

Bad behavior -- preparing for and dealing with disruptive behavior by providers

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Objectives

- define disruptive behavior as behavior that disrupts safe patient care
- identify and recognize antecedents
- appreciate the consequences of inadequately addressed bigger problems
- describe essentials the policy and workable procedures for identifying an intervening but for the perpetrators as well as repairing damage caused by ugly incidents

Disruptive Behavior or Disruptive Person

Disruptive behavior can be chronic, or episodic or time limited

- Stress overload (professional and personal)
- “Having a bad day” (tend to recognize and apologize afterwards)
- Failure to adjust to personal circumstances
 - Problems in personal life undermine resilience at work
 - Unmet personal needs get pursued at work
 - E.g., romance, companionship, displaced anger.
 - Coping efforts backfire (compulsive overwork, alcohol or drug use, more intensely controlling or plagued with uncertainty)

A definition of the “Disruptive Clinician”

- *“Displays a chronic pattern of inappropriate, contentious, threatening, intractable, litigious behavior that deviates significantly from the cultural norm of the peer group. (and disruptive behavior) This behavior creates an atmosphere that interferes with the efficient functioning of the healthcare staff and the institution.”*

From “Problem physicians: a national perspective” Georgia Composite Board of Medical Examiners 1995. G. Douglas Talbott, MD editor

Disruptive Behavior or *Disruptive provider*

- 3 to 5% of physicians behaved disruptively
 - typically disrespect and intimidation
 - 96% of nurses witnessed disruptive behavior
- 68% of respondents reported witnessing disruptive behavior by nurses (e.g., “Mean girls grown up” by C. Dellasaga)
- 40% of clinicians responded passively to known intimidator despite concerns (ISMP 2004)

Antecedents to disruptive behavior

- Personality issues
 - Narcissism, compulsive/controlling, anti-social, passive-aggressive
 - often show behavior as a medical student (NEJM, 2005)
- Substance abuse
 - The disruptive behavior may be exacerbated by misuse of drugs or alcohol to cope or could be chemical dependency. Important to clarify this.
- psychiatric problems: depression, anxiety, bipolar disorder, ADHD
- Immaturity (lack of self discipline around emotions) without adequate limit setting (feel entitled to blow up)
- Emphasis on authority, autonomy, status hierarchy, modeling, gender issues, culture of tolerance, fear of retaliation etc.
- High stress, high expectations, high stakes
- Life stresses external to the worksite

Joint Commission standard re: behaviors that undermine the culture of safety

- Create a code of conduct that defines acceptable, disruptive and inappropriate behaviors
 - See <http://www.e-tmf.org/conduct.php> for sample policy from the Tennessee Medical Foundation
- Implement a process for managing disruptive behaviors from recognition to resolution to effective monitoring.

Develop a proactive, positive statement of expected physician behavior

- Use it in addressing any behavioral concerns that arise

“Members of the group behave as healers, leaders and partners. As healers they attend to the emotional as well as the technical needs of their patients. Patient needs are foremost in shaping their response in any situation. As leaders they positively work on solving problems and reject blaming, cynicism and divisiveness. Their behavior and attitude exemplifies maturity, respect, ethical sensitivity and self discipline. As partners they contribute to an attitude of collegiality, cooperation, civility and foster trust and transparency.”

Disruptive behaviors to staff

- Generally, problems in cooperating with others and maintaining a mature, respectful demeanor that disrupts safe patient care
 - Intimidation
 - Extreme competitiveness
 - Heartless focus on income and doing only what takes to earn it
 - Extreme moodiness
 - Abusive language
 - Female forms of bullying one
 - Refusing to cooperate or assist
 - Demeaning other staff
 - Blaming/shaming others
 - Threats of, or actual violence, retribution or litigation that preclude mature problem solving
 - Unwanted sexual invitations, comments
 - Recurrent conflict with others
 - Irrational, oppositional resistance to group norms, clinical guidelines

Inappropriate responses to patients

- Uncooperative, defiant, rigid, inflexible
- Avoidant, unreliable, unstable, unpredictable
- Late or unsuitable replies to pages and calls
- Unwilling to help
- Unprofessional demeanor or conduct
 - arrogant, disrespectful, passive aggressive, avoidant
- Inadequate communication in quantity, quality and promptness
 - (Hickson JAMA 2002)

Obstacles and challenges: ambivalence about what to do

- The original norm allowed a great deal of disruptive behavior to occur without a plan to address it.
 - E.g., 38.9% of phys execs said higher revenue generators are treated more leniently (Keogh 2004. Phys Exec)
 - older nurses who “eat their young”
- Pendulum may be swinging towards “zero tolerance” equaling capital punishment
 - the flyswatter or the sledgehammer (Leape 2006)
- Can we create a code of conduct for all staff even if adjudicated by different pathways
- Can we create a process of recovery and reconciliation after ugly incidents that satisfy to all parties?

Applying the code of conduct formally and informally

- Make physician or nurse behavior discussable by any member of the group or staff by teaching and rewarding assertiveness and crucial conversations
 - “Something happened the other day that I am concerned about and wanted to discuss with you.”
 - utilize facilitator/intermediary much more readily
- Utilize a consistent and equitable reporting system
 - applies to all staff, receives timely and accurate reports of behavior and consequences, identifies witnesses and respects due process
- Establish a progressive discipline approach system with existing labor agreements and staff bylaws

A Progressive Approach

- Progressive steps that take into account the seriousness of the behavior
- Step One
 - Behavior: Mild-moderate irritability, temper outbursts, brusqueness with patient or staff or inappropriate comment/invitation
 - Response: Discussion with “leader” or committee about behavior, clarifying events and getting agreement that behavior will cease. Any follow-up action voluntary/mutual agreement. A note put in personnel file that is dated for removal if no further problems

Don't burden one leader with the task

- Either create a standing or ad hoc committee or bring in an HR representative to assist in the process
- Healthcare providers confronted in these situations can be very defensive!!!
 - They often make the issue personally contentious, and frequently threaten “legal action”, union action etc.
 - Splitting is not uncommon and should be anticipated
 - Reach out to that provider's closest allies and include them in the analysis and decision making or they will undermine focus and impact
- Create written summaries of meetings and conversations, voluntary agreements and organizational requirements and circulate to all parties for acceptance

The Behavior Recurs and/or is serious...

- Step Two (either because mild-moderate behavior has recurred or because a single incident was sufficiently serious)
 - Formal meeting with leader and another colleague or administrator present in which incident(s) is carefully reviewed and a “diagnostic or treatment” plan appropriate to the symptoms is constructed.

Step Two

Elements of the Plan:

- Could include psych or substance abuse evaluation, referral to coaching or counseling of some kind. Evaluation should not be confidential (but coaching/counseling could be).
 - Evaluation is about safety to practice as well as recommendations for treatment/remediation
- If coaching involved, then criteria for job consequences should be behavior on the job, not the opinion of a coach/counselor.
- Clarify voluntary and mandatory elements of plan
- Plan should be drawn up in writing and signed by all parties as immediate follow-up to the meeting.
- Demeanor of leader should be **concern** for provider as well as **concern** for the impact behavior has had on others.

Step Three: Mandatory Action

- Step Three (Behavior has persisted or is sufficiently egregious and/or the physician has failed to follow through on mandatory elements of previous plan)
 - Formal meeting with leader, members of the executive committee and the physician or HR and union representation as appropriate
 - The behavior, its impact, attempts to address are reviewed.
 - A plan is offered that includes mandatory elements, structured monitoring, criteria for evaluating adherence to plan and consequences for continued problems, including when termination would be pursued.
 - It may be useful to encourage the physician to bring legal representation and for the group to have representation at this meeting rather than have this all taking place in the background.

Some Considerations

- Clear limits are helpful to improving the behavior of most healthcare providers
- Physicians and nurses who have behaved poorly are at high risk for “relapse”. Extend the monitoring 2 years into the future before “expunging from your record”.
- Many groups fail because they do not monitor, give feedback and follow-through on their own “supervision” of the problem.
- It is better to get “closer” to the physician or nurse than to distance from him/her when addressing problems (yet the tendency will be to avoid)

Some more considerations

- Expect embarrassment and therefore self-protective anger.
 - Mild defensiveness is to be empathized with. Significant defensiveness is a bad sign and should be addressed with the physician as a major part of the problem.
- Acknowledge if things have been handled differently in the past and why the shift in approach.
- Don't be paralyzed by fear of legal action. Use your lawyer to guide you to a fair and defensible process.
- You can communicate your side of this issue without violating an individual's confidentiality
 - E.g., staff meeting agenda item or reminder memo reaffirming the importance of civility and cooperation

Resources

- Texas Medical Association. Psychiatric illness and disruptive behavior in physicians. A CME course.
<http://www.texmed.org/Template.aspx?id=6829>
- American Medical Association. Physicians with disruptive behavior. In: Code of medical ethics: current opinions and annotations. Chicago (IL): AMA: 2006. p. 279–80.
- Porto G and Lauve R. Disruptive clinical behavior: a persistent threat to patient safety. Patient safety and quality healthcare. July/August 2006. Available online:
<http://www.psqh.com/julaug06/disruptive/html>

Resources

- Rosenstein A, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians: nurses, physicians, and administrators say that clinicians' disruptive behavior has negative effects on clinical outcomes. *Nurs Manage* 2005 Jan;36(1):18-29.
- Rucker C. Addressing nursing to nurse bullying to promote its retention.
<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No3Sept08/ArticlePreviousTopic/NursetoNurseBullying.aspx>

Resources

- Leape LL, Fromson JA. Problem doctors: is there a system-level solution? *Ann Intern Med* 2006;144:107–115
- Defusing disruptive behavior: a workbook for health care leaders. 2008. DDB07. Joint Commission Resources. To order <http://www.jcrinc.com>