Disruptive Physician Behavior: Fact vs. Frenzy

By Alan Rosenstein, MD

The Joint Commission has recently proposed in its 2009 Accreditation Standards that hospitals develop and implement a Code of Conduct policy and provide appropriate education and processes that address disruptive behaviors.

Many think the decision is long overdue, while others have expressed concern that it was just another way for administration to weed out physicians who are openly vocal in expressing contrary views to administrative policies and decisions.

Disruptive behaviors include any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual harassment. Unfortunately, they're all too common in the health care arena, and they affect staff morale as well as patient safety.

I have been researching disruptive behaviors for 10 years, starting in the era of growing concerns about the nursing shortage to see if there was a relationship of between physician disruptive behavior and nurse satisfaction and retention.

In one study, more than 90% of the 2,500 survey participants (physicians, nurses and senior level administrators) witnessed disruptive behaviors in physicians and more than one-third were aware of a nurse who left the hospital specifically because of physician disruptive behaviors.

What we learned from this research was how serious an issue it really was and more importantly, the impact it had on staff relationships, communication efficiency and patient outcomes of care.

The second phase of our research focused on not only physician disruptive behaviors, but also disruptive behaviors in nurses and other hospital employees. We also assessed the relationship of disruptive behaviors to human factor issues affecting decision making, task fulfillment and performance (stress, frustration, concentration, communication and information transfer) and the linkage between disruptive behaviors and negative outcomes of care (adverse events, errors, compromises in quality or patient safety and mortality).

Once again we were astounded by the frequency and significance of our findings and in particular the acute and downstream negative effect of these incidents on patient care and patient safety.

Our recommendations for action include:

1. Raise awareness
2. Conduct an internal assessment
3. Develop and implement behavioral policies and procedures that outline and reinforce appropriate professional code of conduct standards
4. Assess potential underlying factors that may precipitate disruptive events and provide appropriate educational courses (diversity training, sensitivity training, conflict management, assertiveness training)
5. Provide tools that improve communication efficiencies and team collaboration (SBAR, team collaboration training, improved language/ linguistic skills)
6. Implement an effective and consistently applied reporting and follow-up system that assures that all incidents be addressed with appropriate action and feedback as part of the loop
7. Have a consistent criteria based system for addressing chronic disruptive behaviors to include multidisciplinary review and follow up recommendations that may include counseling and/or suspension of privileges
8. Use a clinical champion to foster the cause
9. Secure leadership support and endorsement
10. Reinforce the importance of the end goal which is to improve patient safety and quality as an integral part of the organizational culture and other patient safety, quality and risk management programs.

The historical issue of the reluctance of management and clinicians to address other physicians who bring patients into the hospital and are a major source of revenue makes addressing this issue difficult. Also, traditional monitoring and credentialing activities focus on demonstration of clinical or technical competence. We have not really been trained on the merits of communication competency. If you do nothing, you run the risk of staff dissatisfaction and its associated repercussions on staff recruitment and retention, risks to compromises in patient safety and quality outcomes of care, risks to your reputation, and even financial liability.

So what should you do? First, develop the business case around patient safety. Many physicians are not aware of the downstream effect of many of their actions and their primary goal is always to provide optimal patient outcomes of care. Focus on health care complexity and the opportunity to improve understanding, communication and collaboration as ways to improve efficiencies and outcomes of coordinated health care delivery rather than taking a primary punitive confrontational approach.

Make sure you have criteria, guidelines, standards and processes in place that address critical issues of concern to help thwart the potential concerns about a hospital witch hunt. Be up front in addressing and following up on physician complaints and issues brought to your attention. Get a better understanding on what makes people react the way they do. With increasing diversity in the medical marketplace providing educational and training programs on culture and ethnicity, generational issues and ways to improve communication and collaboration skills.

About the Author

Alan Rosenstein is the medical director and a vice president at VHA West Coast, a health care consulting firm. He reported no conflicts of interest related to this post.

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