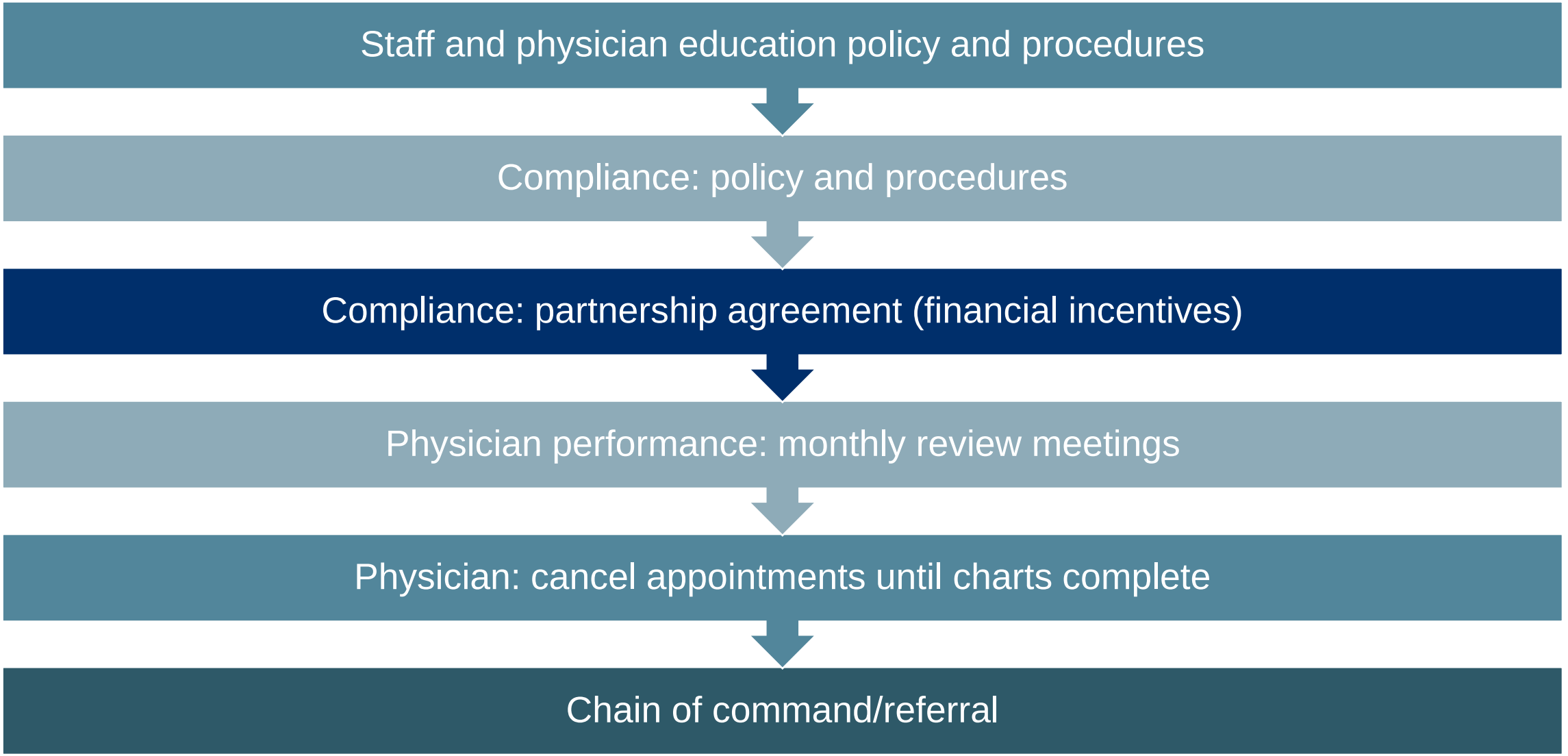
Organizational risk strategies

Risk strategies for physicians and other providers



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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