

*Chapter 7*

**“MANAGING DISRUPTIVE BEHAVIORS IN THE  
HEALTH CARE SETTING: PROCESS, POLICY,  
PREVENTION AND INTERVENTION”**

***H. Alan Rosenstein\****

Medical Director Physician Wellness Services, San Francisco, California

**ABSTRACT**

Disruptive behavior in the healthcare environment can have a significant impact on staff relationships, communication efficiency, and patient outcomes of care. The ever increasing introduction of new research, knowledge, and medical technology has made health care an increasingly complex industry which is becoming more and more dependent on mutual understanding and respect of individual roles and responsibilities with the need for more interactive team collaboration to assure effective information flow and task accountability. Despite the noted impact of human factor issues affecting quality and safety of patient care, until recently, the health care industry has been reluctant to address the issue of disruptive behavior head on. Much of has to do with the history and autonomy of physician practice. The call for action is here. What health care organizations need to do is to get a better understanding of the dynamics related to the cause and effect and ramifications of disruptive behaviors and take a proactive approach toward preventing such episodes from occurring, mitigating the acute and down stream effects if they do, and have policies in place to address chronic offenders. This is what we are trying to do.

**INTRODUCTION**

What is disruptive behavior? We have defined disruptive behavior as “any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual

---

\* Cooresponding autor: Email: ahrosensteinmd@aol.com.

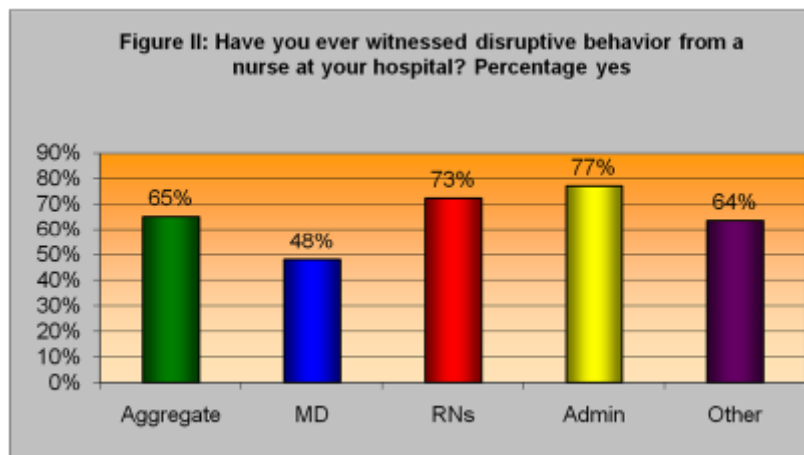
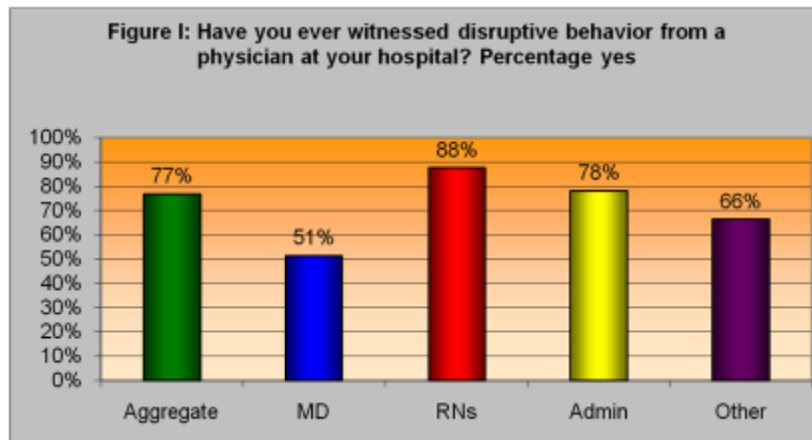
harassment”. [1] There are several other working definitions out there, but they all lead to the same universal conclusion, people acting badly and negatively impacting those who are the target of the behavior. [2’ 3] it’s a serious situation, and when it occurs in the health care environment, it can have serious consequences on staff working relationships, communication efficiency, and patient outcomes of care.

Disruptive behavior is not a new phenomenon. In many industries disruptive behavior has been shown to adversely affect productivity and efficiency and they have taken a heavy handed approach in dealing with disruptive behaviors in the workplace. This is not quite the case in the health care industry. Up until recently, many organizations were reluctant to address the issue, particularly if it involved a prominent physician, because of the imbedded hierarchy of physician stature and the fear that if they approached the physician that he or she would bring their patients to the hospital next door. The issue was further compounded by potential conflicts of interest, personal resistance to intervene, and a general lack of skill set or training in behavioral interventions.

Fortunately, things have changed. Concerns about staff turnover, noted negative impacts on patient care, a tarnished hospital reputation, increasing liability, and the new accreditation mandate from The Joint Commission requiring hospitals to have a disruptive behavior policy in place as part of its new 2009 leadership standard, have forced the issue to the forefront. [4] Hospitals can no longer afford to look the other way.

## **BACKGROUND**

We originally began our work on disruptive behaviors in 2001 during the first signs of the nursing shortage. Working through our VHA West Coast member physician network, every year we would query our hospital Medical Directors to find out what were the key issues they were facing in their jobs. Starting in 1996, disruptive behavior was always one of the top issues on their radar screen. Then in early 2000 we first noticed that the nursing shortage appeared as a concern for the Medical Directors. They realized that without a full complement of nurses the hospital had to cancel scheduled surgeries, close programs or medical units, go on divert status for Emergency Room visits, and worry about patient care. At this point we went to the literature to assess if there was a relationship between physician disruptive behaviors, nurse satisfaction, and nurse turnover. Other than noting a few anecdotal stories of physicians yelling at nurses and making them feel bad, there weren’t any real studies or objective data that addressed this topic, so we decided to develop our own survey. What we found was striking! More than 90% of the 2500 respondents (which included physicians, nurses and senior level administrators from more than 100 acute care hospitals across the United States) reported that they witnessed disruptive behavior in a physician. More than one third of respondents said that they knew of a nurse who had left the hospital specifically because of experiences with a disruptive physician.[1, 5] What was truly worrisome was that it was occurring so frequently, and nobody was doing anything about it.



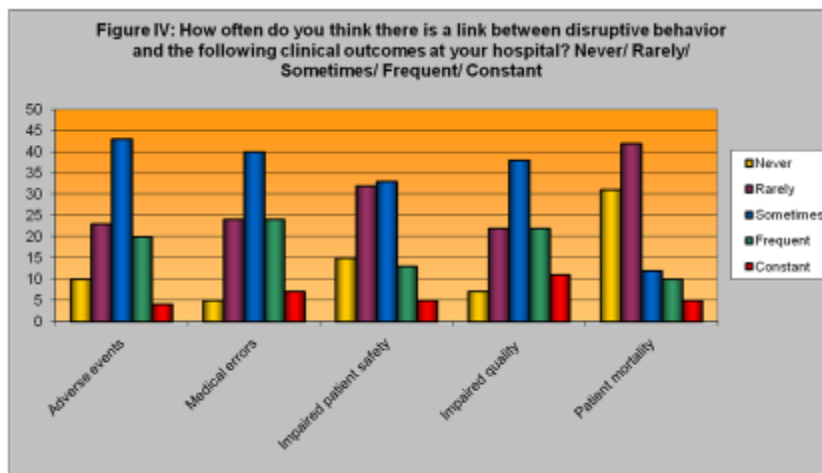
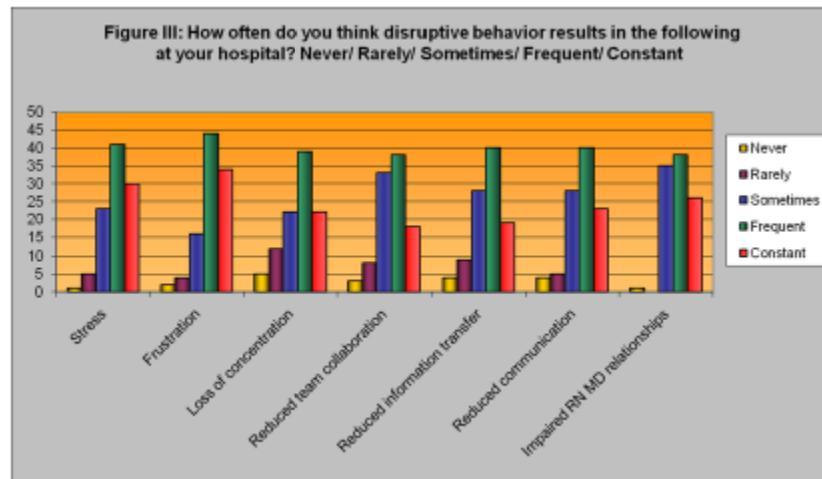
We learned a lot from this first phase of the survey. Disruptive physician behavior occurred much more frequently than ever realized, there was a big difference in perception of seriousness of the episodes between nurses, physicians and administrators, and it had a profoundly negative impact on staff relationships, satisfaction and morale. Based on comments received from phase I, we developed phase II of the survey to address disruptive behaviors in other disciplines, particularly in nursing, and looked to see if there was a correlation between disruptive behaviors and patient outcomes of care.

We again went to the literature to see if we could find any studies linking disruptive behaviors with any ill effects on job performance and outcomes of patient care. Once again we came up empty handed. We could find good reference support for the benefits of strong team collaboration in improving outcomes, particularly in the intensive care and emergency room setting, but couldn't find anything on the results of disruptive behaviors, or poor teamwork and collaboration and its effect on clinical care. Once again we had to develop our own survey. Phase II survey results were reported in 2005 summarizing input from more than 5000 survey respondents from over 150 hospitals across the nation. [6] Overall, more than three quarters of the respondents reported that they had witnessed disruptive behavior in a physician. Interestingly, more than two thirds of the respondents reported that they had

witnessed disruptive behavior in a nurse, with the bulk of that being nurses seeing it in other nurses. (Figures I, II). We found a strong linkage between disruptive behaviors and elevated levels of stress, frustration, loss of concentration, impaired communication, collaboration and information transfer, all which led to gaps in task fulfillment and patient care. There was a strong correlation between disruptive behaviors and a negative impact on patient outcomes of care including the occurrence of adverse events, medical errors, compromises in quality and patient safety, and even patient mortality. (Figures III, IV). Many of these perceptions were reinforced through a series on comments made by survey participants (Table I).

**Table I. Selected Comments**

<ul style="list-style-type: none"> <li>• Most nurses are afraid to call Dr. X when they need to, and frequently won't call. Their patient's medical safety is always in jeopardy because of this.</li> </ul>
<ul style="list-style-type: none"> <li>• Staff was afraid to approach MD despite fact order was clearly incorrect. Disruptive behavior policy "wildly ineffective" Complaints delivered to a "black hole:"</li> </ul>
<ul style="list-style-type: none"> <li>• Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended</li> </ul>
<ul style="list-style-type: none"> <li>• MD became angry when RN reported decline in patient's condition and did not act on information. Patient required emergency intubation and was transferred to ICU. This caused the family much unnecessary heartache and disruption in family grieving process</li> </ul>
<ul style="list-style-type: none"> <li>• Poor communication post-op because of disruptive reputation resulted in delayed treatment, aspiration and eventual demise</li> </ul>
<ul style="list-style-type: none"> <li>• The disruptive behavior from nurses is much more upsetting because I expect that behavior from the surgeons NOT the nurses b/c I rely on them as my peers (RN)</li> </ul>
<ul style="list-style-type: none"> <li>• When patient brought to unit for GI bleeding patient saw MD yelling at nurses. Patient asked if that was his doctor. Yes. Patient refused treatment and was transferred to another hospital. I am retiring early and never recommend someone becoming a nurse</li> </ul>
<ul style="list-style-type: none"> <li>• Disruptive behavior results in medication errors, slow response times and treatment errors!</li> </ul>
<ul style="list-style-type: none"> <li>• Specific group of MDs with poor communication habits which adversely affect patient care and nurse role. Dr. X is so condescending to nurses that we are very reluctant to call him on patient's behalf.</li> </ul>
<ul style="list-style-type: none"> <li>• My concern is that the new nurses are afraid to call about patient problems and issues that truly need to be addressed in a timely manner impacting outcomes.</li> </ul>
<ul style="list-style-type: none"> <li>• It seems there is an increasing lack of respect by nurses and other ancillary caregivers toward practicing clinicians in the hospital environment. Decisions by clinicians are frequently challenged and some orders are flatly disobeyed or at least not carried thru with almost reflexive propensity, and with little or no forethought</li> </ul>
<ul style="list-style-type: none"> <li>• "Are you aware of any specific adverse events ....?" Yes. Death as a result of disruptive behavior. Staff nurses advocated for better patient care but MD would not willing to listen to reason. As a result patient died. The doctor chose to undo all the help that various staff had been working on for weeks to get this patient the help so badly needed.</li> </ul>



Phase III of the survey focused on the impact of disruptive behaviors in high intensity areas such as Peri-operative Unit, Neurosciences, and the Emergency Department. [7-9] Phase IV of the survey focused more specifically on the impact of disruptive behavior on communication gaps and compromises in patient safety.[10] Results were similar to the previous studies.

## PRECIPITATING EVENTS

Now that we had the data to support the cause, the next step was to try to assess why these episodes occur. I don't think anyone starts the day out planning to be disruptive. In some cases the individuals are totally unaware of the way they are behaving and its impact on others ("emotional intelligence/ situational awareness"). Others may have subconsciously (or consciously) learned that acting disruptively gets you what you want and people tend to leave you alone and there are a few who probably do it intentionally. [11] The goal is to get a better understanding of the factors that may precipitate a disruptive event and see if

something could be done to prevent it from occurring. [12] None of these categories are mutually exclusive and they all contribute to individual behavioral tendencies and communication styles. (Table II).

**Generational Differences:** There has been a lot of research done on the attitudes, styles, preferences, and behavioral tendencies related to a person's age. A set of age based generational cohorts links common experiences, attitudes and preferences of each generation which were influenced by the current events of the time affecting societal, family and individual values. The Veteran generation (1900-1945) who experienced the depression and First World War, are focused on job security as a way to provide for their family. They will stay at one job forever and do whatever is asked of them. The Baby Boomer generation (1946-1964) was brought up during the good times of the 50s, 60s and 70s. They also remain loyal to their organization, pride themselves in putting in whatever time is necessary to see a task completed, and appreciate being recognized for all their hard work. The Generation Xers (1965-1980) and Generation Yers (1981-1999) are brought up on technology. If it's not electronic, it's archaic. They want to feel like they're part of the team and have a participative team approach to authority. Their primary focus is work life balance. When their shift is done, they're out of there. Many find it normal to move from job to job rather than staying with one organization for a long period of time. All of these traits impact the perception of workplace performance and commitment. It's not that any one generation is any better than any other, but with the generation gap in the workplace now being extended, understanding each other's values, preferences and ways of doing business will provide for a much more efficient and satisfying workplace environment. This is particularly true for nurses and physicians.

**Gender Differences:** in his book "Men are from Venus Woman are from Mars" John Grey provides a classic description of gender based tendencies.[13] Men are task oriented, prefer to work independently, pride themselves on competency, and tend to be domineering. Women are much more gregarious, prefer the social contact, enjoy listening and sharing and look for group consensus. One can see how under stress males may become more bullying or independent while woman will look for group support from their peers. This too is particularly relevant in the health care environment.

**Culture and Ethnicity:** The health care market is becoming increasingly diverse. In some areas of the country more than 50% of the health care workers were either not born in or not trained in the United States. Beyond language based difficulties in communication, cultural and ethnic views toward power, hierarchy, gender, wealth, religious beliefs and relational behaviors all impact communication style and reactions.

**Personality traits:** There are many different types of personality classifications used to describe a set of common traits attributed to a particular personality type. Using the Myers-Briggs classification, the "Beavers" are usually Directors who are hard working, independent, domineering, task driven individuals who are driven toward high achievement and don't like to be thwarted from their course. The "Dolphins" are the socializers who more gregarious, sharing, and collaborative types who are more apt to listen and share and look for group input to support their cause. The "Owls" are the deep thinking intellectuals who thrust for supporting information to support their views. The "Foxes" are on the surface the easy going

relaters who go with the flow, but deep down may undermine efforts through behind the scenes passive aggressive tendencies. Each of these personality types plays a significant role in the group process. During crisis time, one can see how these groups may adversely interact with each other. This is particularly true in the discipline specific hierarchy structure common in medical organizations.

**Family/ Life experiences:** Many of our attitudes are molded in early childhood and reflect the values and attitudes of family upbringing, schooling and life experiences.

**Training:** Beliefs, attitudes and preferences are modeled by ones training experience. This is particularly true for physicians. To start off with, certain specialties draw certain personality types. The physical get it done quickly types are drawn to the surgical specialties. The more people oriented information processors are drawn to the primary care specialties. The more psychosocial behaviorists are drawn to the psychiatric specialties and so on. Next is the way we are trained. On day one in medical school you learn that you know nothing and it quickly becomes obvious from the way people treat you. This results in a sense of isolation which perpetuates feelings of low self confidence and self esteem. You learn on your own. As a result you become very independent and autocratic. Your skills are based on technical and knowledge competency. When you need to make a critical decision your reaction is to bark out orders and direct people on what to do. There is little if any training in communication and team collaboration and in today's complex health care environment, this can turn out to be a liability.

**External forces:** On top of these deep seated values are the more acute or sub-acute external influences. Problems resulting from growing stress, frustration, burnout, fatigue, depression, or substance abuse can all affect ones demeanor and performance.[14, 15] Many of these factors can be easily triggered or provoked by an acute event that sets the mood for the day all of which may consciously or unconsciously affect one's attitude and actions.

**Table II. Precipitating Events**

Deep seated values:	
1.	Age
2.	Gender
3.	Culture and ethnicity
4.	Family' life experiences
5.	Training
6.	Personality
Contributing factors:	
1.	Stress/ Frustration
2.	Burnout/ Fatigue
3.	Depression
4.	Substance abuse
External influences:	
1.	"Bad day"
2.	Provoked response

**Table III. 10 Step Strategic Plan**

1.	Organizational leadership
2.	Awareness and Accountability
3.	Education
4.	Special Education
5.	Communication/ Collaboration tools
6.	Clinical Champion(s)
7.	Policies and Procedures
8.	Reporting process
9.	Intervention process
10.	Support or organizations patient safety/ quality/ risk management programs

Disruptive behavior can occur anywhere. In the health care environment it tends to occur in more frequently in the high stress acute settings such as the Peri-operative area, Emergency Department, Intensive Care Unit, Labor and Delivery, or general Medical/ Surgical Units. It may involve a direct face to face interaction, it may occur over the phone, or it may take a more indirect path through written correspondence or behind the scenes gossip and communication. It may be overt, or it may be passive aggressive. When it involves physicians it's usually direct, obvious, right in front of you. When you look at nurses, it's usually more insidious, more passive aggressive, undermining a person from behind. [17] In any event, it is a detrimental force that needs to be addressed.

## CALL TO ACTION

Disruptive behavior in the health care environment is nothing new. The problem is that organizations have been reluctant to address it in the past. This was particularly true if it involved a very prominent physician who was technically adept and "voluntarily" brought lots of patients and revenue into the organization. One overriding concern was the fear of antagonizing the physician and the threat that he or she would bring their patients to a different facility. A second concern focused on who would do the intervention and what the resulting outcome might be. Issues related to overall willingness to address a colleague on non- clinical matters, potential conflicts of interest, and possessing the necessary skill set to effectively address these types may impede a successful intervention. Physicians are competent in addressing other physicians on technical and knowledge competency, but have never been taught how to effectively address problems related to behavioral issues.[18]

Things have changed. Recent events have highlighted the concerns about disruptive behaviors to the point where you can no longer afford to look the other way. First is the negative impact on nurse satisfaction and turnover. Second is the negative impact on quality and patient safety. Third is the growing liability for not addressing the issue. Fourth is the impact on reputation. And fifth is the need to comply with the new Joint Commission standard requiring hospitals to have a disruptive behavior policy in place and provide appropriate education as one of their accreditation requirements. The risks of not addressing disruptive behaviors are much greater than the risk of avoidance. The call to action is there. So here's what you need to do. (Table III).



**Organizational Leadership:** To effectively address disruptive behaviors it is crucial that the organization be committed to making it happen. The commitment needs to come from top level governing and leadership bodies which includes the Board and senior level administrative and clinical leadership and extend through to middle management and front line staff. The organization needs to endorse a non tolerance approach toward disruptive behaviors and be willing to take action when individuals refuse to comply with expected behavioral standards.

**Awareness, Recognition and Accountability:** Many of the individuals who act disruptively are truly unaware of their actions and its impact on the surroundings. In order to get a better picture of what's going on at the organization, we recommend performing a confidential internal self-assessment. This can be done either through individual interviews, focus groups or survey assessment. Presenting organization specific results to the medical staff and employees will raise levels of awareness. Discussing contributing factors and individual roles and responsibilities will heighten accountability. When addressing these issues we recommend that the organization take the positive route of using this information as an opportunity for improvement rather than a punitive approach of identifying bad apples.

**Education:** Education can occur at several different levels. First would be the high level overview of what disruptive behavior is, what it does, and why it's important to address it. These sessions should focus on reaching a multidisciplinary audience which includes Administration, Human Resources, Risk Management, Nursing, Medical Staff, and when appropriate, students in training. Educational sessions can be presented at a number of different venues including Grand Rounds, Departmental meetings or special sessions. Having your own data helps to make a more compelling case for action.

**Special education:** More in-depth educational sessions can focus on such topics as diversity training, sensitivity training, assertiveness training, linguistics, conflict management or any other topic germane to the organization's individual needs.

**Communication and Team Collaboration Training:** Extending the boundaries beyond just addressing disruptive behavior opens up the opportunity to improve overall efficiency in communication and collaboration. Whereas 3-5% of the staff overtly exhibit disruptive behaviors, another 30-50% are ineffective communicators.

One way to improve communication is to create an opportunity for individuals to get to know each other. Informal get togethers, career days, community days, cultural celebration days, town hall meetings, focus groups and/ or multidisciplinary task forces can be put together to discuss roles, responsibilities, assumptions and perceptions. These events will do a lot to promote mutual understanding and respect.

The next level is to provide programs that directly enhance communication efficiency. Several new tools have been introduced that enable an individual to better organize their thoughts and presentation style through a structured format or script designed to enhance information flow. One such tool is the SBAR tool (Situation/ Background/ Assessment/ Recommendation). The tool provides consistent process for organizing thoughts and presentation flow that will enable the receiver to better understand the information being

presented and then be able to better provide the appropriate advice or recommendation that is being requested.

Whereas the SBAR tool is effective in enhancing one on one communication efficiency several new techniques have been successfully introduced to enhance team communication. Based on the same principles utilized in the airline industry (crew resource management), racing industry (pit crew management), and nuclear plant safety, these tools focus on the importance of team collaboration by fostering a better understanding of purpose, expectations, roles and responsibilities, and actions required by each team member. These team building techniques are particularly effective in the Peri-operative, Intensive Care, Emergency Department, and Obstetrical/ Newborn setting.

**Clinical Champion(s):** Having a program sponsor is often a key to success. Key characteristics are passion and enthusiasm for the cause, peer group respect, and the necessary communication and persuasiveness skills to make things happen. It's helpful if the champion is a clinician. You never know where and how the champions may surface so always look for an opportunity to stimulate and cultivate candidates who have expressed an interest in the topic. Sometimes added value is gained if they are not part of the paid executive staff.

**Policies and Procedures:** Policies and procedures are necessary to set the standards, guidelines, criteria, and expectations for appropriate behavior. These standards need to be incorporated and adopted as part of the standard operating procedure for the organization. Paid employees need to agree to follow these standards as part of their employee agreement. For non- salaried medical staff, the standards need to be supported by the medical staff bylaws and physicians need to agree to comply with these standards as part of the credentialing and re-credentialing process. As mentioned previously, in 2009 the Joint Commission introduced a new requirement that hospitals must have a disruptive behavior policy in place and provide appropriate supporting services as part of the hospital accreditation process.

Having a guideline or policy by itself is not enough. The two biggest barriers to policy success are lack of consistency in application and lack of follow through. One of the most frequent complaints we heard from our survey respondents was the inequity between the way the policies were applied and reinforced particularly when it came to the physicians. One representative comment we heard was "if a nurse did this she would be fired. If a physician did this the organization looked the other way". The second barrier was lack of notable change. "We report and report and nothing ever changes. It's like our report goes into a deep black hole".[6]

The obvious recommendation is to have one universal disruptive behavior policy which needs to be consistently applied and reinforced across all levels of the organization. In regard to feedback, it is a confidential manner and discussing specifics of follow up action need to be held in that regard, but thanking the person for bringing it to your attention and letting them know that the issue will be addressed is essential to maintain faith in the process.

**Reporting process and follow through:** Similar to the issues raised in regard to the implementation and follow through process for the disruptive behavior policy, there needs to be consistency in both the front end and back end of the reporting process. In order to assure success our recommendation is that the organization outlines a formal process for event

reporting and event review. Having all complaints forwarded to one designated reviewing entity rather than a casual report to a supervisor or colleague will assure that each incident will be handled in a consistent fashion. Having a multidisciplinary group review each complaint and make the appropriate recommendation for follow up will help assure equity by avoiding any individual bias or conflicts of interest. The review committee should also take responsibility to monitor follow up actions and outcomes. Not everyone has the right skill set to deal with these issues. If an event is referred to a Department Chief or Unit Supervisor, one needs to make sure that they are able to effectively address the situation and facilitate the desired outcome.

**Intervention process:** Once a disruptive event occurs, it is essential for the organization to take the necessary steps to address the issue. Similar to the process outlined for reporting, it is crucial to have a consistent process of evaluation and follow through. Our recommendation is that all events be reviewed by a core multidisciplinary team of skilled individuals who conduct the necessary interviews and make appropriate recommendations for follow up action.

There are several possible outcomes from the intervention process. As mentioned previously, most of the time the individuals involved are unaware of their actions and the impact it has on their colleagues. Part of this may be related to “emotional intelligence” and/or their understanding of the definition of disruptive behaviors. In many cases individuals may think that disruptive behavior is defined by actions constituting sexual harassment or physical abuse. While these types of behaviors are the most serious types of disruptive behaviors, they occur relatively infrequently. Most of the disruptive behaviors cite intimidating, condescending, disrespectful, berating behaviors as the most frequent types of disruptive behaviors reported by survey respondents. [1,6,7,19 ] In the majority of cases, once an individual is made aware of their actions and its downstream consequences, they make the necessary adjustments to avoid further episodes.

In the middle of the spectrum are individuals who need more intensive services. Many of the individuals in this group are chronic offenders. These individuals may require a more comprehensive program which may include special courses in diversity training, sensitivity training, conflict management or the like. Some individuals may require more in-depth psychological or psychiatric consultation. Always be aware of the possibility of underlying drug or alcohol abuse and be able to offer these services when appropriate.

At the end of the spectrum is the individual who refuses to make any changes. On the employee side, the only choice may be termination. On the physician side, the only choice may be to curtail privileges or suspend the individual from the medical staff.

The greatest potential for success in the intervention process is to intervene before a disruptive event actually occurs.[20] Once an event occurs the damage is already done and the intervention takes on more of a confrontational punitive nature. The goal should be to focus efforts on preventing such events from occurring. On one side is raising levels of awareness and sensitivities about factors contributing to values, attitudes and perceptions that set the framework for individual communication styles and preferences and provide appropriate training programs designed to enhance understanding and improve interactions that affect working relationships. On the other side is to identify individuals at high risk for a disruptive event and provide supporting services to lessen the likelihood of occurrence. On the physician side, this is a particularly important consideration.

Today's health care environment has placed a lot of stress on physicians. Growing intervention by outside parties, greater accountability, increasing complexity, higher expenses, and lower reimbursement are just a few of the issues that have significantly changed traditional practice settings. Physicians are not only frustrated and dissatisfied, there is a greater degree of burnout and depression which is significantly impacting their behaviors. Some physicians have retired early and others are beginning to leave practice in search of other employment opportunities. There is a growing concern about future physician shortages particularly in the areas of primary care and general surgery. The goal is to treat the physician as a valued resource and support him or her with services that will increase physician satisfaction, productivity and enhance working relationships.

While the intent is admirable, the crucial step is to get the physician to recognize the problem and be willing to do something about it. Most physicians are not aware that they are working under increasing levels of stress and even if they are aware, feel that they have been working under stress all their life and are able to handle it by themselves. Several organizations are beginning to develop programs specifically designed to assist physicians under stress or duress with the prime goal of increasing physician satisfaction. Working through a physician comfortable convenient peer to peer coaching/ counseling format, physicians are able to confidentially share their concerns and work toward solutions that improve personal satisfaction which will help reduce stress, improve productivity and efficiency, and improve personal and staff relationships. [20, 21]

**Patient Safety/ Risk Management program support:** All of the strategies described above should be integrated in with all the other organizational strategies designed to enhance patient safety and quality management. In addition to reducing the frequency and impact of disruptive events is the opportunity to increase communication and information flow between all components of the health care team which will enhance collaboration and coordination which ultimately improve patient outcomes of care.

## CONCLUSION

Disruptive behavior is a difficult issue to address. The problem is compounded by a history of tolerance, a complex hierarchal based medical care system, and an economic structure where most physicians are not salaried employees and have multiple allegiances and priorities. Recognizing the negative impact these behaviors have on staff relationships and patient outcomes of care, we can't afford to look the other way. Organizations need to provide, support and enforce the necessary policies and procedures to address the issue head on. Most individuals pride themselves on their desire and ability to provide best patient care. Taking a positive supportive approach to identify potential problem areas early on and implementing appropriate programs to not only address disruptive behaviors but also to enhance opportunities to improve satisfaction, communication and collaboration will provide the best opportunities for success.

## REFERENCES

- [1] Rosenstein, A. "The Impact of Nurse-Physician Relationships on Nurse Satisfaction and Retention" *American Journal of Nursing*, June 2002, Vol.102 No.6, 26-34.
- [2] Model Medical Staff Code of Conduct American Medical Association 2009 <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.shtml>
- [3] *Joint Commission Sentinel Alert* Vol. 40 July 9, 2008 [http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_40.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm)
- [4] *Joint Commission Hospital Accreditation 2009 Leadership Standard* [http://www.jointcommission.org/NewsRoom/PressKits/Behaviors+that+Undermine+a+Culture+of+Safety/app\\_stds.htm](http://www.jointcommission.org/NewsRoom/PressKits/Behaviors+that+Undermine+a+Culture+of+Safety/app_stds.htm)
- [5] Rosenstein, A; Lauve, R; Russell. H. "Disruptive Physician Behavior Contributes to Nursing Shortage" *The Physician Executive*, November-December 2002, 8-11.
- [6] Rosenstein, A; O'Daniel, M. "Disruptive Behavior and Clinical Outcomes: Perceptions of Nurses and Physicians" *American Journal of Nursing*, January 2005, Vol. 105 No.1, 54-64.
- [7] Rosenstein, A; O'Daniel, M. "Impact and Implications of Disruptive Behavior in the Peri-Operative Arena" *Journal of American College of Surgery*, July 2006, Vol.203 No.1 96-105.
- [8] Rosenstein, A; O'Daniel, M. "Impact of Disruptive Behaviors on Clinical Outcomes of Care" *Journal of Neurology*, 2008, Vol.70 No.17 April 24, 1564-1570.
- [9] Rosenstein, A; Naylor, B; O'Daniel, M. "Impact of Disruptive Behaviors in the Emergency Department" *The Journal of Emergency Medicine In review*.
- [10] Rosenstein, A; O'Daniel, M. "A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety" *Joint Commission Journal on Quality and Patient Safety*, August 2008, Vol 34 No8, 464-471.
- [11] Tarkan, Laurie "Arrogant, Abusive and Disruptive- and a Doctor" *NY Times*, December 2, 2008 D1, 6.
- [12] Rosenstein, A; O'Daniel, M. "Nurse- Physician Communication: The Impact of Disruptive Behaviors on Factors Affecting Decision Making Affecting Patient Outcomes of Care" *Chapter VII The Psychology of Decision Making*, Nova Science Publishers, New York 2007.
- [13] Gray, J. *Men are from Mars: Woman are from Venus* HarperCollins publishers New York 2004.
- [14] Krasner, M; Epstein, R; Beckman, H; Suchman, L. et. Al. "Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians" *Journal of the American Medical association*, September 23.30 2009, Vol.302 No.12, 1294-1300.
- [15] Chen, Pauline "When the Doctor is Distressed" [nytimes.com](http://nytimes.com) October 1, 2009.
- [16] Shanafelt, T; Balch, M; Bechamps, G; Russell, T. et. Al. "Burnout and Career Satisfaction Among American Surgeons" *Annals of Surgery*, September 2009, Vo.250 No.3, 463-471.
- [17] Bartholemew, K. *Ending Nurse to Nurse Hostility: Why Nurses Eat Their Young and Each Other* HC Pro Inc., Publishers Marblehead, MA 2006.

- [18] Leape, L; Fromson, J. "Problem Doctors: Is There a System Level Solution?" *Annals of Internal Medicine*, February 2006, Vol.144 No.2, 107-115.
- [19] Johnson, C. "Bad Blood: Doctor-Nurse Behavior Problems Impact Patient Care" *The Physician Executive Journal of Medical Management*, Vol.35 No.6 November/December 2009, 6-11.
- [20] Rosenstein, A. "Early Intervention Can Help Prevent Disruptive Behavior" *The Physician Executive Journal of Medical Management*, Vol.35 No.6 November/December 2009, 14-15.
- [21] Darves, Bonnie "*Physician Wellness*" The New England Journal of Medicine <http://www.nejmjobs.org/career-resources/physician-wellness.aspx>