The Impact of Disruptive Behavior

Strategies to Minimize Risk
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 in 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.
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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 effect disruptive behavior can have on patients and professional practice.
- Recognize behavior in themselves, peers, and/or staff that might be considered disruptive behavior.
- Implement effective strategies to address disruptive behaviors when encountered in the workplace.
“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 healthcare team.)

“Disruptive behavior by a physician does not include criticism that is offered in good faith with the aim of improving patient care.”
Prevalence

American College of Physician Executives and QuantiaMD® survey results

- 70% indicated physician disruptive behavior occurs monthly in their organizations
  - 59% 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

## Disruptive behaviors

<table>
<thead>
<tr>
<th>Passive</th>
<th>Passive aggressive</th>
<th>Aggressive</th>
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</table>
| • 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
Disruptive behaviors


Retaliation against any member of the healthcare team who has reported an instance of violation of the code of conduct or has participated in the investigation of such an incident, regardless of the perceived severity of the report.
Themes

- Comments that undermine trust
- Comments that undermine self-confidence
- Failure to address safety concerns or patient needs
- Intimidating behavior that suppresses input
- Deliberate failure to follow policy and procedures

Impact

Adverse event as a result of disruptive behavior (% surveyed) 17%

Adverse event preventable (% of above surveyed) 78%

Negative impact (% surveyed) 83%+

Impact

Institute for Safe Medication Practices survey

- 49% felt pressured to dispense or administered a drug despite serious and unresolved safety issues
- 40% kept quiet rather than question a known intimidator

Coping methods
- Avoid the abuser at all costs
- Avoid making suggestions to improve care

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

Case – Physician anger

Doctor answering phone in dark on-call room

“This better be good, I just got to sleep.

Wait a minute…stop talking! Is it a car accident or a C-section?

You mentioned something in your babbling about blood pressure.

Does the patient have an IV? Why don’t you know?

You idiots call me all the time!

Just get me the information and call me back.”
Consequences

- 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
Findings

National survey of 1,627 physician executives

- 36%: most behavior problems are between physicians and staff members, including nurses
- 43%: behavior problems are not linked to alcohol or substance abuse
- 50%: reported only when a doctor is completely out of line and a serious violation occurs
- 83%: physician behavior problems involve disrespect
- 95%: met with a disruptive physician to discuss behavioral problems

Disrespect is the most common physician disruptive behavior

Findings

Peer messengers share behavior reports directly with recipients

- Vanderbilt: co-worker 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)

Early intervention

Disruptive behavior report
- Investigate immediately
- Document process

Meet with provider
- Describe unacceptable behavior and consequences

Interventions
- Monitoring

Identify root causes

Patterns (or high risk incident)
- Comprehensive evaluation

Provide feedback to reporter
Risk strategies

- Policy and procedures (code of conduct)
- Medical executive committee and leadership support
- Early interventions and monitoring
- Staff education and team training
- Handoff procedures, e.g., SBAR
- Culture of safety surveys

SBAR: Situation, Background, Assessment, Recommendation
Office nurse finds physician snoozing in office

“‘Where have you been?! Dr. Johnson had to take your 11 and 12 o’clock patient!’

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

Office nurse smells alcohol on his breath and says, ‘I think the rest of your day is at home. You need to go home right now!’”
Consequences

Patient safety risks

Practice reputation

Staff workarounds to accommodate disruptive behavior

Poor staff morale

Poor documentation
Findings

Physician impairment studies

- Substance abuse
- Chronic sleep deprivation
- Physical illness
- Mental illness
- Declining competencies

8%-12% of physicians will develop a substance abuse disorder in his/her lifetime

Risk strategies

- Address patient care and safety needs first
- Coordinate immediate intervention
- Use corporate agreement for cause drug testing per policy
- Use state medical societies, referral agencies, and employee assistance programs
- Monitor and follow up
- Establish partnership/operating agreements
Office staff complains about physician displaying inappropriate behavior

“I’m sorry to bother you but it’s gotten out of control: looking at me, dirty jokes.

I can’t get a chart with him trying to give me a massage. Everything he does matches sexual harassment from what I read.

I really need this job. Frankly, I can’t take it anymore.”
Consequences

- Sexual harassment
- Fear of job loss
- Hostile work environment
- Patient safety compromised — communication/handoff issues (avoidance)
Findings

Fear of reporting

- Intimidation
- Fear of “troublemaker” label
- Concern for job
- Fear of conflict
- Concern for confidentiality
- Belief organization will not act
- Staff not sure to whom to report

Staff is reluctant to report disruptive behavior
Risk strategies

- Staff and physician education policy and procedures
- Zero tolerance
- No retribution
- Investigate all allegations
- Early intervention and monitoring
Case – Physician process breakdown

"I’m looking for it right now (chart). The office is a complete disaster!

I haven’t seen him since this morning. ...he completely bit my head off! I guess I can call the patient, make up 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..."
Issues and consequences

- Assessment of situation
- Burden on practice, staff
- Inefficiencies in office
- Chaotic environment
- Patient confidence eroded
Findings

PA Patient Safety Authority analysis: 177 disruptive behavior events

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

Disruptive behaviors are a potential cause of patient harm

Risk strategies

Staff and physician education policy and procedures

Compliance: Policy and procedures

Compliance: Partnership agreement (financial incentives)

Physician performance: Monthly review meetings

Physician: Cancel appointments until charts complete

Chain of command/referral
Real Life

Real Consequences
Situation

Precipitating events start in the operating room and end in the pump room

- Engaging in shouting match
- Using foul language
- Posturing
- Slamming down utensils, hand, etc.
- Displaying disparity in size, vocals, authority, and power
**Outcome**

“Victim” (perfusionist)
- Walks out
- Does not return
- Takes medical leave
- Sues surgeon (assault)
- Sues corporation (negligent hiring, intentional infliction)
- Sues hospital (hostile work environment, breach of contract)
## Consequences

<table>
<thead>
<tr>
<th>Entity: Lesson learned</th>
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<tbody>
<tr>
<td>Equal Employment Opportunity Commission: Hostile work environment</td>
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<td>Interference: Business relationship</td>
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<tr>
<td>Patient and care issues, complaints</td>
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<tr>
<td>Negligent credentialing</td>
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<td>Breach of contract</td>
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<td>State agency: Access to “protected peer review”</td>
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The problem that kept giving . . .
Consequences

Disruptive surgeon

- Assault
- Intentional infection of emotional distress
- Peer review action
- Privileges, bylaw action

The problem that kept giving . . .
Consequences

The final result

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

The problem that kept giving . . .
Risk strategies

- Adhere to staff and physician education policy and procedures
- Compliance: Comply with policy and procedures
- Allegations: Deal with quickly
- Allegations: Address each and every time
- Allegations: Don’t forget the “victim”
- Be proactive: Disruptive behavior is not a risk worth taking
<table>
<thead>
<tr>
<th>Disruptive behavior threatens patients, teams, and organizations</th>
<th>Culture of fear and intimidation</th>
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<tbody>
<tr>
<td></td>
<td>Low staff morale</td>
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<td>Staff turnover</td>
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<td>Erodes collaboration</td>
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<td>Erodes communication</td>
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<td>Patient safety and harm</td>
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<td>Litigation</td>
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**Risk strategies begin with culture of respect**

<table>
<thead>
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<th>Culture of accountability and respect</th>
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<tr>
<td>Policy &amp; procedures, code of conduct</td>
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<td>Team training and communication</td>
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<td>Early interventions and monitoring</td>
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<td>Reporting, incident management</td>
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Resources

- Directory of Physician Assessment and Remedial Education Programs (Federation of State Medical Boards):
- MedPro Group resources: www.medpro.com
- Anger management programs
- Employee/physician assistance programs
- Wellness programs
- Professional associations
- State medical boards
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