Hospital Practice

http://informahealthcare.com/hop
ISSN: 2154-8331 (print)

Hosp Pract, 2015; Early Online: 1–5
DOI: 10.1080/21548331.2015.1083838

Taylor & Francis
Taylor & Francis Group

CLINICAL FEATURE
PERSPECTIVE

Taking a new approach to reduce the incidence of physician disruptive behaviors

Alan H Rosenstein

139 15th Avenue, San Francisco, CA 94118, USA

Abstract

Disruptive behaviors continue to play a disturbing role in today's healthcare environment, negatively affecting care relationships that can adversely impact outcomes of patient care. Many organizations have implemented a number of different strategies in an effort to address this important issue with varying degrees of success. New complexities and changing roles, responsibilities and accountabilities for the delivery of appropriate, high-value, high-quality, safe, satisfying care have added increasing pressures on healthcare organizations to better integrate and coordinate healthcare delivery across the entire spectrum of care. Physicians play a crucial role in this process. When disruptive behaviors occur, rather than taking the traditional more remedial punitive approach to behavioral management, organizations would do better to try to focus on strategies that address physician and staff needs and provide appropriate supportive services to help them better adjust to stress and pressures of today's healthcare environment. Increasing levels of stress and burnout are taking their toll on physician attitudes and behaviors resulting in increasing levels of disillusionment, dissatisfaction and frustration affecting physician well-being and performance. Physicians often won't act on their own and we need to look to the organizations they are affiliated with to take the initiative by providing appropriate administrative, clinical and emotional support services before the occurrence of an unwanted event. Allowing physicians' input, listening to their concerns and providing needed support will enhance physician satisfaction, engagement, compliant attitudes and behaviors that lead to less disruption and better patient care.

Keywords:

Disruptive behaviors, organizational culture, physician wellness, care management

History

Received 2 June 2015
Accepted 13 August 2015
Published online 26 August 2015

Background

We first reported on the incidence and impact of disruptive behaviors in 2002 describing the nature of disruptive physician behaviors, who was doing it and the impact it had on nurses' morale, satisfaction and turnover [1,2]. Follow-up studies extended the scope of work to address disruptive behaviors in nursing and other disciplines and its impact on psychological factors that negatively affect job performance and patient outcomes of care [3]. Our publication in the Joint Commission Journal on Quality and Patient Safety was timed with the release of Sentinel Event #40 alerting organizations to the concerns about the linkage between disruptive behaviors and compromises in patient safety which lead to the adoption of a new accreditation standard requiring hospitals to have a disruptive behavior policy in pace and provide support for its intent [4,5]. Since then there have been numerous other studies documenting the negative impact of disruptive behaviors on patient care. While disruptive behaviors can been seen across all specialties and service lines, they are most evident in high stress areas such as Surgery, the Emergency Department and Obstetrical arena. [6-8]. Despite growing awareness and organizational responsiveness, several recent studies have shown that disruptive events continue to occur with alarming frequency [9-11]. We need to take another look at what's precipitating these behaviors and see what we can do to minimize its occurrence and consequences.

Perspective

No one plans to start out the day being disruptive. Disruptive events are usually triggered by a combination of internal and external factors influencing individual values, attitudes, perceptions and mood, which ultimately affect their actions and behaviors. A listing of these contributing factors is presented in Table 1.

From an internal perspective, many behavioral tendencies are related to more deeply ingrained factors associated with age and generational values, gender-based traits and preferences, ethnic, cultural or spiritual values (particularly

Correspondence: Alan H. Rosenstein M.D, M.B.A. 139 15th Avenue, San Francisco, CA 94118, USA. Tel: +1 41 53 70 77 54.
E-mail: ahrosensteinmd@aol.com

Table 1. Factors affecting physician behavior.

Internal	External
Age (generation)	Training
Gender	Debt
Culture & ethnicity	Work environment
Geographics/life experiences	Home environment
→ Personality profile	→ Reality & expectations

with regard to hierarchy, power structure dominance and communication styles) and other life experiences that help shape one's personality. While deep-seated preferences and biases may be more difficult to change, education and training courses on emotional intelligence, diversity management, cultural competency, generational differences, personality traits and conflict management may help address these issues in a constructive fashion.

Contributing external factors include training experiences, debt and financial obligations and environmental factors influencing the workplace and home environment. These factors have a more obvious impact on day-to-day realities affecting expectations, attitudes, moods and behaviors. For physicians many of these influences begin during the training process. Many studies equate medical school training to a fraternity hazing process where individuals start out with low self-esteem, try to prove themselves through long hours of independent study that breed isolation, autonomy and insensitivity and lead to demanding dictatorial types of behaviors. Skill sets are built on knowledge and technical competency with little attention spent on development of personal skill traits focused on improving communication and collaboration efficiency. Recent studies have also highlighted the significant amounts of stress and burnout experienced by medical students which also contribute to negative attitudes and behaviors in students [12]. All of these occurrences may increase the predilection for disruptive behaviors. Fortunately, there is now a growing effort to redesign the medical school admission and training process by selecting the "right students", revising the core curriculum by adding courses and rotations that focus on the importance of team collaboration and social sensitivity, and making efforts to address the underlying stress and burnout experienced throughout training [13,14].

One of the key environmental factors affecting work place dynamics is Health Care Reform. Value Based Care and other new healthcare initiatives have introduced a number of new challenges to healthcare delivery resulting in increasing levels of stress, dissatisfaction and burnout in the physician population [15-17]. With a greater emphasis on metric-based performance accountability, changing incentives, priorities and models of care, the push toward electronic documentation and reporting compliance and the growing focus on economics and productivity, these forces are affecting both the physical and emotional well-being of practicing physicians [18-20]. Dissatisfaction can lead to cynicism and apathy which can lead to depression and other behavioral disturbances that can disrupt work relationships that negatively impact patient care. Organizations need to recognize the impact this is having on physician attitudes and, emotions, and their willingness and capability to provide care. With a growing concern about physician well-being, many organizations are promoting the extension the Triple Aim concept (enhancing the patient experience, population management and cost-efficient care) to a Quadruple Aim focus to emphasize the vital link between physician wellness, physician satisfaction and optimal organizational performance [21,22]. Not only do we need to more effectively deal with disruptive behaviors, we need to do what we can to help our physicians thrive in today's healthcare environment.

Call to action

It is common practice for outside industries to have policies and procedures in place to deal with the toxic effects of workplace bullying and intimidation in an effort to support a positive workplace environment. In healthcare it hasn't quite been as forthcoming. Factors contributing to this reluctance include either a lack of overall awareness, permissive tolerance, concerns about supply and demand or resistance to respond due to problems with organizational hierarchy or the fear of antagonizing a physician who may choose to bring his or her business elsewhere. The original call to action was stimulated by the new Joint Commission requirement in conjunction with growing recognition of the negative clinical and economic impact that disruptive behaviors had on staff satisfaction and turnover, care efficiency, compliance with organizational standards and priorities, patient complaints and compromises in patient safety and quality of care [23,24]. The new call to action focuses on the importance of committed physician leadership and team partnerships needed to manage service delivery across the full spectrum of care. With the growing emphasis on accountability for metric-based performance outcomes providers are facing significant financial penalties for poor compliance with core quality indicators, poor patient satisfaction (HCAHPS), high readmission rates and higher than expected mortality. As more of the financial risk for healthcare management falls on the shoulders of providers, the greater the need to develop a network of best practice providers who are willing to collaborate as part of a well-coordinated multidisciplinary team organized to provide best practice care [25,26].

Recommendations

There is no easy solution to the problem of dealing with disruptive behaviors. Successful outcomes will depend upon a strong organizational commitment to a professional code of conduct supported by applicable training and intervention services that enhance attitudes and behaviors that lead to best patient care. Table 2 provides an overview of strategies that support this goal.

As mentioned previously, many of these issues start during the training environment. One of the first areas to focus on is the "qualifications" of the medical school applicant. There is a growing push to attract students who have focused on areas outside the traditional math and sciences looking for more well-rounded students who have also concentrated studies in the area of social sciences. The new Medical College

Table 2. Strategies for improvement.

Medical school admissions and training
Recruitment/on-boarding
Organizational/leadership culture
Education and training
Physician support
Physician engagement
Policies and procedures
Incident reporting
Intervention strategies
Recognition/thank you/staff satisfaction

Admission Test has added a new series of questions that focus on sociology and philosophy in an attempt to assess the student's aptitudes in addressing questions about social behavior [13,27].

The next issue is finding the right applicant for the job. Many organizations have made a conscious effort to screen candidates as to their "cultural fit" to assess whether or not the applicant's job expectations fits in well with the organization's mission and way of doing business [28]. After hiring, many organizations then provide a comprehensive "on-boarding" process to welcome the physician, discuss organizational needs and priorities and offer support and assistance to help the physician adapt to the new environment.

One of the key underpinnings is the underlying organizational culture. Having an organization committed to a culture focused on patient-centric care and its willingness to support its staff members in providing this care is crucial to set the tone of a positive work environment where members can thrive [29-31].

Next is the role of training and education. This takes several forms. First is general education to familiarize physicians as well as other members of the workforce about the changes in the healthcare environment and how this may impact their roles and responsibilities. When physicians begin to recognize the impact of external issues on their practice and the benefits of combining efforts with mutually agreed upon organizational and individual goals and incentives, they will be more receptive to making the needed changes.

Providing a deeper level of training to include workshops on such topics as emotional intelligence, customer satisfaction, diversity management, cultural competency, conflict management and improving communication and team collaboration skills will provide context and content to help physicians better understand how their behaviors can impact work relationships and patient care. Improved communication and collaboration skills are key to improving relationships. Unfortunately, many physicians are not the best communicators [32]. Organizations that have devoted the time and resources to these projects have dramatically improved both patient and staff relationships and clinical outcomes of care demonstrating a significant overall return on investment [33,34].

Another key area is for the organization to gain a better understanding of the pressures physicians are facing in clinical practice. Issues around lingering debt, reduced revenues, greater external scrutiny and performance accountability and changing contractual arrangements with newly evolving models of care have added a significant degree of stress, dissatisfaction, anxiety, depression and burnout that has affected physician attitudes and behaviors. A recent survey conducted by Cejka Search and VITAL WorkLife reported that more than 88% percentage of physicians reported significant degrees of stress and burnout, and what was even more alarming was the reluctance by the physicians or their organization to do anything about it [35,36]. Physicians either don't recognize they're under stress, or if they do, feel like they can handle it themselves. Even if they want outside help, ego, concerns about competency and fears about confidentiality get in the way. They put it aside and just continue with their demanding schedule. The new approach is for the organizations they work for to recognize the problem and proactively supply the needed administrative, clinical and emotional support. Do what is necessary to promote the physician's state of well-being [37]. Offering coaching and counseling either internally through Human Resources, Physician Wellness Committees, a Physician EAP (Employee Assistance Program) or bringing in outside resources to work with physicians to help them adjust to their environment will provide great benefit in lowering stress and improving physician satisfaction. Early intervention is the best strategy for reducing the likelihood of a disruptive event [38].

Another approach focuses on improving overall physician engagement [39,40]. Instead of just telling the physician what you want them to do, make and take time to listen to what their needs and concerns are and be prepared to help provide support. Allowing physicians input through discussion groups, Town Hall meetings, Department meetings, task forces, subcommittees or through one-on-one meetings will go a long way in helping to understand what is needed and what all members of the organization need to do to work together to achieve mutual goals.

Even with all the above strategies in place there will still be episodes of disruptive behavior. In order to address such behaviors, the organization needs to have a disruptive behavior in place outlining what constitutes disruptive behavior and what are the processes and ramifications for those who are non-compliant. There needs to be a standard reporting policy where all complaints are assessed and evaluated in a consistent, equitable, non-biased manner, with recommendations made for appropriate follow-up. Interventions need to be conducted by individuals trained in dispute resolution and conflict management, and not simply turned over to the Chief of the Department.

Interventions can take several forms. The simplest form is the informal "coffee time" conversation geared to raise levels of awareness. Many physicians exhibiting disruptive behaviors don't know they're doing it and are unaware of any unwanted downstream effect. Raising their level of awareness and suggesting alternative ways of handling the situation often provides the necessary cure. More chronic and serious events will require behavioral correction. This phase requires a more authoritative approach holding the physician accountable for their actions and making specific recommendations for behavioral correction. This may include training in anger, stress or conflict management. Individual counseling may

Table 3. Consequences of high stress and burnout.

Physicians:
Decreased job satisfaction
Feelings of irritability, moodiness, cynicism, apathy
Sleep disturbances, fatigue
Negative impact on physical health
Negative impact on emotional health (anxiety, depressions, behavioral disorders)
Performance liability
Patient safety issues
Patient satisfaction
Career issues
Organizations:
Culture, relationships, morale, staff satisfaction
Increased turnover, recruitment and retention challenges
Poor care coordination/productivity/efficiency
Disruptive behaviors
Patient safety and quality issues related to poor responsiveness, ineffective communication, judgment errors causing adverse events
Patient satisfaction/reputation
Penalty/liability

also be recommended. More severe cases may require a more concentrated focus on behavioral correction offered by a variety of state or national resources. In some cases, the only recourse may be either suspension or termination of privileges.

The final phase is recognition and thank you for a job well done. We need to look at physicians as an over-extended precious resource. Showing them respect, establishing trust, recognizing and thanking them for all they do will go a long way in improving their attitudes, outlook, satisfaction and behaviors.

Conclusion

Physicians pride themselves on the virtues of providing best patient care. Behavioral issues arise from multiple inciting forces which may lead to disturbances in care relationships that negatively impact care management. Many of these influences come from deep-seated values, attitudes and perceptions, and others come from more externally influenced life experiences, the consequences of which may impair both the physician and the organization with which they are involved (Table 3). Understanding physician behaviors, taking time to listen to their needs and concerns, providing appropriate training, counseling and support and soliciting their input and involvement will go a long way in improving physician acceptance, understanding, involvement and engagement, which will lead to more compliant behaviors that affect their disposition, compliance, staff relationships and patient outcomes of care.

Declaration of interest

The author has no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending or royalties.

References

[1] Rosenstein A. The Impact of Nurse-Physician Relationships on Nurse Satisfaction and Retention. Am J Nurs 2002;102:26–34.
[2] Rosenstein A, Lauve R, Russell H. Disruptive physician behavior contributes to nursing shortage. Physician Exec 2002;28:8–11.
[3] Rosenstein A, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. Am J Nurs 2005;105:54–64.
[4] Rosenstein A, O'Daniel M. A Survey of the impact of disruptive behaviors and communication defects on patient safety. Jt Comm J Qual Patient Saf 2008;34:464–71.
[5] The Joint Commission. Behaviors that undermine a culture of safety. Sentinel Event Alert 2008:1–5.
[6] Cochran A, Elder WB. A model of disruptive surgeon behavior in the periopeartive environment. J Am Coll Surg 2014;219:390–8.
[7] Rosenstein A, Naylor B. Incidence and impact of physician and nurse disruptive behaviors in the emergency department. J Emerg Med 2012;43:139–48.
[8] Veltman L. Disruptive behavior in obstetrics: a hidden threat to patient safety. Am J Obstet Gynecol 2011;196:187e1–5.
[9] ISMP Medication Safety Alert. Disrespectful behavior in healthcare: have we made any progress in the last decade. 2013. Available from http://www.ismp.org.
[10] Sanchez LT. Disruptive behaviors among physicians. JAMA 2014;312:2209–10.
[11] Rosenstein A. Bad medicine: managing the risks of disruptive behaviors in health care settings. Risk Manage 2013;60:38–42.
[12] Drybe L, Massie F, Eacker W, Harper D, et al. Relationship between burnout and professional conduct and attitudes among US medical students. JAMA 2010;304:1173–80.
[13] Schwartzstein R. Getting the right medical students- nature versus nurture. N Engl J Med 2015;372:1586–7.
[14] Muller D. Reforming pre-medical education: out with the old, in with the new. N Engl J Med 2013;368:1567–9.
[15] Shanafelt T, Sonja S, Tan L, Dyrbye L, et al. Burnout and satisfaction with work-life balance among us physicians relative to the general US population. Arch Intern Med 2012;172:1377–85.
[16] Danielson D, Ketterling R, Rosenstein A. M.D Physician stress and burnout: causes, effects, and impact on performance and behavior. AMGA Group Practice J 2013;62:38–41.
[17] The Physician Foundation/Merritt Hawkins. Health reform and the decline of physician practice. 2010. Available from http://www.physiciansfoundation.org.
[18] RAND Association/AMA Report. Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. 2013. Available from www.rand.org.
[19] Privitera M, Rosenstein A, Plessow F, LoCastro T. Physician burnout and occupational stress: an inconvenient truth with unintended consequences. J Hospital Administration 2014;4:27–35.
[20] Heponiemi T, Aalto A-M, Puttonen S, Vanaska J, Elovainio M. Work-related stress, job resources, and well- being among psyciatrists and other medical specialists in Finland. Psyciatric Serv 2014;6(65):768–801.
[21] Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573–6.
[22] Wallace E, Lernaire B, Ghali W. Physician wellness: a missing quality indicator. Lancet 2009;374:1714–21.
[23] Rosenstein A. The economic impact of disruptive behaviors: the risks of non-effective intervention. Am J Med Quality 2011;26:372–9.
[24] Hickson G, Federspiel C, Pichert J, Miller C, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. J Am Med Association 2002;287:2951–7.
[25] Sullivan M, Kiovsky R, Mason D, Hill CD, Dukes C. Interprofessional collaboration and education: working together to ensure excellence in health care. Am J Nurs 2015;115:47–55.
[26] Brock D, Abu-Rish E, Chiu C, Hammer D, Wilson S, Vorvick L, et al. Interprofessional education in team communication: working together to improve patient safety. Postgrad Med J 2013;89:642–51.

[27] Beck M; The Wall Street Journal. Innovation is sweeping through U.S medical schools. Available from http://www.wsj.com/articles/innovation-is-sweeping-through-u-s-medical-schools-1424145650. Last accessed 16 February 2014.
[28] Byington M. Hiring for cultural fit at our medical practice. Physician Pract 2013. Available from http://www.physicianspractice.com/blog/hiring-cultural-fit-your-medical-practice.
[29] Beckman H. The role of medical culture in the journey to resilience. Acad Med 2015;90:1–3.
[30] Changing culture, leading strategy at health care organizations. HealthLeaders Roundtable Discussion 2014;42–6.
[31] Shanafelt T, Gorringe G, Menaker R, Storz K, Reeves D, Buskirk SJ, et al. Impact of organizational leadership on physician burnout and satisfaction. Mayo Clin Proc 2015;90:432–40.
[32] Rosenstein A. Physician communication and care management: the good, the bad, and the ugly. Physician Exec 2012;38:34–7.
[33] Available from http://teamstepps.ahrq.gov/taq_index.htm.
[34] Measuring the impact of interprofessional education on collaborative practice and patient outcomes. Institute of Medicine Brief 2015.
[35] Rappleye E; Becker Hospital Review. Study: current physician burnout solutions ineffective. 2015. Available from http://www.beckershospitalreview.com/hospital-physician-relationships/study-current-physician-burnout-solutions-ineffective.html.
[36] Rosenstein A. Addressing physician stress, burnout, and compassion fatigue: the time has come. Isr J Health Policy Res 2013;2:32–1–3f.
[37] West C, Dyrbye L, Rabatin J, Call T, Davidson JH, Multari A, et al. Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. JAMA Intern Med 2014;174:527–3.
[38] Rosenstein A. Early intervention can help prevent disruptive behavior. Physician Exec 2009;37:14–15.
[39] Rosin T; Becker Hospital Review. Bridging the divide: how the level of physician engagement can make or break your hospital. 2015. Available from http://www.beckershospitalreview.com/hospital-physician-relationships/bridging-the-divide-how-the-level-of-physician-engagement-can-make-or-break-your-hospital.html.
[40] Rosenstein A. Meeting the Physician's needs: the road to organizational-Physician engagement. Hospital Trustee 2015;19–22.