

## Approaches To Transform A Disruptive Physician Into A Productive Member Of Your Faculty

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## No Disclosures

### Outline

#### What is Disruptive Behavior?

#### The Impact of Disruptive Behavior

#### Dealing with the Disruptive Provider

### What is Disruptive Behavior?



You ask me if I have a God complex...  
 Let me tell you something: I AM God.

### How Common is Disruptive Behavior?

- 1-5 % of individuals in organizations may be considered disruptive
- Problem: this was once celebrated in medicine.



**The Joint Commission**  
**Sentinel Event Alert**  
 Issue 40, July 9, 2008  
**Behaviors that undermine a culture of safety**

Intimidating and disruptive behaviors can foster medical errors. (1,2,3) contribute to poor patient refusal to answer questions, return phone calls or pages, misreading language or voice intonation; and impatience with questions.(2) Covert and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) Intimidating and disruptive behaviors are unprofessional and disrespectful.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) For one, such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is

**The Joint Commission**  
**Sentinel Event Alert**  
**Issue 10, July 9, 2008**  
**Behaviors that undermine a culture of safety**  
 Intimidating and disruptive behaviors can foster medical errors. (1, 2, 3) contribute to poor patient outcomes. Organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often:

“Intimidating and disruptive behaviors can foster medical errors.”

Have kept quiet or remained passive during patient care events rather than question a known error.

“Intimidating and disruptive behaviors in health care organizations are **not** rare.”

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The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is unable to maintain its standards and those standards threaten the safety of patients.

**The Joint Commission**

- “Overt actions such as **verbal outbursts and physical threats, as well as passive activities** such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities”
- “Reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions”

erodes professional behavior and creates an unhealthy or even hostile work environment – one that is unable to maintain its standards and those standards threaten the safety of patients.

**The Joint Commission.** Behaviors that undermine a culture of safety. *Sentinel Event Alert*: 9 Jul 2008. Available online from [http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/Issue\\_10.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/Issue_10.htm).

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 AMERICAN MEDICAL ASSOCIATION

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Resources

**Opinion 9.045 - Physicians with Disruptive Behavior**

(1) 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.

Ethics Group Internship Program

(2) Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that

<https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.page>

**What is Disruptive Behavior?**

- Raising Voice/Yelling
- Berating
- Throwing instruments
- Physical Abuse

**What is Disruptive Behavior?**

**Disruptive Behavior = Workplace Bullying**

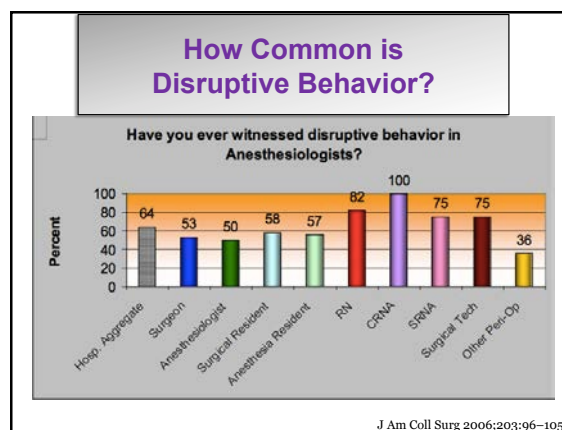
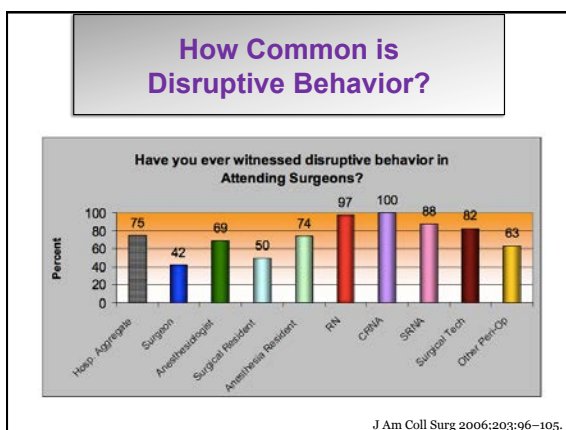
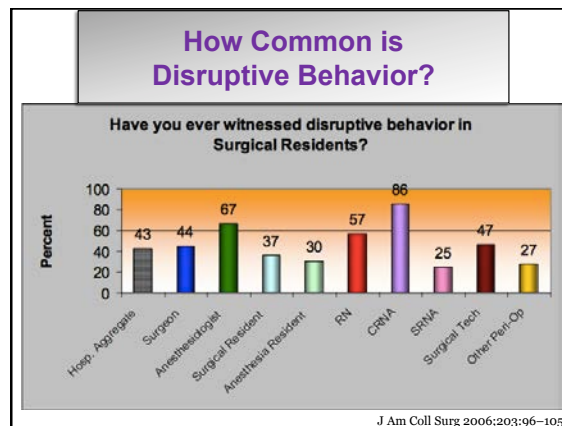
**EDUCATION**

**Impact and Implications of Disruptive Behavior in the Perioperative Arena**

Alan H. Rosenstein, MD, MBA, Michelle O'Daniel, MHA, MSQ

- Study Design:
  - 25 question customized survey
  - distributed in large urban academic medical center, having difficulty managing disruptive behavior in OR
  - Each member of OR team represented (244 completed survey total)
  - Results analyzed and compared to national research database

J Am Coll Surg 2006;203:96-105.



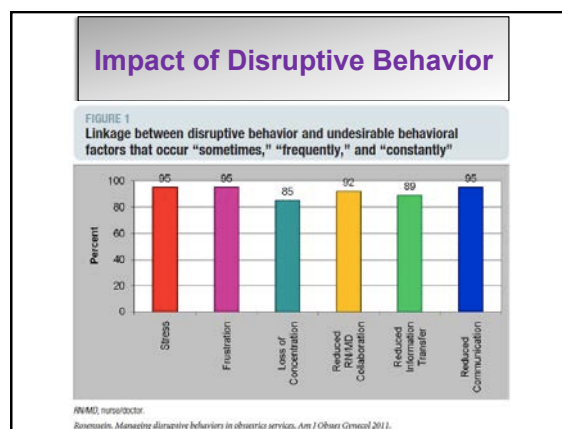
EDUCATION

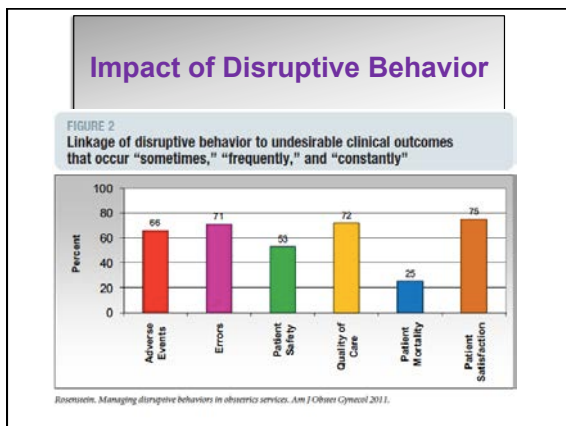
### Impact and Implications of Disruptive Behavior in the Perioperative Arena

Alan H. Rosenstein, MD, MBA, Michelle O'Daniel, MBA, MSQ

- **Conclusions:**
  - Disruptive behaviors are extremely common in the perioperative setting
  - Significant **negative impact on team dynamics**
  - Significant **negative impact on communication flow among the team**
  - Significant **negative impact on patient care**
- Impact on career decisions

J Am Coll Surg 2006;203:96-105.





### Is there Legal Guidance?

- April 2008—\$325,000 jury award for hospital employee who sued cardiac surgeon for bullying him
- March 2008—New York state law establishing a cause of action for employees who are subjected to an abusive work environment
- The 'right to criticize' is **NOT** the right to malign

Martin WF. Is Your Hospital Safe? Disruptive Behavior & Workplace Bullying

### How does the Disruptive Provider See Themselves?

Usually very believing the point of others.

**'I'm the only one who cares.'**  
— Swan song  
of the  
disruptive physician

THE PHYSICIAN EXECUTIVE JANUARY/FEBRUARY 2002

### How do Others See the Disruptive Provider?

- Arrogant
- Entitled
- Bully
- Morale Killer

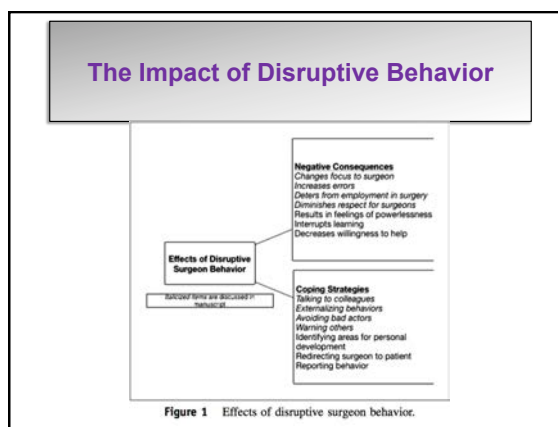
Anesthesiology 2005; 110:760-2 Copyright © 2005, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.

### Professionalism in Anesthesiology

"What Is It?" or "I Know It When I See It"

*Editor's Note:* This is the fourth in a four-part editorial series on the topic of excellence in anesthesia, which includes how it is designed, how it is measured, and how interventions to improve it might be assessed.

James C. Eisenach, M.D., Editor-in-Chief



### The Impact of Disruptive Behavior

- Physician disruptive behavior decreases nurse satisfaction and retention (*Am J Nurs* 2002;102:26-34)
- Negative effects on patient outcomes (*Am J Nurs* 2005;105:54-64)
- Decreases respect for physicians and changes career paths for students (*J Am Coll Surg* 2006;203:96-105.)
- Reduces morale amongst other workers if behavior does not change--? Punishment (*Academic Radiology* vol 20:9 2013)

### The Impact of Disruptive Behavior

- 12 % of staff members leave hospitals because of disruptive behavior
- 70% of 840 physicians reported witnessing disruptive behavior at least monthly. 10% reported seeing it daily.
- 7% of medication errors may be attributed to dysfunctional behavior
- Estimated cost of \$1,000,000/year for a 400 bed hospital
  - Not including costs of readmissions, litigation, infection or time spent managing these situations

Rawson J. Acad Radiol 20(9) Sep 1074-76.

### The Impact of Disruptive Behavior

**TABLE 2. Program Director Time Needed to Support Impaired Resident.**

Impaired Resident Support	Time Spent
Discovery phase	12 hours
Time investigating complaint	5 hours
Time meeting with resident	4 hours
Time meeting with others - DIO, CMO, chair, attorneys	3 hours
Decision/treatment phase	55 hours
Time meeting with resident to plan for treatment	5 hours
Time meeting with others - DIO, CMO, chair, attorneys	2 hours
Estimated that it would take up ~ 8 workdays/impaird provider	
Redesign of schedule/curriculum for resident absence	8 hours
Weekly reports	24 hours
Supporting resident, his/her family, and other residents through treatment process	12 hours
Return-to-work phase	9 hours
Paperwork for school, hospital, medical board, Family Medical Leave Act	2 hours
Graduation and future employment	6 hours
Paperwork/phone calls for summary residency, fellowship application, practice interview, medical staff application	2 hours
Time meeting with resident	2 hours
Time meeting with others - DIO, CMO, chair, attorneys	2 hours

CMO, chief medical officer; DIO, designated institutional official.

### Outline


#### What is Disruptive Behavior?

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## THE NO ASSHOLE RULE

*Building a Civilized Workplace and Surviving One That Isn't*



### Rule #1: Don't Hire Them if you Know they are Disruptive

### The Past can Predict the Future

THE NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

#### Disciplinary Action by Medical Boards and Prior Behavior in Medical School

Maxine A. Papadakis, M.D., Arienne Teherani, Ph.D., Mary A. Banach, Ph.D., M.P.H., Timothy R. Knettler, M.B.A., Susan L. Rattner, M.D., David T. Stern, M.D., Ph.D., J. Jon Veloski, M.S., and Carol S. Hodgson, Ph.D.

**Table 1. Description of the 740 Violations among 235 Physicians That Led to Disciplinary Action on the Part of 40 State Medical Boards.**

Type of Violation	No. (%)
Unprofessional behavior	
Use of drugs or alcohol*	108 (15)
Unprofessional conduct	82 (11)
Conviction for a crime	46 (6)
Negligence	42 (6)
Inappropriate prescribing or acquisition of controlled substances	39 (5)
Violation of a law or order of the board, of a consent or rehabilitation order, or of probation	32 (4)
Failure to conform to minimal standards of acceptable medical practice	31 (4)
Sexual misconduct	29 (4)
Failure to meet requirements for continuing medical education or other requirements	26 (4)
Fraud or inappropriate billing practices (e.g., Medicare billing irregularities)	20 (3)
Failure to maintain adequate medical records	19 (3)
Failure to report adverse actions against oneself in accordance with rules of the board	10 (1)
Conduct that might defraud or harm the public	10 (1)
Other (less than 1% of any single category)	52 (8)
<b>Total</b>	<b>551 (74)</b>
Incompetence	
Health-related problems, incompetence, or impairment	44 (6)
Unknown†	
Violation imposed by another board or agency	87 (12)
License revocation or suspension	28 (4)
Inappropriate treatment or diagnosis of patients or malpractice	7 (1)
Other or not available (less than 1% of any single category)	23 (3)
<b>Total</b>	<b>145 (20)</b>

Predictor variables			
Male sex — no. (%)	123 (52.3)	242 (51.6)	0.83
Undergraduate science GPA	3.3±0.5	3.5±0.5	0.002
MCAT z score	0.6±0.6	0.8±0.6	<0.001
Did not pass one or more medical-school courses — no. (%)			
On first attempt	59 (25.1)	60 (12.8)	0.001
In years 1–2	45 (19.1)	39 (8.3)	<0.001
In years 3–4	24 (10.2)	26 (5.5)	0.05
NBME Part 1–USMLE Step 1 z score	0.2±0.9	0.4±0.9	0.003
Displayed unprofessional behavior in medical school — no. (%)	92 (39.1)	90 (19.2)	<0.001

**Unprofessional Behavior Characteristics (Unadjusted analysis):**

- Irresponsibility
- Diminished capacity for self improvement
- Poor initiative
- Impaired relationships with students, nurses, faculty, and residents

**Annals of Internal Medicine | ACADEMIA AND CLINIC**

**Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards**

Maxime A. Papadakis, MD; Gerald K. Ansell, PhD; Linda L. Blank; Eric S. Holmboe, MD; and Rebecca S. Lipner, PhD

- 66171 physicians entering IM programs b/t 1990-2000
- Compared disciplined vs. non-disciplined physicians

**Table 2. Performance and Demographic Characteristics of Internal Medicine Diplomates\***

Characteristic	Physicians Not Disciplined (n = 49,939)	Physicians Disciplined (n = 428)
<b>Performance measures</b>		
Internal medicine residency training, n (%)		
1 y	21 (0.0)	0
2 y	1480 (2.3)	9 (1.4)
3 y	59,940 (91.0)	268 (92.3)
4 y	3789 (5.5)	40 (6.3)
≥5 y	296 (0.3)	1 (0.3)
ABIM Resident's Annual Evaluation Summary rating, n (%)		
<b>Professionism ≤4</b>	<b>1127 (2.0)</b>	<b>27 (5.6)</b>
Physical examination ≤4	1403 (2.5)	28 (5.6)
Procedural skills ≤4	1695 (3.1)	26 (5.6)
Medical knowledge ≤4	3773 (6.8)	39 (12.1)
Across all years of residency training		
Professionism ≤4	2116 (4.8)	48 (10.7)
Medical interviewing ≤4	2842 (4.3)	55 (8.6)
Physical examination ≤4	2523 (3.9)	49 (7.7)
Procedural skills ≤4	3611 (5.5)	42 (10.5)
Medical knowledge ≤4	7344 (11.3)	72 (19.8)
<b>Mean performance on initial ABIM Internal Medicine Certification Examination (SD)</b>	<b>0.1 (0.9)</b>	<b>-0.3 (1.0)</b>
Attempts at ABIM certification examination, n (%)		
1 attempt	56,758 (86.6)	477 (74.8)
2–3 attempts	8775 (13.4)	161 (25.2)
No subspecialty certification, n (%)	39,752 (60.7)	458 (71.8)

**One Model of dealing with Disruptive Employees**

- Say the rule, write it down and act on it
- Disruptive providers will hire other disruptive providers
- Get rid of them fast!
- Treat them as incompetent
- Power breeds nastiness—don't promote them!
- Model and teach **constructive** confrontation

Sutton RI, The No-Asshole Rule

**Managing the Disruptive Physician/Provider**

- Have a clear policy on disruptive behavior (Joint Commission requirement)
- Mechanism for individuals to file anonymous complaints
- Collegial Intervention
- Formal Investigation
- Meeting with the Provider
  - Don't let the provider set the agenda
  - Document the meeting
  - Focus on behavior not personality or its cause
  - Do not send mixed messages

Kisson et al, Diagnosis and Therapy for the Disruptive Physician

## Managing the Disruptive Provider— AMA/Joint Commission Approach

**TABLE 1. Essential Steps that an Organization Should Take to Deal with Disruptive Behaviors as Outlined by the American Medical Association.**

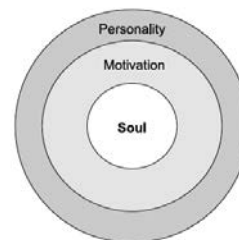
- Clearly state which behaviors will not be tolerated.
- Adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive.
- Establish a process to review or verify reports of disruptive

**TABLE 3. Guiding Principles for Hospital's Peer Review Process of an Alleged Disruptive Physician.**

- They must operate with a reasonable belief that they are improving the quality of patient care.
- They must only make their decision to revoke or refuse renewal of staff privileges after a reasonable effort to obtain the facts.
- They must provide a fair hearing.

Grogan MJ, Knechtges P, The Disruptive Physician: A Legal Perspective

## Managing the Disruptive Provider— Theoretical Models



**Figure 1. Theoretical Model.**

Piper LE. A Theoretical Model to Address Organizational Human Conflict and Disruptive Behavior in Health Care Organizations

## Managing the Disruptive Provider Are there Potential Repercussions?

- Multiple lawsuits have upheld disruptive behavior as a legitimate reason to revoke or refuse renewal of staff privileges
- Federal Healthcare Quality Improvement Act of 1986
  - Courts defer to hospitals peer review process
  - Supported by the AMA
- ADA—'The disabilities act forbids discriminating because of physical or mental disability BUT the law does not require affirmative action for the mentally ill, nor are employers expected to tolerate drug abuse, disruptive behavior, or violence.'

Grogan MJ, Knechtges P, The Disruptive Physician: A Legal Perspective

## Managing the Disruptive Provider— Additional Resources

- Professional Renewal Center, Lawrence KS
- Vanderbilt Comprehensive Assessment Program for Professional
- LifeWings: <http://www.saferpatients.com/services/disruptive-behavior/>

## Conclusions

- Disruptive behavior can adversely impact patient care and patient safety
- Disruptive behavior also has financial, social, and morale implications
- Creating a culture of 'zero tolerance' is not only an admirable goal, but a Joint Commission requirement
- Modifying behaviors with disruptive providers can be difficult but not impossible that requires a multifaceted approach

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