PATIENT SAFETY SERIES

Managing disruptive behaviors in the health care setting: focus on obstetrics services

Alan H. Rosenstein, MD, MBA

Disruptive behaviors can have a significant negative impact on staff relationships, communication flow, task responsibility, and team collaboration, all of which can adversely impact patient outcomes of care. Addressing disruptive behaviors in a positive manner by emphasizing the benefits of mutual understanding, shared goals and priorities, and adherence to accepted standards of care will enhance communication flow and improve the process and outcomes of care. This is particularly relevant in the obstetrics setting, where care is delivered over a continuum of time, with multiple different members of the health care team playing a vital role as the patient progresses from labor to delivery. Critical strategies for success include having strong organizational commitment and leadership support, raising provider insight and awareness, implementing appropriate policies and procedures, providing appropriate educational and training programs, and facilitating action-oriented interventional support.

Key words: disruptive behavior, obstetrics service, patient safety, team collaboration

Disruptive behaviors in the health care setting can have a significant negative impact on staff relationships, team collaboration, and communication flow, all of which can impact patient outcomes of care adversely. It is not that anyone starts out the day planning to be disruptive, it is just that the stress and pressures of the day may trigger an inappropriate or disruptive response, which may result in behaviors that affect coworkers' thoughts and actions that can interfere with process flow and task responsibilities. In most cases, individuals are unaware of the clinical consequences of their behaviors and the downstream effect on patient care. With a primary goal of providing the best quality of care in a safe medical environment, we must address the issue head on. Raising levels of awareness about the seriousness of the issue, holding individuals accountable for their behaviors, and providing strategies not only to reduce the incidence and consequences of disruptive events but also to improve efficiency of communication and team collaboration are the crucial steps that are needed to support these organizational objectives.

From Medical Consultant and Medical Director Physician Wellness Services, San Francisco, CA.

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Reprints: Alan H. Rosenstein, MD, MBA, Medical Consultant in Care Management and Medical Director Physician Wellness Services, San Francisco, 139 15th Ave., San Francisco, CA 94118. ahrosensteinmd@aol.com.

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Background

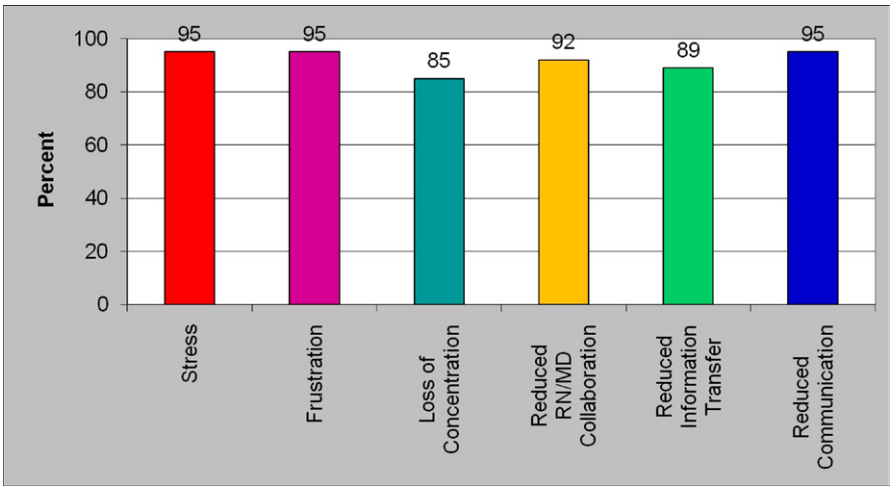
Disruptive behaviors in health care have been around for years but, until recently, were never really addressed in a consistent effective manner. Reasons for the reluctance to address the issue included a history of organizational tolerance that was related to the fear of antagonizing a physician who might threaten to take his or her patients elsewhere, the hierarchal medical structure that propagated physician autonomy and authority, the unwritten code of silence, concerns about conflicts of interest, and the lack of willingness, initiative, skill set, and organizational structure needed to address one's peers on behavioral rather than clinical matters. With the perception of no harm done, organizations were content to look the other way.

However, things have changed. First was the concern about the growing nursing shortage and the relationship of disruptive behaviors to nurse satisfaction, retention, recruitment, and turnover.[1] Second was the growing research that documented the impact of disruptive behaviors on medical errors, adverse events, and patient safety.[2,3] Third was the requirement to have a disruptive behavior policy in place as part of the Joint Commission Accreditation standard.[4] Fourth was the relationship of disruptive behaviors to patient satisfaction, patient complaints, and malpractice proceedings.[5,6] The culmination of these factors can affect the organization's reputation as a workplace of choice and quality provider, which has both staffing and financial implications.

Research

We originally began our research into the impact of physician disruptive behaviors on nurse satisfaction and retention during the height of the nursing shortage crisis in early 2000. When we went to the literature to review the topic, other than finding a few anecdotal reports of physicians who yelled at nurses and nurses feeling bad as a result of the interaction, there were no documented studies that related disruptive behavior to nurse satisfaction. We then decided to develop our own survey tool. For the purposes of this survey, *disruptive behavior* was defined as any inappropriate behavior, confrontation, or conflict, which ranged from verbal abuse (including intimidation, condescension, or berating, disrespectful, or abusive behaviors) to physical or sexual harassment. Surveys were distributed to nurses, physicians, and administrators at >100 acute care

FIGURE 1
Linkage between disruptive behavior and undesirable behavioral factors that occur "sometimes," "frequently," and "constantly"



RN/MD, nurse/doctor.

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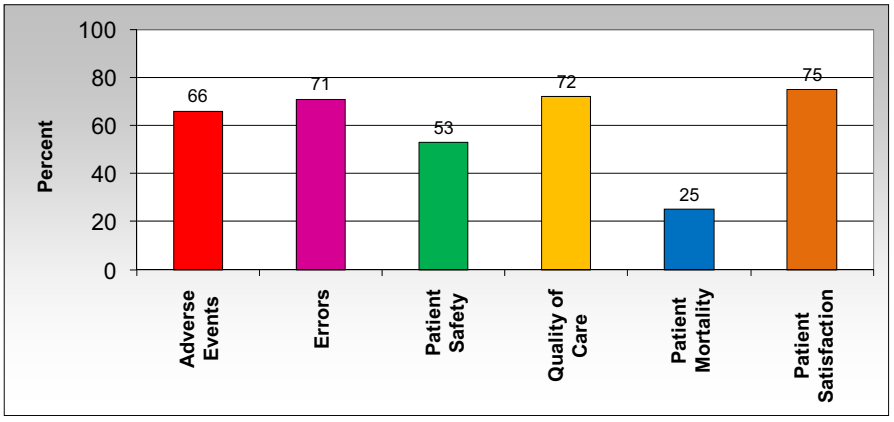
hospitals that agreed to participate in the project. What we found was striking. More than 90% of the respondents reported having witnessed disruptive behavior in physicians, and more than one-third of the respondents reported that they were aware of a nurse who left the hospital because of negative interactions with disruptive physicians.[1]

Based on comments that were received from the first phase of the survey, we enhanced the survey tool to look at not only physician disruptive behaviors but also to assess the incidence of disruptive behaviors in nurses and other health care disciplines. We also added a series of questions to assess the impact of disruptive behaviors on psychologic factors that affect emotions and performance and the linkage of these behaviors to medical errors, adverse events, and compromises in patient safety and quality of care. What we found is that the incidence of nurse disruptive behaviors was almost equal to that of physicians, but it manifested in different ways. Physician disruptive behaviors were usually direct and overt and usually subsided after the event occurred. Nurse disruptive behaviors, on the other hand, were usually more passive-aggressive in nature, had a more continuous undermining current of activity, and usually occurred more frequently in a nurse-to-nurse rather than a nurse-to-physician encounter.[7,8] The most striking findings were in the respondents' perceptions of the psychologic impact of these incidents and the effect on process and outcomes of care. With the use of a response scale of "never," "rarely," "sometimes," "frequently," and "constantly," Figure 1 highlights the high percentage of stress, frustration, loss of concentration, reduced collaboration, reduced information transfer, and reduced communication responses that were based on respondents rating these factors as occurring sometimes, frequently, or constantly. Figure 2 highlights the high percentage of adverse events, errors, compromises in patient safety, compromises in quality, linkage to mortality rate, and negative impact on satisfaction responses based on respondents rating these factors as occurring sometimes, frequently, or constantly.[2,9] Our research and others showed that these events tended to occur more frequently in high-stress areas (Perioperative Department, Intensive Care Unit, Emergency Department, Obstetrics Department) and occurred more frequently in certain specialties (general surgery, anesthesia, cardiovascular surgery, cardiology, neurosurgery, neurology, orthopedics, obstetrics).[10-14]

FIGURE 2
Linkage of disruptive behavior to undesirable clinical outcomes that occur "sometimes," "frequently," and "constantly"



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Cause and effect

In an effort to reduce the incidence of disruptive events, it would be helpful to have a better understanding of the reasons these events occur. This is a complicated process that involves the interplay of a number of different deeply rooted and situational factors (Table 1).

On the deeply rooted side are the values and preferences that are influenced by age and generation, sex, culture and ethnicity, family upbringing, and early life experiences that shape one's person-

TABLE 1
Influencing factors

Deep-seated factors
Age/generation
Sex
Culture/ethnicity
Upbringing/life experiences
Personality
Situational
Medical training
Recent life experiences
Environmental pressures
Stress/frustration
Fatigue/burnout
Depression
Substance abuse
Medical/psychiatric illness
Provoked response: confrontational conversation

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ality and behavioral style. Although it is difficult to change the resulting attitudes and perceptions that are crafted by these exposures and experiences, behavioral reactions may be modified by gaining insight through the introduction of specialized training programs that focus on sensitivity training, diversity training, and personality management and by the provision of workshops that are designed to improve communication efficiency and team collaboration.[15]

Situational factors that are related to medical training and work experiences, later life experiences, and current environmental, home, and work life pressures also contribute to one's demeanor and emotional state that impact behavioral responses. Many of these forces negatively impact personal satisfaction, which is influenced by growing levels of stress, frustration, and anger that may lead to burnout, depression, substance abuse, or severe personality disorders that affect home and work relationships.[16-18] Courses in stress management, anger management, and conflict management may be beneficial in the management of more acute external pressures. Customized approaches, which range from individual coaching and counseling to more comprehensive therapy sessions, may be indicated, depending on the circumstances.

Solution strategies

Fixing disruptive behavior is no easy task. The ultimate goal is to either prevent disruptive events from occurring or to minimize their impact if they do. The overall scope of services includes fostering a strong organizational commitment to patient safety, developing appropriate policies and procedures, providing education and training, having a consistent reporting system, and following up on disruptive events as warranted. Table 2 provides a 10-step process that resulted from experiences gained from different hospitals that have taken steps to address the problem of disruptive behaviors; this process can be used as a template for organizations that are beginning their quest.

The first step is organizational commitment. The commitment must come from top-level governing and leadership bodies, which include the Board and senior-level administrative and clinical leadership, and must extend to middle management and front-line staff. The organization must endorse a no-tolerance approach toward disruptive behaviors and be willing to take action when individuals refuse to comply with expected behavioral standards. An internal assessment will help to identify potential opportunities for improvement. Provision of the necessary resources and support to make it happen are crucial to success. The endorsement of the process by a clinical or project champion will help to drive the program forward. The champion should be a well-respected peer, who firmly believes in the project and has the leadership and communication skills to make it happen.

Raising levels of awareness and accountability are important components to provide insight, affirm roles and responsibilities, and promote individual engagement. Providing educational programs that highlight the downstream negative effect of disruptive behaviors touches the core nature of medical practice. These sessions can be presented at a variety of different levels, including grand rounds, department meetings, or unit-based discussions. Target audiences should include physicians, nurses, pharmacists, technicians, and other clinical personnel, administration, human resources, risk management, patient safety, and quality management. Sessions should be made available to the medical staff, resident staff, medical and nursing students, and all hospital staff members who are involved in the health delivery process.

The provision of more in-depth structured educational programs is often beneficial, depending on the demographics of the organization. As mentioned earlier, there are many deep-seated values and attitudes that affect one's perception that either consciously or subconsciously affect one's behavior. Courses on diversity training, sensitivity training, and differences in generational and cultural values will help to enhance under-

TABLE 2
Strategic approach

1. Organizational culture
Leadership commitment
Internal assessment
Infrastructure/resources
2. Clinical champions
3. Awareness/insight/accountability: general education
4. Structured education/training
Diversity/sensitivity/conflict management
Etiquette/assertiveness training
5. Communication/team collaboration tools
6. Relationship building
7. Policies and procedures
8. Reporting/follow-up procedures
9. Interventions
Pre-event
Concurrent
Retrospective
10. Reinforcement of patient safety initiatives

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standing of which inherent values and priorities individuals have that influence the way they react to others. Other types of programs that might be offered include courses on stress management, anger management, or conflict management to help staff adjust to the pressures of the surrounding environment.

Implementation of processes that improve communication and team collaboration skills is a pivotal part of the solution set. Scripting techniques, such as the situation/background/assessment/recommendation tool, have been extremely helpful in the improvement of the overall efficiency of 1-on-1 communication by providing a template that helps to organize the delivery of important information into a format that effectively outlines the issues at hand and the request for response. Some organizations have introduced a linguistic training program to help individuals for whom English is not the primary language to learn how to converse more effectively with their colleagues.

Team collaboration tools have been demonstrated to be of benefit in certain team settings. Many of these programs have been based on the crew resource management principles that have been set forth in the aviation, auto racing, and nuclear power plant industries that outline the importance of team values related to trust and respect, role understanding, anticipation, assertiveness, and group discussion. In the obstetrics area, the results of these programs are a little more controversial. Some studies have shown only incremental value; other studies have shown more positive results.[19-21] Obviously, more studies in this area are needed.

Communication and team training tools provide an operational structure to improve efficiency of interactions, but they do not deal with the behind-the-scene differences in assumptions, perceptions, biases, conflicting opinions, priorities, and motivations that influence behaviors and the way they impact staff relationships.[22,23] Sitting on top of the deep-seated influences posed by generation gaps, sex, cultural, and training differences is the importance of trust, respect, and mutual understanding. One part of trust and respect is role recognition and competency assurance. Particularly in obstetrics, where the care is delivered more over a continuum rather than as a scheduled timed event or treatment for an emergency situation and where there may be differences of opinion on how best to get there, sharing a mutual goal of processes and protocols that lead to a safe delivery are key to success. Physicians must understand the nurses' role and believe that they are competent in carrying out their responsibilities. Competency is a combination of technical competency, knowledge competency, and communication competency in being able to get the message across. Physicians also must understand the bedside nurse's priorities for patient care, discuss the reason that their priorities might be diverging from accepted procedural guidelines, and make themselves available to advise and assist in a professional manner. Nurses must understand the importance of physician priorities to juggle a busy schedule and maintain work/life balance. Education and discussion that are based on a truthful and open sharing of concerns and priorities is the best way to achieve a happy medium. Changing the practice model through the use of scheduled in-house coverage (laborists) and changing the reimbursement model will also help resolve some of the underlying concerns and priorities.[24]

As part of its basic structure, the organization must have the right policies and procedures in place that define appropriate behavioral standards and set a process for addressing those who are noncompliant. In 2007, the American College of Obstetricians and Gynecologists issued a report that addressed the issues of disruptive behavior.[25] In January 2009, the Joint Commission issued a requirement that a hospital must have a disruptive policy in place and provide supporting education as one of its leadership standards for hospital accreditation.[26] The policy must be consistently and equitably applied across all levels of the organization.

Having a consistent action-oriented approach to event reporting and follow-up procedures helps to ensure that all issues are addressed appropriately in an efficient manner. One recommendation is to have a standard process for incident reviews performed by a multidisciplinary committee that is trained to evaluate each event in a professional nonbiased manner and to make the appropriate recommendation for follow-up procedures. Individuals who register complaints should be given feedback to thank them for the report and to assure them that the event will be evaluated. Although the specific recommendations should not be discussed to maintain confidentiality, they are requested to report back if they do not see any notable changes over a selected period of time.

The intervention cycle is the most crucial part of the solution. On the surface, we recommend that the intervention focus on the opportunity to raise awareness and facilitate improvement though self-correction, rather than approaching the incident in a confrontational punitive manner. Interventions are best conducted by staff members who are trained in conflict management and dispute-resolution skills. There should be no apparent conflicts of interest or other biases that may impede the process and outcome of these interventions.

Interventions can occur at 3 different levels. The first level is the preevent stage. The changing health care environment of increasing complexity, growing accountability, sense of loss of autonomy and control, coupled with reduced reimbursements, the escalating costs of running a practice, and fears of malpractice, have led to increasing levels of dissatisfaction, stress, frustration, burnout, depression, and more, all of which certainly have taken their toll on physicians.[16] The identification of physicians who are at risk early on and a proactive approach in helping them adjust to the surrounding pressures of the environment will help to improve overall satisfaction and productivity that affect relationships at home and the workplace and have a better opportunity for success than waiting for an adverse incident to occur.[27] Many of these services may be available through an organization's existing Physician Wellness Committee, Employee Assistance Program, Human Resources De-

partment, or Medical Staff Office or can be made available through a variety of outside services that use experts in physician coaching or counseling.

Real-time intervention is necessary to prevent a disruptive event from escalating to a point at which it potentially compromises staff or patient safety. The problem with this is that the hierarchal nature of the medical system perpetuates a code of silence in which individuals are reluctant to speak up about a negative incident that involves one of their peers. Courses in assertiveness training and team training help to emphasize the importance of speaking up; however, fears persist, particularly if it involves a physician who has a history of disruptive behavior. The rallying point must be around patient safety. A recent survey of obstetrics services suggested that the decision to speak up is predicated on professional role, years of experience, and the perception of potential for harm, with differing perspectives of harm between physicians and nurses. Individuals must understand that it is their duty to speak up when they see something is wrong, to be taught how to speak up in a professional manner, to feel secure in the fact that the organization is behind them, and to be protected from retaliation.

Interaction after the event falls into several categories. First and easiest to address is the first-time offender. In many cases the individual was not aware of the consequences of the behaviors; after an informal conversation to make the person aware of the incident, he/she will take the necessary steps to correct it. When the level of frequency or intensity escalates, then the intervention should involve a conversation that is conducted by an individual who is trained in conflict-resolution skills. Recommendations at this level might include courses on stress management, anger management, or diversity management or recommendations for therapeutic counseling. Substance abuse must always be kept in mind as a possibility, with appropriate referrals as indicated. The most difficult situation occurs with the physician who is resistant to change. In these cases, the organization must be prepared to sanction the individual and, if necessary, to terminate privileges. In all cases, the attempt is physician salvage. As are all health care professionals, physicians are a precious resource, and we must do our best to work with them in an effort to help them maintain a satisfying productive practice.

In the end, it is all about supporting patient safety. Programs that are aimed at reducing the incidence of disruptive behavior must be intertwined with all the other programs and initiatives that enhance patient safety, quality improvement, and risk-management initiatives.

Given the fact that there are multiple factors that contribute to disruptive behaviors, it is hard to pinpoint a cause-and-effect relationship as to the benefit of each of these steps in the reduction of the occurrence and negative impact of disruptive behaviors on patient care. None of the steps are mutually exclusive; in fact, they all enhance the value of each other. The real question is, are you willing to pay the price of not addressing the problem with only a piecemeal approach?[28]

Conclusion

Disruptive behavior is a difficult issue to address. Recent surveys have confirmed the continued occurrence of disruptive behavior and its adverse impact on staff relationships, communication flow, and patient care.[29] Factors that contribute to this ongoing problem include a history of tolerance, a complex hierarchic-based medical care system, different stakeholder motivations, priorities and incentives to act, and an overall difficulty in addressing behavioral rather than clinical issues. The problem is compounded further in obstetrics services. Issues that are related to timing, convenience, motivation, priorities, roles and responsibilities, and clinical interpretation often put a wedge between the physician, nurse, and patient. With a primary focus on providing best patient care, physicians and nurses must work together to gain a better understanding of each others' roles, responsibilities, and priorities and come up with a mutually agreed on process of care to ensure a positive patient outcome. Organizations must be committed to the process and provide the necessary educational and resource support to make it happen. Taking a positive supportive approach to identify potential problem areas early on and implementing appropriate programs, not only to address disruptive behaviors but also to enhance opportunities to improve satisfaction, communication, and collaboration, will provide the best opportunities for success.

CASE EXAMPLE

- Table 2 gives a list of strategies that are designed to help organizations to address disruptive behaviors. Although the model provides a sound conceptual framework for going forward, in reality, things do not always go according to plan. It is not that people do not know what they must do, it is the barriers that get in the way of doing it. One way to flush out potential strategies for action is to use a case example for group discussion. An illustrative example selected from actual caregiver comments is presented.
- Dr Sour is a 55-year-old obstetrician who brings lots of patients to the hospital. He has always had a very strong demanding personality but recently appears to be acting more agitated. A recent incident occurred in what was scheduled to be a routine delivery. In the course of induction, the nurse became concerned about the protocol that was being used for the pitocin drip and called Dr Sour for clarification. Dr Sour yelled at the nurse for questioning him on what he was doing and told the nurse that he needed to have the baby delivered by 4:00 PM. He then went on to make a sly remark about her training and experience: "Let me know when you finish medical school." Frustrated and intimidated, the nurse continued the drip and then began to notice signs of fetal distress. Given Dr Sour's history, she begrudgingly called Dr Sour again. He responded by raising the level of intensity by screaming at her and questioning her as to how she had the audacity to call him again and said that he did not want to be bothered unless there was an emergency. When asked

to come in to evaluate the patient, he again questioned the nurse about her competency and authority and told her to continue to push the pitocin drip as he had ordered and that he would come in when the patient was ready to deliver. Stressed and aggravated, the nurse called the unit supervisor.

Questions to consider for discussion include:

1. What is the concern?
2. What are the underlying issues (goals/perceptions/motivations/priorities)?
3. What should the nurse do in real time?
4. How do you think it will go?
5. What should the organization do?
6. Who will do it?
7. How will it be done?
8. What else would you like to know about the situation?
9. What can be done to prevent further incidents like this?
10. Describe potential organizational/personal barriers and how they might be addressed.

For the correct answers, contact Dr Alan Rosenstein at ahrosensteinmd@aol.com. ■

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