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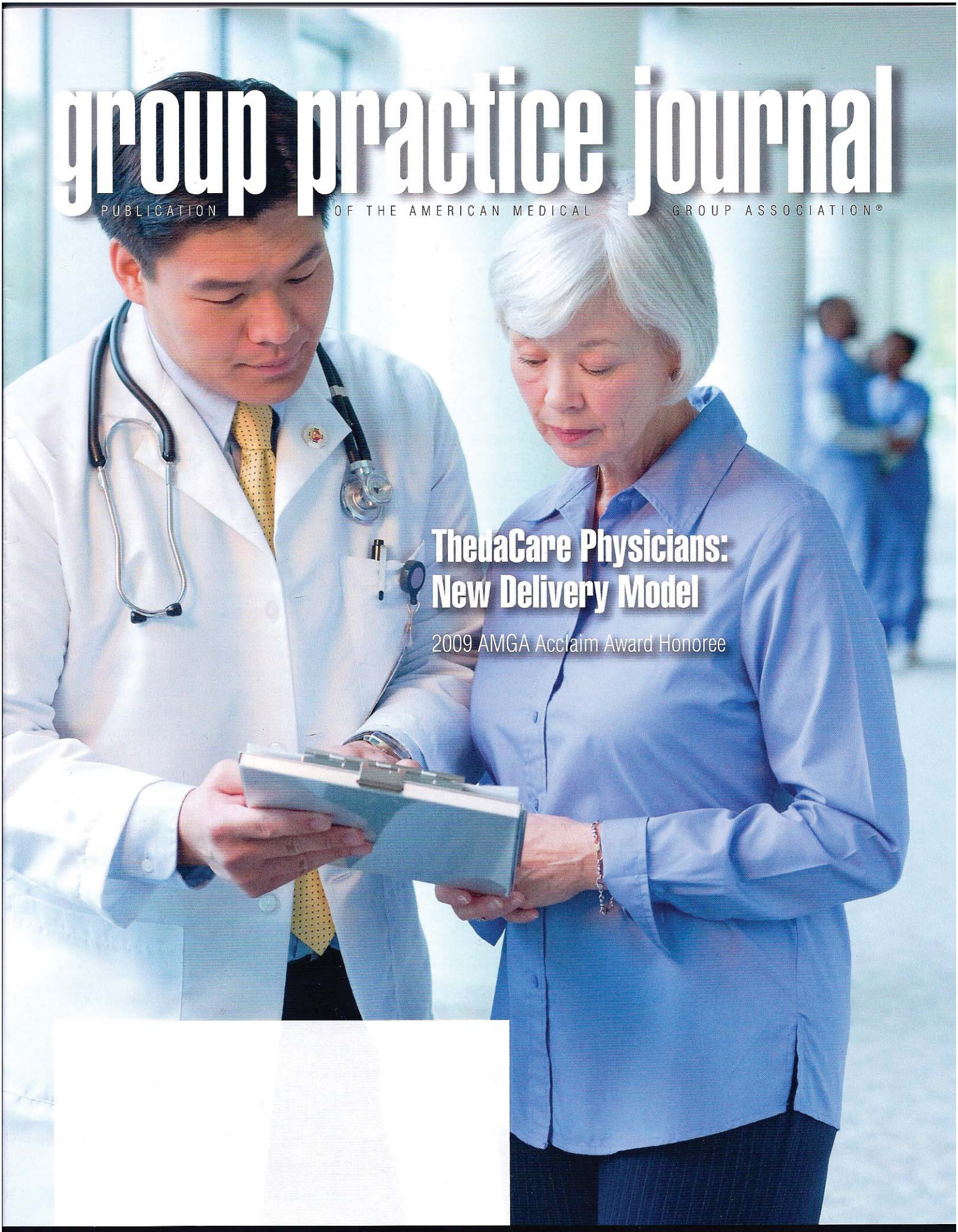

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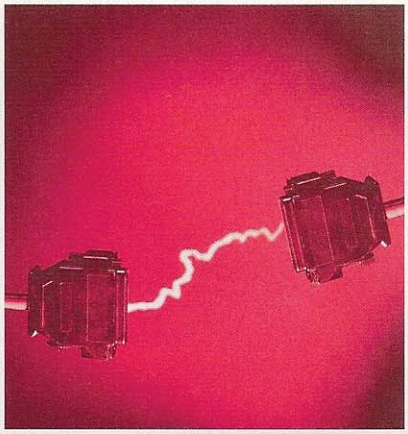

LEAD ARTICLE

FEATURES

FEATURES (CONT.)

COLUMNS

Addressing Physician Disruptive Behaviors to Improve Relationships, Process Flow, and Patient Outcomes

BY ALAN ROSENSTEIN M.D., M.B.A., AND DAVID G. DANIELSON, J.D., C.P.A.

Recent studies have shown that disruptive physician behavior can have a significant adverse impact on staff relationships, communication efficiency, information flow, organizational productivity and efficiency, and patient outcomes. However, there is still a reluctance to address the issue head-on, due to concerns about antagonizing a physician who brings in a large volume of patients and revenue into the organization, potential conflicts of interest, overall lack of willingness to interve http://www.sirius.com/s.gif ne, and lack of training on how to critique a physician on behavioral rather than clinical issues.

But, times have changed. Greater concerns about the impact of disruptive behaviors on staff and patient satisfaction, which affect the organization's reputation and ability to retain and recruit new staff members; the negative impact of disruptive behaviors on care efficiency, quality, and patient safety; the risks related to malpractice and litigation; and the new Joint Commission standard requiring hospitals to have a disruptive behavior policy in place and provide the necessary supporting education as part of the accreditation process, have made the risk of doing nothing much more substantial. Every organization has its own unique history, culture, structure, and capacity, and, accordingly, will take its own approach to the problem.

Several basic mediation concepts were deemed to be central to success in an intervention.

Steps in the Process

The first step in the process is to raise the level of awareness about what disruptive behavior is and its impact on the surrounding environment. We define *disruptive behavior* as any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse (including intimidating, condescending, berating, disrespectful, or abusive behaviors) to physical or sexual harassment, which can negatively impact the recipient. Our original research[1] focused specifically on the frequency of disruptive physician behaviors and their negative impact on nurse satisfaction, morale, and turnover. Follow-up research evaluated the frequency of disruptive behaviors in other disciplines, particularly nursing, its negative impact on behavioral factors (stress, concentration, communication, collaboration, information transfer), and its linkage to potentially preventable negative medical outcomes (adverse events, errors, mortality). Of the 8,000+ survey respondents, 18 percent reported they were aware of an adverse event that occurred as a direct result of an incident involving disruptive behavior.

No one starts the day out planning to be disruptive. In many cases, individuals are not even aware they are acting in a disruptive manner. Even if they are aware, most are

not cognizant of the downstream negative effect of their actions. Raising awareness and establishing accountability for individual actions and their impact on communication, collaboration, information transfer, attention to task, and patient care are critical to moving the process forward.

Once the awareness level has been raised through a variety of educational meetings and presentations, the organization must set the tone by endorsing a culture of non-tolerance for disruptive behaviors and providing leadership commitment and support. Developing a specific structure and process to monitor, assess, and address disruptive behaviors; performing an internal assessment as to the status of disruptive behaviors and staff relationships at the organization; and having an individual or individuals take responsibility for championing the program will heighten the sense of organizational commitment and increase the chances of success.

Education of the entire healthcare team is a key component of the program. Providing an overview of the incidence and negative impact of disruptive behaviors on staff and patient relationships, communication efficiency, and clinical outcomes of care is necessary to gain buy-in. Compiling internal data through surveys or internal reports will help the organization focus attention on specific opportunities for improvement. When appropriate, more-extensive educational programs on diversity, sensitivity and/or assertiveness training or conflict management may be needed. Advanced training in communication and team collaboration skills will help individuals learn what they can do to not only reduce the likelihood of disruptive events, but also increase overall communication efficiency and effectiveness.

Implementing policies and procedures sets the standard for expected behaviors and establishes protocols for addressing non-compliance. In January 2009, The Joint Commission mandated that as part of the accreditation process, hospitals must have a disruptive behavior policy and provide supportive services to ensure compliance. Further, it is important to apply the policy consistently across all disciplines and to deal appropriately with those who are unable to adhere to the standards.

There is still a reluctance to address the issue head-on, due to concerns about antagonizing a physician who brings in a large volume of patients and revenue into the organization.

A standardized, consistent process for reporting and follow-through on a disruptive event is crucial. One recommendation for an effective reporting process is to have all "incidents" channeled to one task force or committee for assessment and follow-through. A recommended multidisciplinary group includes physicians, nurses, and representatives from administration, human resources, and risk management who have been trained in appropriate intervention skills. This multidisciplinary approach helps maintain consistency in assessment and action by avoiding individual biases or conflicts of interest. Proper training ensures that appropriate action or intervention will be taken.

Intervention can be handled in three different ways. The pre-event stage (prior to the occurrence of any specific incident or disruptive event) has the greatest opportunity for success. At one level is the advantage of providing staff education and training on appropriate behaviors, staff interactions, and communication to raise awareness and provide skills that lessen the likelihood of a disruptive event. At a deeper level is the recognition that many physicians are experiencing increasing levels of dissatisfaction, frustration, stress, burnout, and even depression, which affect their willingness and capability to provide best-practice care. Identifying physicians at potential risk and providing them with coaching and mentoring services can do a lot to increase their satisfaction in both their personal and work lives. These services are becoming more widely available through a variety of physician wellness companies utilizing peer coaching and counseling techniques in a comfortable, convenient, supportive, and confidential fashion. Physicians are a precious resource; helping them open up and discuss their concerns in a non-confrontational manner is far preferable to post-incident discussions that can take on a punitive tone, with the potential of increasing physician resistance and antagonism, which can further aggravate the problem.

It is crucial to intervene while disruptive behavior is in progress to prevent an adverse event from occurring. The importance of speaking up has been shown through team collaboration training adopted from the airline industry (such as the Team Steps Training Program, as an example), along with principles endorsed through assertiveness training, (such as Vital Smarts Crucial Conversations training).

Post-event interventions usually fall into one of three categories. The easiest scenario occurs when the physician didn't understand the impact of his actions, takes the concern seriously, and then modifies behaviors accordingly. Another scenario, where the physician has more deep-seated problems related to stress, anger, depression or personality disorders, for example, typically requires a more intensive solution that may involve sensitivity or diversity training or stress, anger, and/or conflict management to help modify emotions and behaviors. Some physicians may require individualized counseling or therapy. The

10-Point Plan: Addressing Disruptive Behaviors

1. Recognition and Awareness
   - Definition
   - Accountability
2. Organizational Culture
   - Leadership Commitment
   - Assessment
   - Structure
3. Clinical Champions
4. Education
5. Structured Education and Training
   - Diversity/Sensitivity Training
   - Anger/Conflict Management
   - Assertiveness Training
6. Communication/Team Collaboration Skills
7. Policies and Procedures
8. Reporting Mechanisms
   - Sources
   - Consistency
   - Follow-Through
9. Intervention
   - Pre-event
   - Concurrent
   - Post-event
10. Reinforcement of Patient Safety Initiatives

possibility of an underlying problem with substance abuse should always be investigated. Finally, in a relatively small number of cases, where the physician refuses to participate in any recommended programs, or to see a counselor or therapist, it may be necessary to suspend privileges.

Every organization facing disruptive physician behavior needs to recognize the importance of addressing these issues, implement an effective process and structure, and provide user-friendly services to support and assist staff in achieving these objectives.

In Practice

Sanford Clinic-South, a division of Sanford Health-MeritCare, employs approximately 400 physicians and an additional 150 non-physician providers. In 2008, Sanford Clinic administrators recognized that the internal process for dealing with provider employment issues was resulting in higher-than-expected discipline and termination rates. After a review of the process, additional administrative resources were allocated to design and implement a program to identify those providers that exhibited disruptive behaviors, with the intent to intervene earlier to attempt to change behaviors and thereby potentially avoid last-stage administrative remedies.

When the Joint Commission issued its Sentinel Event Alert regarding disruptive providers, the decision was made to integrate the early intervention process as part of the Sanford Health's overall policy for both Joint Commission and non-Joint Commission-accredited facilities.

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Sanford Health leadership was and is committed to dealing with disruptive individuals as part of its overall safety/quality/risk management programs. The Sanford Health Corporate Human Resources department, which has overall responsibility for employment issues, in conjunction with Sanford Medical Center and Sanford Clinic administration, was directed to design an overall approach to disruptive behavior including policy development, infrastructure requirements, and personnel skill development. Other processes to be developed were intake procedure, care management, and follow-up reporting.

Several individuals from the Sanford Human Resources department and Sanford Clinic administration were selected for focused training in mediation as it was believed that this skill set would provide the broadest base for conflict resolution. Through a "train the trainer" model, executive staff attended both legal and interest-based (a method to move individuals from focusing on their complaints to solutions in their own interests) mediation training, with additional managers identified for later training.

Several basic mediation concepts were deemed to be central to success in an intervention. The individuals selected for the interventions needed to be perceived by the physician as neutral or at least unbiased. Therefore, a clear distinction was made between the decision makers who made the referral to the intervention group and the individuals who would intervene. The intervention group had no direct line authority to discipline or terminate the physician (although recommendations could be made) and more importantly, would not have the ability to choose those providers who received the interventions.

It was decided that a two-person teams (including both a clinical as well as administrative background) would be used when an intervention for a disruptive physician was required. In general, when clinical decision making was to be cited, another physician was paired with an administrator who would "lead" the discussion. The discussion would be focused on the patient care issues, with emphasis on the potential for patient harm when communication breaks down between physicians. The discussion would avoid personal attacks and be non-aggressive, with the ultimate goal of enabling the disruptive physician to understand the issues involved and developing an action plan to correct a behavior. An evaluation of that understanding and receptivity for correction would be made by the interveners and submitted to for the decision-making group for follow-up. Finally, a follow-up monitoring plan would make sure the action plan was working or if additional interventions

needed to occur.

The intervention group would also be on the alert for underlying issues causing the behavior. While not excusing the behavior, issues such as substance abuse and emotional problems might be important in creating a sustainable action plan.

A recent intervention illustrates this point. A 48-year-old family medicine physician was referred for an intervention by the Operations Group for a variety of reasons, including a dramatic increase in patient complaints, many of which related to communication issues. In addition, this individual was generating an increasing number of partner complaints relating to lack of follow-through on patient care issues while on call, which resulted in several near-misses at the tertiary medical center. The intervention team, consisting of a conflict resolution-trained physician and a clinic administrator, was assigned and, after reviewing the above information, scheduled a meeting with the physician. At the meeting, the focus was on the patient care issues that created the near-misses at the medical center and how they could have been handled differently, followed by a discussion of the recent increase in patient complaints (from zero in previous years to eight in one year). As the physician was discussing this, he revealed that there had been a personal tragedy in his immediate family. After further questioning, it appeared that he had returned to work the next day (patients came first) and almost all of the issues had occurred since that time. The physician was very receptive to an action plan to improve his patient care, which included a referral to an employee assistance program. The follow-up monitoring program, which took place one year post-intervention, has indicated an increase in both patient and partner satisfaction.

Conclusion

In order to be successful in correcting disruptive physician behavior, an organization must start with a commitment by leadership to deal with the issue for the overall health of the organization and its providers. With that commitment, investments , including the training for the intervention group, can be made. The use of dedicated neutral teams with the appropriate skill sets and commitment to early intervention will lead to positive results for both the providers and the patients they serve.

References

1. A. Rosenstein and M. O'Daniel. 2005. Disruptive Behavior and Clinical Outcomes: Perceptions of Nurses and Physicians. *American Journal of Nursing*, 105(1).

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