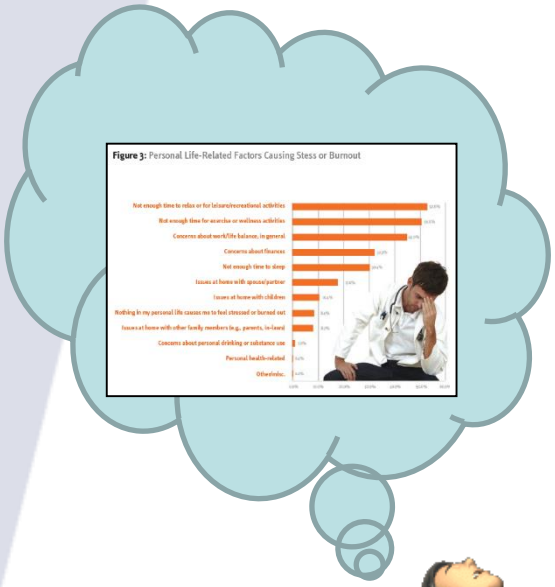
The Ins and Outs of Physician Well- Being and It's Impact on Attitudes and Behaviors Affecting Patient Care



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Definition of Well- Being

Merriam-Webster

well–being : the state of being happy, healthy, or successful

noun | well–be·ing | \ˈwel-ˈbē-iŋ\

Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life.[1] "

...a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." - The World Health Organization[2]

Not well- being:

- Not being happy
  - Frustration/ anger/ apathy/ cynicism
- Not feeling healthy
  - Physical/ Emotional/ Behavioral
- Not being successful
  - Dissatisfaction/ Loss of purpose/ Career?
  - Care management: outcome success?

Wants and Wishes

Physicians:

- Good patient care
- Happiness/ success/ respect
- Control
- Work-life balance
  - Work hours/ responsibilities
  - Rest and relaxation
  - Wellness activities
- Administrative support
  - Recognition and concern
  - Input and understanding
  - Leadership responsiveness
    - Administrative support
    - Clinical support
    - Emotional support
    - Career support
    - Thank you

Organizations:

- Mission/ Culture/ Morale
- Success/ Reputation
- Recruitment and retention
- Achieve objectives
  - Metric compliance
  - Less disruption/ productivity
  - Enhanced communication and team collaboration
  - Conflict resolution
  - Best practiced quality/ safety
- Professional behaviors
- Patient/ staff satisfaction
- Physician satisfaction/ success

Disturbances in the Force

- Ideology vs reality
- Hierarchy, habit, expectations, accountabilities
- Internal biases
  - Age/ Gender/ Culture/ Ethnicity/ Personality
- External pressures
  - Training/ Reform/ Life/ Stress and burnout
- Physical/ Emotional/ Behavioral liabilities
- Resiliency?
- Resource support?
- Life/ Career impact?

Learning Objectives

- Gain a better understanding of the factors affecting physician attitudes and behaviors toward patient care
- Discuss the growing significance of stress and burnout and other factors negatively impacting physician well-being, care relationships, satisfaction, patient safety, and quality of care
- Learn how to develop an effective process to better understand physician needs and concerns and provide appropriate strategies to help physicians better adjust to the pressures of medical practice and attain a healthier more satisfying personal and professional life to enhance physician well-being and patient care

Understanding and Managing Mood and Behaviors

Happy: Energetic

Content

Anger/ frustration

Stress/ burnout

Physical impairment

Behavioral impairment

Fully engaged: collaborative

Engaged: participative

Non- compliant

Passive aggressive

Disruptive

Destructive

Disruptive Behaviors

- Non- engagement
- Non-compliant
- Non- participative
- Non- communicative
- Passive- aggressive
- Bullying
- Intimidating
- Abusive
- Destructive
  - Self destruct
  - Team destruct
  - Care destruct

The Joint Commission Journal on Quality and Patient Safety

Leadership

A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety

Alan H. Rosenstein, M.D., M.B.A.; Michelle O'Daniel, M.H.A., M.S.G.

Ever since the publication of the Institute of Medicine Report *To Err Is Human*, health care organizations have received the wake-up call that they need to address the growing concern about patient safety[1]; several follow-up reports have documented moderate improvement, but there are still large, disconcerting gaps between what we have been able to achieve and where we need to go.[2,3] To advance further we need to improve our processes, systems, and technology, and at the same time address the human factor issues that affect bedside care.

We originally reported on the impact of disruptive physician behavior on nurse satisfaction and retention in 2002. The results of this research showed a significant relationship between disruptive physician behavior, poor nurse satisfaction and morale, and an increase in nurse turnover.[4,5] As part of the research for this study, we searched for information on a relationship between disruptive behaviors and negative outcomes of care, but other than a few anecdotal stories, we could find no documented studies directly linking disruptive behavior to negative clinical outcomes.

In an effort to address the relationship of disruptive behaviors to potential compromises in patient outcomes of care, we extended the scope of the survey to include assessment of disruptive behaviors in nurses and other health care disciplines and evaluated their perceptions and experiences as to the impact of disruptive behaviors on patient care. These studies showed a significant relationship between both physician and nurse disruptive behaviors and worrisome psychological and behavioral traits, which led to impaired working relationships hampered by intimidation, hostility, stress, frustration, loss of focus, poor communication, and reduced transfer of necessary information, all of which adversely affected patient outcomes.[6,7]

The Joint Commission reports in its root cause analysis of sentinel events that nearly 70% of the events can be traced back to a problem with communication.[8] Effective January 1, 2009, The Joint Commission will require that the hospital (organization) "has a code of conduct that defines acceptable, disruptive,

Article-at-a-Glance

Background: A recent survey was conducted to assess the significance of disruptive behaviors and their effect on communication and collaboration and impact on patient care.

Survey: VHA West Coast administered a 22-question survey instrument—Nurse-Physician: Impact of Disruptive Behavior on Patient Care—to a convenience sample. Of the 388 member hospitals (in four VHA regions) invited, 102 hospitals participated in the survey (26% response rate). Results from surveys received from January 2004 though March 2007 are represented. Of the 4,530 participants, 2,846 listed their titles as nurses, 944 as physicians, 40 as administrative executives, and 700 as "other."

Results: A total of 77% of the respondents reported that they had witnessed disruptive behavior in physicians—88% of the nurses and 51% of the physicians. Sixty-five percent of the respondents reported witnessing disruptive behavior in nurses at their hospitals—73% of the nurses and 48% of the physicians. Sixty-seven percent of the respondents agreed that disruptive behaviors were linked with adverse events: the result for medical errors was 71%, and patient mortality, 27%.

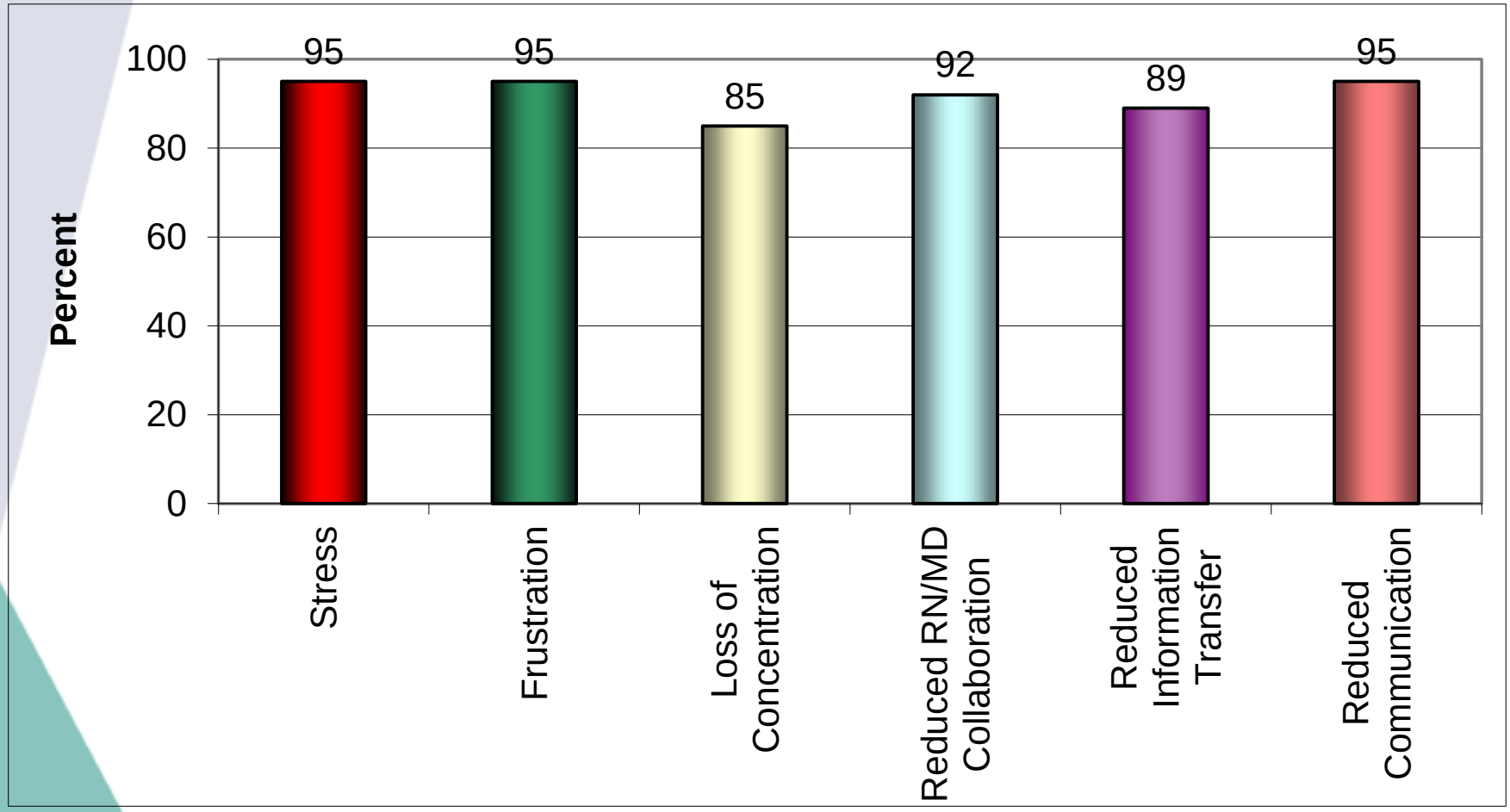
Discussion: The results from the survey show that disruptive behaviors lead to potentially preventable adverse events, errors, compromises in safety and quality, and patient mortality. Strategies to address disruptive behaviors should (1) prevent disruptive events from occurring, (2) deal with events in real time to prevent staff or patient harm, and (3) initiate postevent review, actions, and follow-up.

Recommendations: Twelve recommendations—including recognition and awareness, policies and procedures, incident reporting, education and training, communication tools, discussion forums, and intervention strategies—address what hospitals and other organizations can do now to address disruptive behaviors.

How Often Does Disruptive Behavior Result in the Following?

	Never	Rarely	Sometimes	Frequent	Constant
Stress	☐	☐	☐	☐	☐
Frustration	☐	☐	☐	☐	☐
Loss of concentration	☐	☐	☐	☐	☐
Reduced team collaboration	☐	☐	☐	☐	☐
Reduced information transfer	☐	☐	☐	☐	☐
Reduced communication	☐	☐	☐	☐	☐
Impaired Nurse-Physician relationship	☐	☐	☐	☐	☐

Linkage Between Disruptive Behavior and Undesirable Behavioral Factors Occurring Sometimes, Frequent and Constant

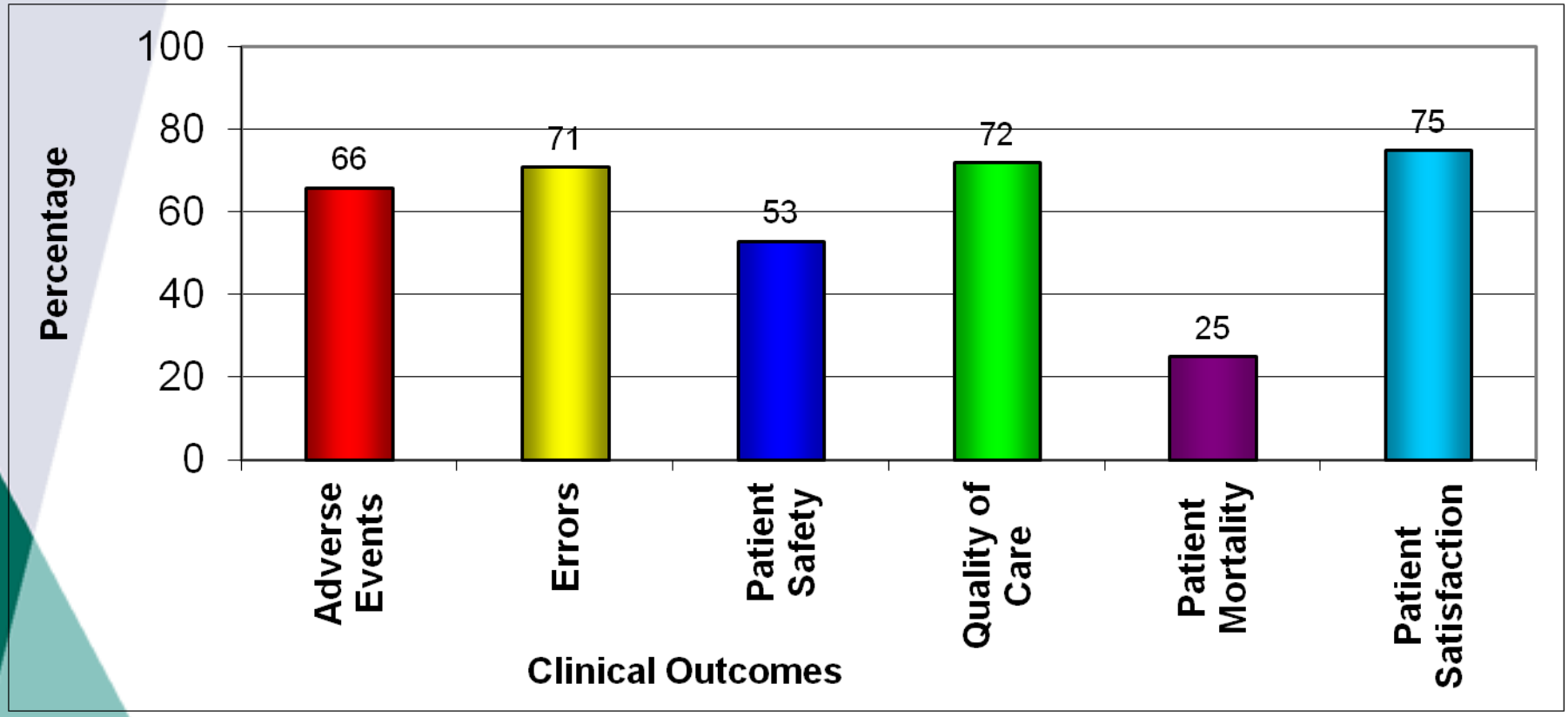


How Often Do You Think There Is a Link Between Disruptive Behavior and the Following?

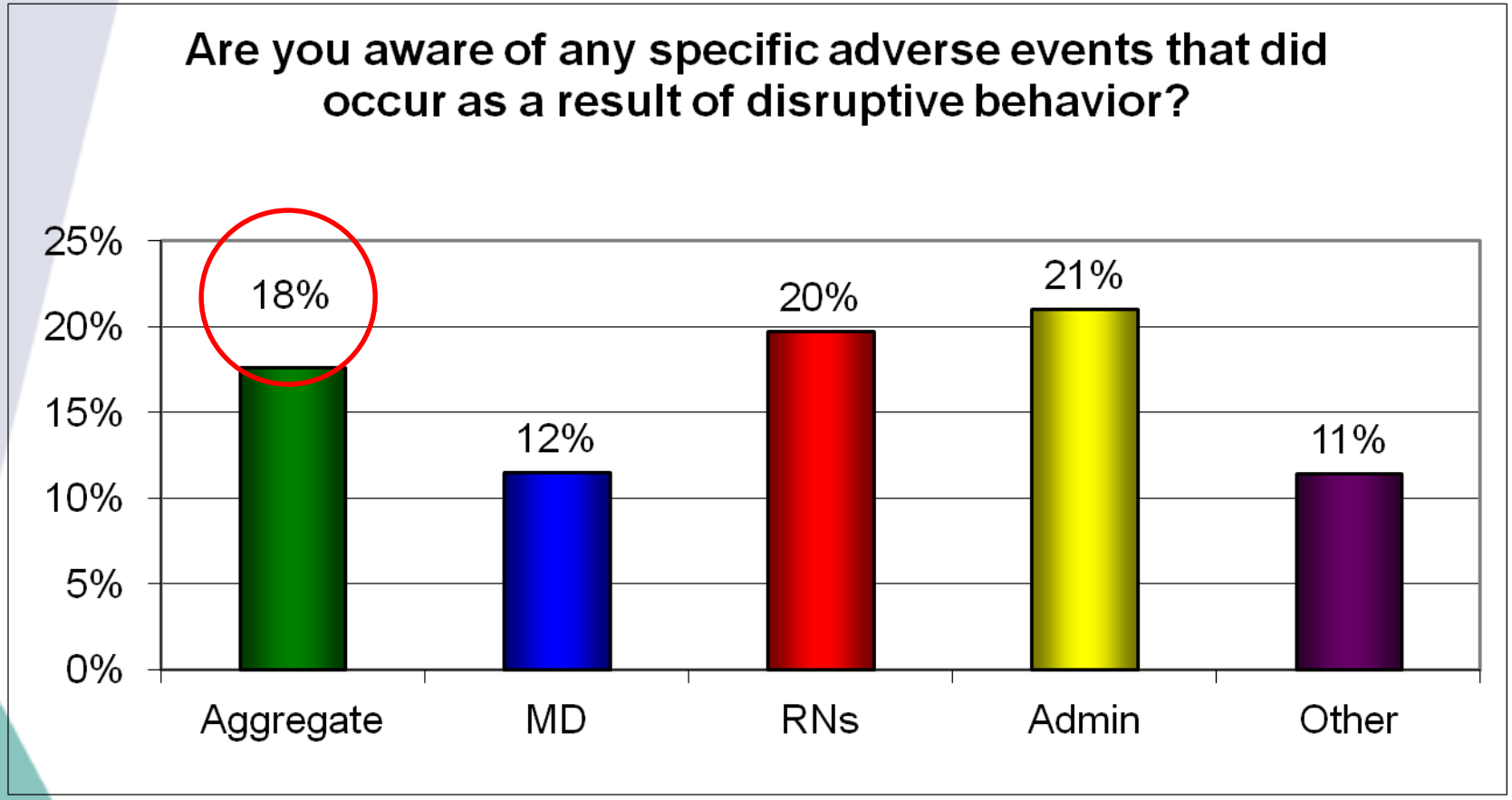
	Never	Rarely	Sometimes	Frequent	Constant
Adverse Events*	☐	☐	☐	☐	☐
Errors	☐	☐	☐	☐	☐
Patient safety	☐	☐	☐	☐	☐
Quality of care	☐	☐	☐	☐	☐
Patient mortality	☐	☐	☐	☐	☐
Nurse satisfaction	☐	☐	☐	☐	☐
Physician satisfaction	☐	☐	☐	☐	☐
Patient satisfaction	☐	☐	☐	☐	☐

*Adverse Events: Any undesirable clinical patient experience that occurred during the hospitalization

Linkage of Disruptive Behavior to Undesirable Clinical Outcomes Occurring Sometimes, Frequent, and Constant



Are You Aware of Any Specific Adverse Event That Occurred as a Result of Disruptive Behavior



Addressing Disruptive Behaviors

Hospital Practice

https://informahealthcare.com/hop
ISSN: 21544331 (print)

Hosp Pract, 2015; 43(4): 221–225
DOI: 10.1080/21548331.2015.1083858

Taylor & Francis
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CLINICAL FEATURE
PERSPECTIVE

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

Alan H. Rosenstein

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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 concern 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

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Early Intervention Can Help Prevent Disruptive Behavior

By Alan H. Rosenstein, MD, MBA

In this article...

Identifying people who may exhibit disruptive behavior and counseling them can help reduce future incidents.

It's not like a doctor or nurse starts the day out planning to be disruptive. There are a series of deep-seated, sub-acute, and acute events that may trigger a disruptive response (see Table 1).

Unfortunately, most of the interventions start in the post-event stage after a disruptive event has already occurred. Interventions at this stage of the process often take on a confrontational, punitive approach, that have varying degrees of success.

For some individuals simply discussing the event and raising the level of awareness about how the event was perceived at the receiving end impacting the individual's perception and reaction is enough to raise their level of awareness and sensitivities to the point that another disruptive event would be unlikely to occur.

In others there are more deep-seated issues that may benefit from participation in educational programs or training workshops. Some individuals may require more intensive counseling. For the small number who refuse to comply, disciplinary action such as temporary suspension or termination may be required.

But a greater opportunity for success would be to intervene earlier on in the process. Identifying individuals who are "at risk" for a disruptive event and proactively providing coaching or emotional support is a more positive and successful approach than the post-event intervention process.

Values

There are several forces at work here. Values are set early in life. Some of these values are formed by genetics, family upbringing and life experiences. There are different sets of assumptions, perceptions and "ways of doing business" based on an individual's age, gender, cultural beliefs, and personality.

For physicians, we know that certain personality types are linked to choice of specialty. Life experiences and training are other contributing factors. Think of the medical school and residency model. When you start out it's made very clear that you know nothing and are at the very bottom of the food chain that promotes low self-esteem and confidence.

You learn to work independently, building fortitude and competency based on knowledge and technical expertise. You have ultimate responsibility for making critical decisions that are often carried out with an autocratic domineering tone that in some cases may be perceived as being "disruptive."

Unfortunately, what's lacking are the people skills, communication skills, and team collaboration skills so important in today's complex medical environment.

Below the surface are issues related to "emotional intelligence," which simply stated is your perception, awareness and sensitivity to what's going on around you. Other contributing factors include the growing stress and frustration with the health care environment that may lead to anger and resentment, fatigue, burnout, and depression. In some cases, there is also a history of underlying substance abuse.

A variety of external factors may influence one's mood and demeanor and subsequent interactions with others. These may include a recent serious event (family illness, other), operational inconvenience (wrong equipment/scheduling inefficiencies/inadequate staff support) or being provoked by another individual or stressful event.

Recommendations

Having the right policies and procedures in place, supporting the program with appropriate education and leadership, and addressing disruptive events from a perspective of prevention, real-time intervention and follow-up action are all the right things to do.

What Influences Physician Attitudes & Behaviors?

Internal:

- Age and generation
- Gender
- Culture and ethnicity
- Geography/ life experiences

⇨ Personality:

  - Dictatorial
  - Narcissism, stoicism
  - Perfectionism/ desensitization
  - Low Emotional Intelligence

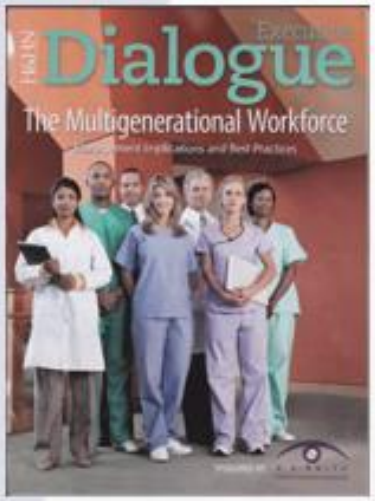
External:

- Training
- Healthcare environment
- Work environment/ event
- Life/ personal issues

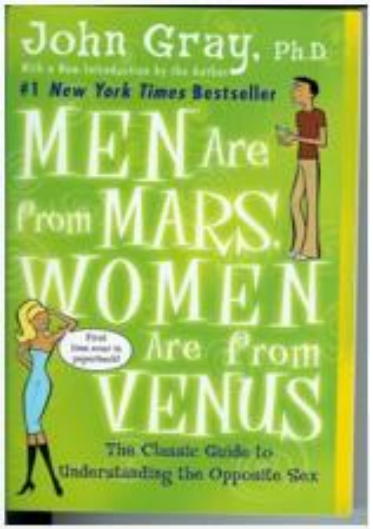
⇨ Behavioral health/wellness:

  - Stress/ fatigue/ apathy/ burnout
  - Frustration/ anger/ depression
  - Substance abuse
  - Suicidal ideation

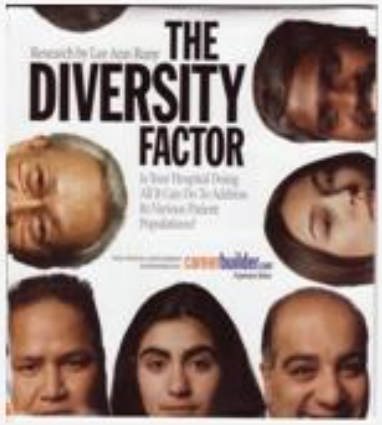
Internal Factors



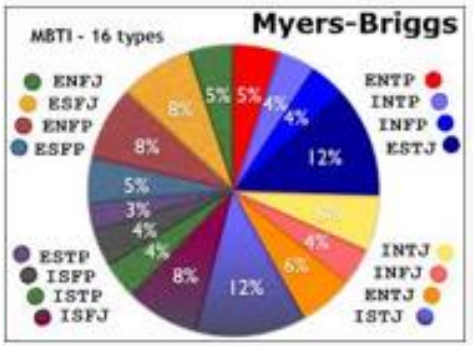
Age & generation



Gender

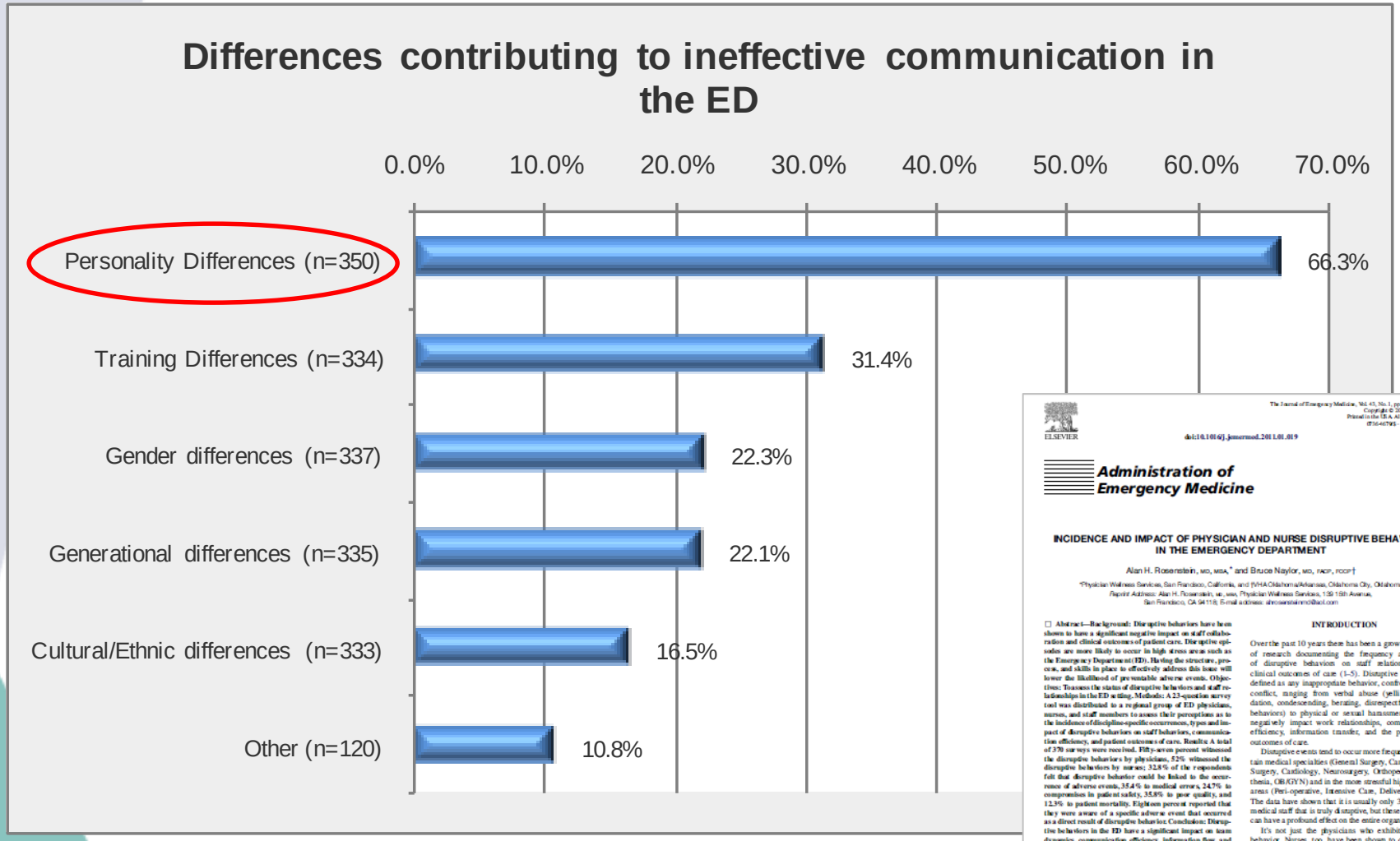


Culture & Ethnicity



Life/ Personality

Survey Results



ELSEVIER

Administration of Emergency Medicine

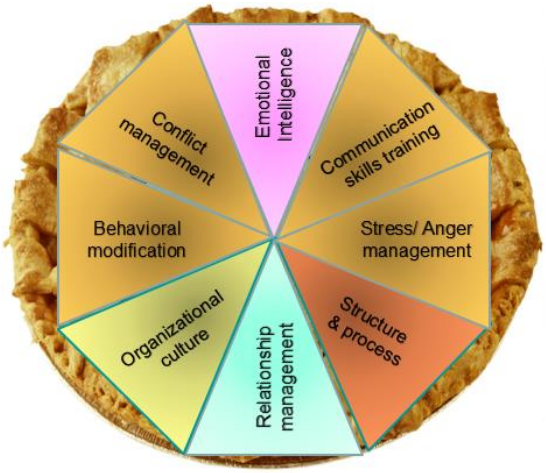
INCIDENCE AND IMPACT OF PHYSICIAN AND NURSE DISRUPTIVE BEHAVIORS IN THE EMERGENCY DEPARTMENT

Alan H. Rosenstein, MD, MBA,* and Bruce Naylor, MD, FACP, FCCP†

INTRODUCTION

Personality Training: Relationship Management

- Emotional Intelligence/ Mindfulness
- Sensitivity training
- Diversity management
- Cultural competencies
- Conflict management
- Negotiation skills
- Stress/ time/ anger management
- Sexual Harassment
- “Personalysis”
- Project management
- Communication skills
- Team building



External Factors:

Training

Reform

Stress & Burnout

External Factors: Training and Reform

Training:

- Rights of passage
- Competitive nature
- Hierarchy
- Low self- esteem
- Focus on knowledge/ technical expertise
- Independence/ autonomy
- Authoritative/ controlling
- Desensitization/ Low EI
- Stress and burnout

Health Care Reform:

- Value based care
- Performance accountability
- Accountable care organizations
- Risk based contracting
- Payment restructuring (fixed/ bundled/ P4P incentives
- Non-clinical mandates (EMR/ ICD 10/ PQRS/ MIFS/ Meaningful use)
- Capacity management
- Productivity

Physician Support and Development

Medical School re-engineering:

- Medical School admissions
- Curriculum re-design
- Personal skills development
- Business education

Post graduate support:

- Job selection
- On-boarding
- On-going education
- Resource support
- **Stress and burnout**
- **Work-life balance**
- Career management

Modern Healthcare

The new basic training for next gen physicians

By Michael Sandler | January 30, 2016

Medical schools seeking to train physicians to adapt quickly to changing delivery-system models

In a 1,500-word article, Modern Healthcare (1/30, Sandler, Subscription Publication) reported on the "growing movement among U.S. medical schools to train...physicians in ways that will allow them to adapt quickly to changing delivery-system models." According to Modern Healthcare, "High on the list of skills the programs seek to instill in students is how to work in teams and understand the roles played by other professionals." The AMA "has awarded $12.5 million in grants to 32 medical schools in the Accelerating Change in Medical Education Consortium." The association's group vice president for medical education, Dr. Susan Skochelak, "said the schools in the consortium are committed to the idea that training future physicians involves not only following or shadowing professionals, but integrating students into healthcare teams and advocating for patients."

The NEW ENGLAND JOURNAL of MEDICINE

Getting the Right Medical Students — Nature versus Nurture

Richard M. Schwartzstein, M.D.

N Engl J Med 2015; 372:1586-1587 | April 23, 2015 | DOI: 10.1056/NEJMp1501440

Consortium of med schools to orient curriculum toward health system fluency

The Harrisburg (PA) Patriot-News (3/7, Wenner) reports Penn State Hershey College of Medicine is one of "32 medical schools around the country which are revamping their curriculums to give medical students a better understanding of the overall health care system." Being able to help patients navigate the US healthcare system is "often what patients care the most about," said Dr. Susan Skochelak of the American Medical Association, yet also something doctors traditionally "haven't been good at." Penn State-Hershey will host the annual meeting of the consortium of schools this week.

Stress and Burnout

ORIGINAL ARTICLE

MAYO CLINIC

Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014

Tait D. Shanafelt, MD; Omar Hasan, MBBS, MPH; Lotte N. Dyrbye, MD, MHPE; Christine Sinsky, MD; Daniel Satele, MS; Jeff Sloan, PhD; and Colin P. West, MD, PhD

Abstract

Objective: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 (P<.001). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; P<.001). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; P<.001) and were less likely to be satisfied with work-life balance (odds ratio, 0.68; 95% CI, 0.62-0.75; P<.001).

Conclusion: Burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout.

 Mayo Clin Proc. 2015;90(12):1600-1613

For editorial comment, see page 1593; for a related article, see page 1694

From the Division of Hematology (T.D.S.), Division of Primary Care Internal Medicine (L.N.D.), Division of Biomedical Statistics and Informatics (O.H., D.S., J.S., C.P.W.), and Mayo Clinic Center for Innovation (C.S.), Mayo Clinic, Rochester, MN.

Affiliations continued at the end of the article.

Medicine is both a demanding and a rewarding profession. Physicians spend more than a decade in postsecondary education, work substantially more hours than most US workers in other fields, and often struggle to effectively integrate their personal and professional lives.[1] They engage in highly technical and intellectually demanding work that often requires complex, high-stakes decision making despite substantial uncertainty. These challenges are offset by meaningful relationships with patients, the intellectual stimulation of the work, and the satisfaction of helping fellow human beings.[2-4] Physicians are also well compensated relative to many professions, are part of a fraternity of supportive colleagues, and often enjoy the respect and appreciation of their community.

The cumulative effect of these forces on the personal and professional satisfaction of each physician is unique. Although future physicians begin medical school with mental health profiles better than those of college graduates pursuing other fields,[5] this profile is reversed 1 to 2 years into medical school.[6] Once in practice, physicians have generally high degrees of satisfaction with their career choice but experience high degrees of

Mayo Clin Proc. ■ December 2015;90(12):1600-1613 ■ http://dx.doi.org/10.1016/j.mayocp.2015.08.023
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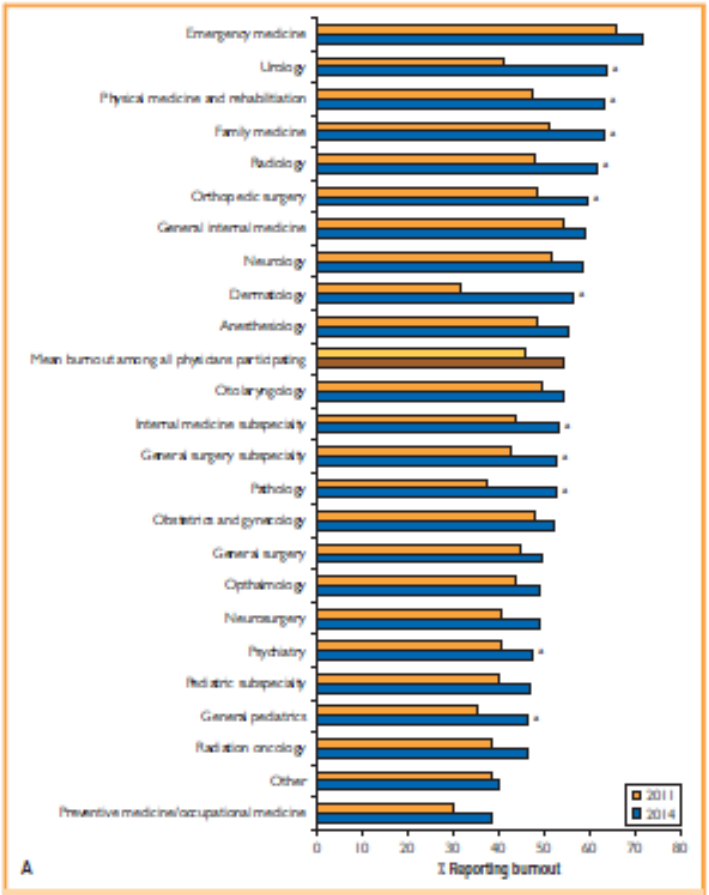


FIGURE 1. Burnout (A) and satisfaction with WLB (B) by specialty 2014 vs 2011. For 1A and 1B, specialty discipline is shown on the y axis and burnout (A) and satisfaction with WLB (B) are shown on the x axis. For 1C, satisfaction with WLB is shown on the y axis and burnout on the x axis. GIM = general internal medicine; OBGYN = obstetrics and gynecology; PM&R = physical medicine and rehabilitation; Prev = Preventive medicine, occupational medicine, or environmental medicine; WLB = work-life balance. *P<.05 from comparison 2014 to 2011.

Stress and Burnout

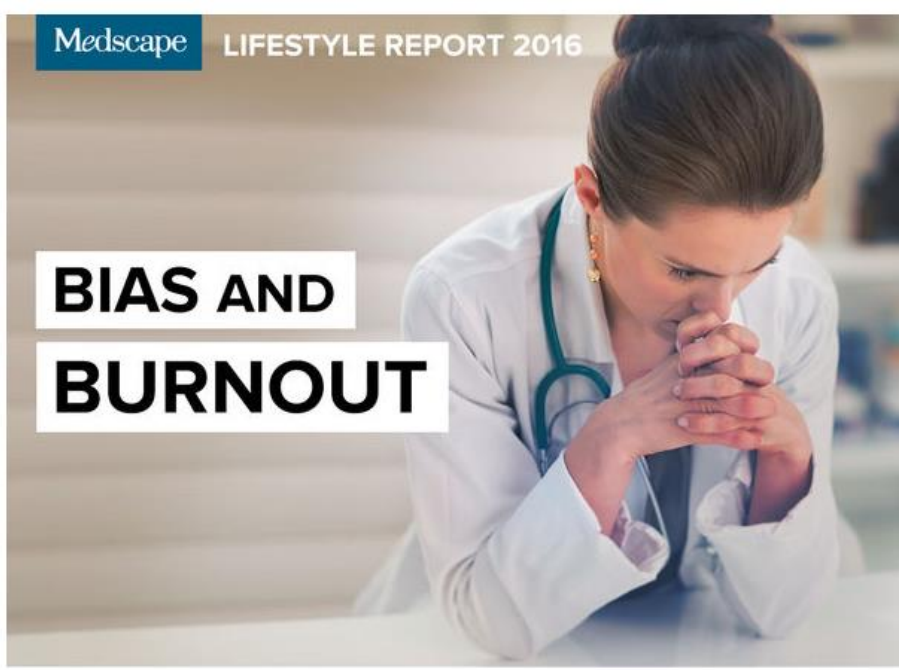
H&HN
HOSPITALS & HEALTH NETWORKS

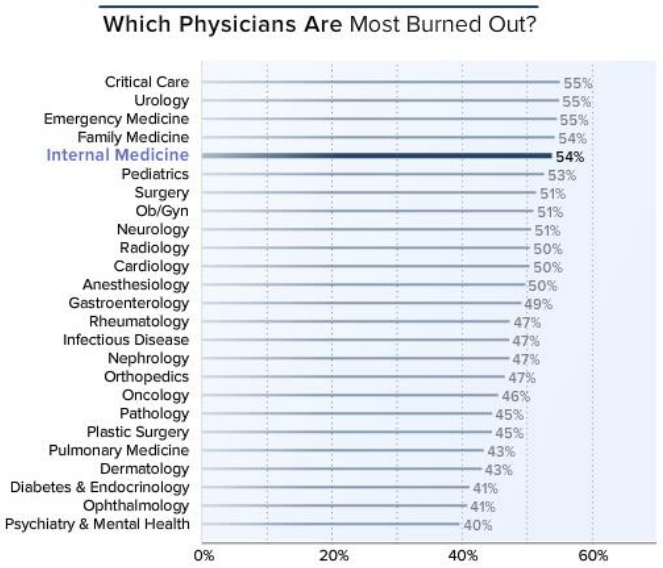
Physician Burnout Rates Increase across Specialities: Study

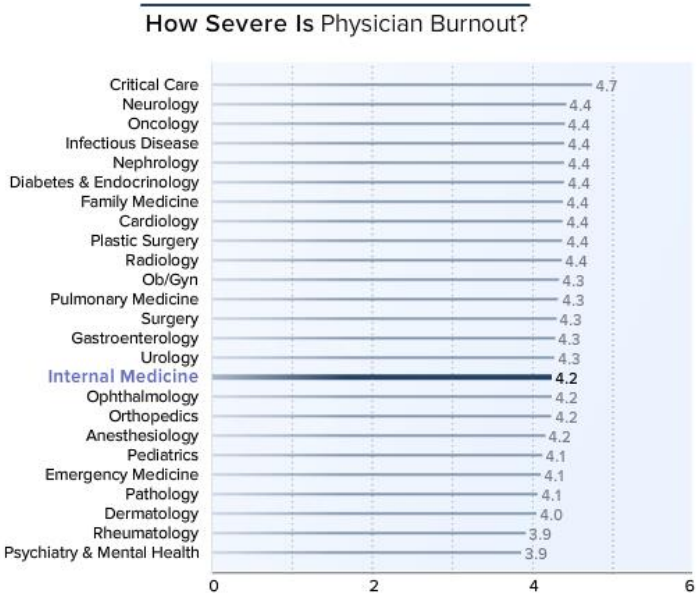
January 13, 2016

Burnout severity rates also up from last year

Today, Medscape released its "Medscape Lifestyle Report 2016: Bias and Burnout" that surveyed 15,800 physicians from more than 25 specialties. Responses found burnout rates for all physician specialties are higher than last year, as is the reported severity of their burnout.







www.scirp.org/jha Journal of Hospital Administration 2015, Vol. 4, No. 1

REVIEWS

Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences

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Received: September 26, 2014 **Accepted:** November 27, 2014 **Online Published:** December 4, 2014
DOI: 10.5430/jha.v4n1p27 **URL:** http://dx.doi.org/10.5430/jha.v4n1p27

Abstract

Healthcare providers and staff are the proximal source of quality of care provided to patients. Today's world of health care reform and other value-based initiatives have added new levels of significant complexity to health care delivery. This cumulative chronic high-level stress is imposed by multiple regulatory, insurance, federal, and state forces that do not coordinate well with one another resulting in disparate, conflictual, or confusing mandates. Each have authoritative capital. Together they have potential to affect healthcare workers on a personal, physical, emotional and cognitive level which in turn adversely affects care relationships and quality of patient care. We need to be concerned about the effect that this enormous occupational stress has on them as individuals and how it impacts the care provided. Physician shortages exist and are projected to get worse. There is a high burnout rate in current physicians. Some are retiring early, leaving medicine, or worse dying of suicide from job related stress. Mechanisms of this negative effect of stress and Burnout on providers, institutions and healthcare quality are discussed. The aim of this paper is to provide an overview of current state of knowledge merging information from various fields on this issue. Areas that require action are identified and possible solutions are efficed.

Key Words: Stress and burnout, Workforce issues, Public health, Organization and delivery of care, Physicians, Medicine/Clinical issues

1 Thesis and background

Healthcare providers and staff are the proximal reason for the quality of care provided to patients. What effect does increasing high-level and chronic occupational stress on providers and staff imposed from multiple uncoordinated sources have on them personally and ultimately the patients they serve? Has physician burnout been multiplied and yet underappreciated in impact?

We currently have a time-challenged, overburdened, and burned-out healthcare workforce. There exists no single group to oversee the reasonableness of the total human burden on staff and providers placed by regulatory, certification, national, state, and industry sources. There is no agency or mandate that ensures coordination and collaboration of these independent forces to be cognizant of total logistical impact. 46% of surveyed physicians reported burnout, with even higher rates in front line doctors (Fam-

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American Hospital Association's
PHYSICIAN LEADERSHIP FORUM

Forum Focus – Recognizing and Addressing Physician Stress and Burnout to Improve Satisfaction and Patient Care

Posted on **March 26, 2015**

By Alan H. Rosenstein MD, MBA, Michael R. Privitera MD, MS

There are a growing number of surveys and reports attesting to the increasing amount of stress and burnout impacting physicians in today's health care environment, affecting nearly 80% of practicing physicians.[1] The downstream impact of protracted stress and burnout can lead to a number of problems ranging from dissatisfaction, frustration, and anger, to more serious physical and emotional states that affect behavior and can compromise work relationships and patient care.[2,3] While many organizations are beginning to recognize the impact of stress and burnout on satisfaction, productivity, care coordination, and clinical performance, there are still a number of barriers that need to be resolved.

First is the issue of perception. Many physicians are working at full capacity but may not recognize that their mind and body are working under stress. The cultural norm in pre-med, medical school, and residency is to push oneself beyond usual human abilities. Usual human feedback systems are often suppressed, and even when physicians realize stress may be taking a toll, many choose to handle it themselves and are often reluctant to seek outside help because of self- ego, stoicism, questions about competency, or concerns about confidentiality. Often problems related to stress are only addressed after a career-changing decision or disruptive event occurs where intervention may be focused more on damage control than emotional support.

NPSF
National Patient Safety Foundation®

Burnout as a Safety Issue: How Physician Cognitive Workload Impacts Care

*Posted By **Administration**, Monday, August 24, 2015*
Updated: Monday, August 24, 2015

Chronically high levels of physician distress are creating a dangerous practice environment. Interventions to help reduce clinician burnout need to occur at multiple levels to make our health system safer.

*by **Michael R. Privitera, MD, MS; Franziska Plessow, PhD;** and **Alan H. Rosenstein, MD, MBA***

The stressors that cause burnout may vary from profession to profession, but the human condition that results is common to all. Burnout is defined by three factors:

1. Physical and emotional exhaustion despite attempting to rest
2. Depersonalization including dysfunctional coping mechanisms, cynicism, sarcasm, and compassion fatigue
3. An objective and/or subjective lack of efficacy

Burnout is a frequent phenomenon across many health care professions, including nursing, medicine, pharmacy, social work, and other roles. Research on physician burnout shows lower levels of patient satisfaction, job satisfaction, and productivity; higher levels of medical errors, malpractice claims, leaving medicine, and early retirement; and higher personal levels of depression, heart disease, suicide, divorce, and substance abuse.

The average burnout rate among doctors in the US has been **estimated to be 46%,** while only 2% to 4% of physicians are disruptive in the workplace. In many cases of disruptive behavior, burnout from high chronic occupational stress has been found, suggesting a direct relationship between the two. The Joint Commission has issued **a sentinel event alert warning** that disruptive behavior can compromise patient safety and foster medical errors.

The **biopsychosocial model** was coined by George Engel to encourage consideration of biological, psychological, and social contributions to and consequences of clinical conditions. Applying this approach, we can see commonalities in cause and inter-relationships between physician burnout, altered safety of medical decision-making, and disruptive behaviors. Social components (health care reform environment, consequent occupational stress when unharmonized and uncoordinated) interact with psychological (rationality in decision-making, emotional control) and biological aspects (intrinsic biology of the physician and changed biology of their body from chronic high levels of stress), which then impacts the community that needs sufficient health care workforce to take c

Conceptual Issues for Discussions:

- Awareness of down-steam consequences that occur by accumulation of unharmonized duties
- Efforts to assess and recognize potentially negative impact on delivery of physician services before policy decisions are agreed upon
- Efforts for stakeholder agencies to better coordinate plans and logistics
- Need for health care organizations to provide sufficient resource services (career/ business/ administrative/ clinical/ behavioral) to lower occupational stress and Burnout of physicians by assisting them with innovation rollout and ongoing operations
- Are there ways in the meantime to have authoritative sources of mandates and regulations to attempt a collaborative effort? The goal would be to pare down the total cognitive load on the physicians to a safer level

Physician Response

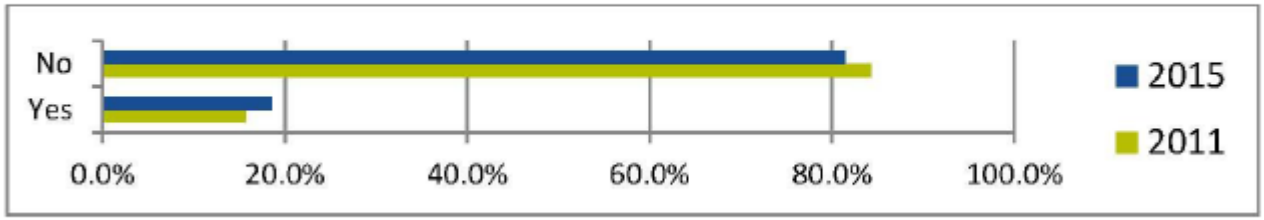
- I’m not under stress
- Yes, I’ve been under stress my entire life
- Yes, I can handle it
- Yes, I’ll make more time for relaxation …. Ooops
- You don’t understand my world
- You don’t care
- Even if they want to reluctance to act barriers:
  - Stoicism
  - Time
  - Questions about competency
  - Fear of retribution
  - Concerns about confidentiality

Organizational Response

- You are a precious resource
- Approach: Here to help you deliver best practice care
- Empathy: We understand. What can we do together?
  - Listen/ respond/ enhance physician engagement
  - Focus on job fulfillment/ physician satisfaction
- Administrative support
  - Scheduling/ productivity/ capacity management
  - Clerical assistance (scribes)/ Clinical assistance (PAs/ NPs)
  - Mandated time off
- Emotional support
  - Wellness activities
  - Education: Mindfulness/ Stress management
  - EAP/ Counseling/ Therapy

Organizational Response

Question 20: Does your organization do anything currently to help physicians deal more effectively with stress and/or burnout?



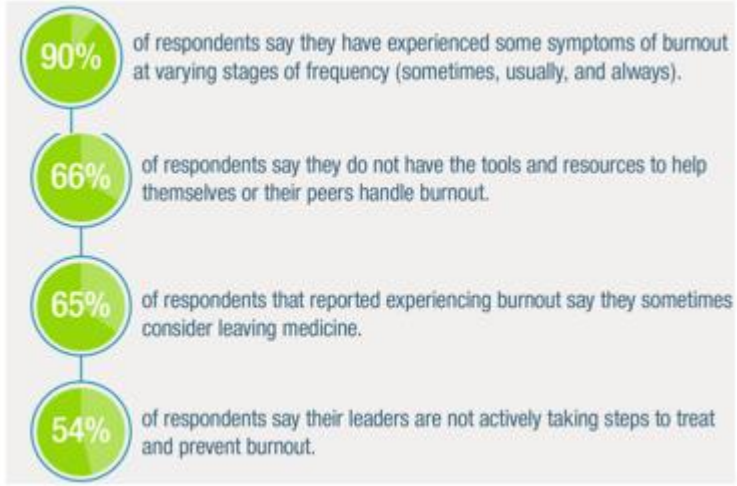
VITAL WorkLife & Cejka Search Physician Stress and Burnout Survey 2015

Studer Group: More than half of physicians feel leaders don't do enough to combat burnout

Written by Emily Rappleye (Twitter | Google+) | February 03, 2016

Of more than 350 practicing physician respondents, 90 percent have experienced symptoms of burnout at some point in their career. Of those who have experienced burnout, 65 percent said they even have considered leaving medicine because of it.

According to the survey, physicians would like leadership to give them a greater say in operational decisions, more leadership opportunities and access to resources and education on burnout. Physicians also felt having adequate post-call recovery time and vacation time, realistic scheduling and an appropriate balance of quality over productivity would help prevent feelings of burnout, according to the survey.



Recommendations:

1. Recognition/ priority
2. Organizational Culture/ Work environment:
   - Leadership commitment/ structure and process
   - Mutual alignment around goals and objectives
3. Education:
   - Awareness/ Responsibility/ Accountability
4. Relationship training:
   - Diversity/ Sensitivity/ Stress/ Conflict management
   - Emotional Intelligence/ Customer satisfaction
5. Communication skills/ Team Collaboration training
6. Behavioral policies and procedures/ Reporting
7. Intervention:
   - Tiered approach
8. Staff support:
   - Administrative/ Clinical/ Behavioral
9. Physician engagement
10. Physician Well- Being

Recognition and Priority

The Quadruple Aim: care, health, cost and meaning in work

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Received 5 March 2015
Revised 6 May 2015
Accepted 16 May 2015

In 2008, Donald Berwick and colleagues provided a framework for the delivery of high value care in the USA, the Triple Aim, that is centred around three overarching goals: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare.[1] The intent is that the Triple Aim will guide the redesign of healthcare systems and the transition to population health. Health systems globally grapple with these challenges of improving the health of populations while simultaneously lowering healthcare costs. As a result, the Triple Aim, although originally conceived within the USA, has been adopted as a set of principles for health system reform within many organisations around the world.

The successful achievement of the Triple Aim requires highly effective healthcare organisations. The backbone of any effective healthcare system is an engaged and productive workforce.[2] But the Triple Aim does not explicitly acknowledge the critical role of the workforce in healthcare transformation. We propose a modification of the Triple Aim to acknowledge the importance of physicians, nurses and all employees finding joy and meaning in their work. This 'Quadruple Aim' would add a fourth aim: improving the experience of providing care.

The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfilment that results from meaningful work. In the UK, the National Health Service has captured this with the notion of an engaged staff that 'think and act in a positive way about the work they do, the people they work with and the organisation that they work in'.[3]

The evidence that the healthcare workforce finds joy and meaning in work is not encouraging. In a recent physician survey in the USA, 60% of respondents indicated they were considering leaving practice; 70% of surveyed physicians knew at least one colleague who left their practice due to poor morale.[2] A 2015 survey of British physicians reported similar findings with approximately 44% of respondents reporting very low or low morale.[4] These findings also extend to the nursing profession. In a 2013 US survey of registered nurses, 51% of nurses worried that their job was affecting their health; 35% felt like resigning from their current job.[5] Similar findings have been reported across Europe, with rates of nursing job dissatisfaction ranging from 11% to 56%.[6]

This absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment. Workforce injuries are much more frequent in healthcare than in other industries. For some, such as nurses' aides, orderlies and attendants, the rate is four times the industrial average.[7] More days are lost due to occupational illness and injury in healthcare than in mining, machinery manufacturing or construction.[7]

The risk of physical harm is dwarfed by the extent of psychological harm in the complex environment of the healthcare workplace. Egregious examples include bullying, intimidation and physical assault. Far more prevalent is the psychological harm due to lack of respect. This dysfunction is compounded by production pressure, poor design of work flow and the proportion of non-value added work.

The current dysfunctional healthcare work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th

To cite: Sikka R, Morath JM, Leape L. *BMJ Qual Saf* Published Online First: [please include Day Month Year] doi:10.1136/bmjqs-2015-004160

REFLECTION

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

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ABSTRACT

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

Ann Fam Med 2014;12:573–576. doi: 10.1370/afm.1713.

Patient experience
Population health
Reducing costs
Work life balance

INTRODUCTION

Since Don Berwick and colleagues introduced the Triple Aim into the health care lexicon, this concept has spread to all corners of the health care system. The Triple Aim is an approach to optimizing health system performance, proposing that health care institutions simultaneously pursue 3 dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.[1] The primary Triple Aim goal is to improve the health of the population, with 2 secondary goals—improving patient experience and reducing costs—contributing to the achievement of the primary goal.

In visiting primary care practices around the country,[2] the authors have repeatedly heard statements such as, "We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts our ability to achieve the 3 aims." These sentiments made us wonder, might there be a fourth aim—improving the work life of health care clinicians and staff—that, like the patient experience and cost reduction aims, must be achieved in order to succeed in improving population health? Should the Triple Aim become the Quadruple Aim?

RISING EXPECTATIONS OF PHYSICIANS AND PRACTICES

Society expects more and more of physicians and practices, particularly in primary care. Patients want their health to be better, to be seen in a timely fashion with empathy, and to enjoy a continuous relationship with a high-quality clinician whom they choose.[3] A patient-centered practice has been described as, "They give me exactly the help I need and want exactly when I need and want it."[4] Yet for primary care, society has not provided the resources to meet these lofty benchmarks.

PHYSICIAN BURNOUT

The wide gap between societal expectations and professional reality has set the stage for 46% of US physicians to experience symptoms of

Conflicts of interest: authors report none.

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Organizational Culture/ Leadership

- Workplace environment
- Leadership commitment
- Staff respect and support
- Aligned incentives
- Process Management
- Relationship management
- Patient centric care
- Patient/ staff satisfaction
- Organizational assessment

ORIGINAL ARTICLE

MAYO CLINIC

Impact of Organizational Leadership on Physician Burnout and Satisfaction

Tait D. Shanafelt, MD; Grace Gorringe, MS; Ronald Menaker, EdD; Kristin A. Storz, MA; David Reeves, PhD; Steven J. Buskirk, MD; Jeff A. Sloan, PhD; and Stephen J. Swensen, MD

Abstract

Objective: To evaluate the impact of organizational leadership on the professional satisfaction and burnout of individual physicians working for a large health care organization.

Participants and Methods: We surveyed physicians and scientists working for a large health care organization in October 2013. Validated tools were used to assess burnout. Physicians also rated the leadership qualities of their immediate supervisor in 12 specific dimensions on a 5-point Likert scale. All supervisors were themselves physicians/scientists. A composite leadership score was calculated by summing scores for the 12 individual items (range, 12-60; higher scores indicate more effective leadership).

Results: Of the 3896 physicians surveyed, 2813 (72.2%) responded. Supervisor scores in each of the 12 leadership dimensions and composite leadership score strongly correlated with the burnout and satisfaction scores of individual physicians (all $P<.001$). On multivariate analysis adjusting for age, sex, duration of employment at Mayo Clinic, and specialty, each 1-point increase in composite leadership score was associated with a 3.3% decrease in the likelihood of burnout ($P<.001$) and a 9.0% increase in the likelihood of satisfaction ($P<.001$) of the physicians supervised. The mean composite leadership rating of each division/department chair (n=128) also correlated with the prevalence of burnout (correlation=−0.330; $r^2=0.11$; $P<.001$) and satisfaction (correlation=0.684; $r^2=0.47$; $P<.001$) at the division/department level.

Conclusion: The leadership qualities of physician supervisors appear to impact the well-being and satisfaction of individual physicians working in health care organizations. These findings have important implications for the selection and training of physician leaders and provide new insights into organizational factors that affect physician well-being.

 Mayo Clin Proc. 2015;90(4):432-440

The Role of Medical Culture in the Journey to Resilience

Howard Beckman, MD

Abstract

There is growing concern about the difficulty primary care practices are experiencing both recruiting and retaining practitioners. Frustrations stemming from integrating electronic medical records, satisfying external documentation requirements for oversight and billing, and the divide created between inpatient and ambulatory care teams all contribute to practitioner and staff burnout.

Addressing the current culture of medical education and primary care is clearly an essential issue for health care leaders and medical educators.

Using two experiences, a workshop on resilience with a large primary care practice group and a medical student studying for the United States Medical Licensing Examination Step 1, the author describes the cultural imperative, beginning in medical school, to sacrifice self-care for productivity and individual achievement. This approach has consequences for practitioners' levels of burnout and selecting primary care as a career. The author concludes by providing recommendations for both individual and organizational approaches to addressing these concerns.

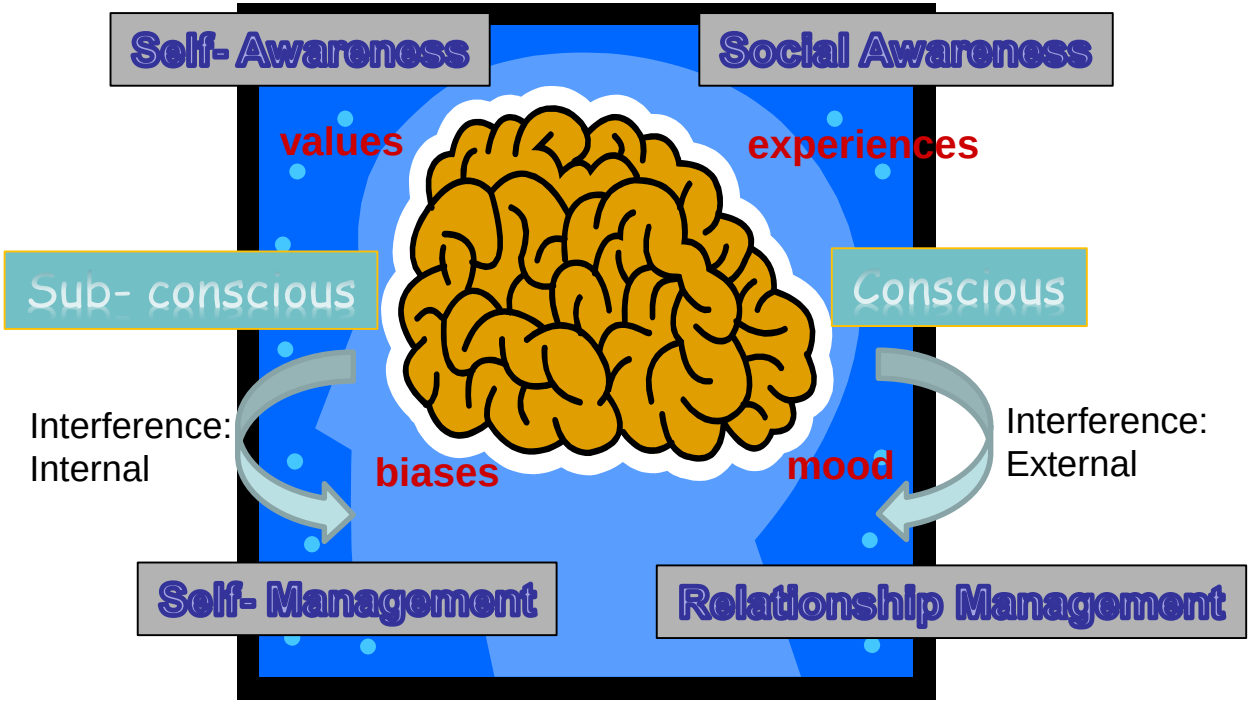
Academic Medicine, Vol. 90, No. 6 / June 2015

Education/ Training

- General education (all staff)
  - Awareness
  - Accountability
- Relationship training
  - Phone etiquette/ charm school/ sensitivity training
  - Diversity management/ cultural competency
  - Emotional Intelligence
  - Time management/ stress management
  - Conflict management/ anger management
  - Facilitation/ negotiation skills
  - Assertiveness training/ language support
  - Service excellence/ customer satisfaction
  - Project management

Emotional Intelligence

- Ability to perceive, evaluate, understand, respond to, and influence emotions …..
- Social intelligence/ Mindfulness/ Empathy



Mindfulness Training

- Purposeful attentiveness and self- reflection as to one's own thoughts, feelings, and reactions
- Promote greater awareness of self and others
- Connection to what's meaningful
- Skills to lower reactivity and enhance responsiveness to stressful situations
- Mindfulness practices:
  - Meditation/ reflection/ stress reduction
- Advantages:
  - Reduces stress and burnout
  - Promotes well-being
  - Improves responsiveness to patient needs
  - Enhance patient/ individual care experience

A Multicenter Study of Physician Mindfulness and Health Care Quality

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Conflicts of interest: The authors reject none

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ANNALS OF FAMILY

ABSTRACT

PURPOSE Mindfulness [ie, purposeful and nonjudgmental attentiveness to one's own experience, thoughts, and feelings] is associated with physician well-being. We sought to assess whether clinician self-rated mindfulness is associated with the quality of patient care.

The Efficacy of Mindfulness-Based Interventions in Primary Care: A Meta-Analytic Review

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Conflicts of interest: authors reject none.

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ABSTRACT

PURPOSE Positive effects have been reported after mindfulness-based interventions (MBIs) in diverse clinical and nonclinical populations. Primary care is a key health care setting for addressing common chronic conditions, and an effective MBI designed for this setting could benefit countless people worldwide. Meta-analyses of MBIs have become popular, but little is known about their efficacy in primary care. Our aim was to investigate the application and efficacy of MBIs that address primary care patients.

METHODS We performed a meta-analytic review of randomized controlled trials addressing the effect of MBIs in adult patients recruited from primary care settings. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) and Cochrane guidelines were followed. Effect sizes were calculated with the Hedges g in random effects models.

RESULTS The meta-analyses were based on 6 trials having a total of 553 patients. The overall effect size of MBI compared with a control condition for improving general health was moderate (g = 0.48; P = .002), with moderate heterogeneity (I^2 = 59; P <.05). We found no indication of publication bias in the overall estimates. MBIs were efficacious for improving mental health (g = 0.56; P = .007), with a high heterogeneity (I^2 = 76; P <.01), and for improving quality of life (g = 0.29; P = .002), with a low heterogeneity (I^2 = 0; P >.05).

CONCLUSIONS Although the number of randomized controlled trials applying MBIs in primary care is still limited, our results suggest that these interventions are promising for the mental health and quality of life of primary care patients. We discuss innovative approaches for implementing MBIs, such as complex intervention and stepped care.

Ann Fam Med 2015;13:573-582. doi: 10.1370/afm.1863.

INTRODUCTION

There is growing recognition of the value of mindfulness-based interventions (MBIs) for clinicians and policy makers.[1,2] One important challenge for psychosocial intervention is to confirm the efficacy found in randomized controlled trials (RCTs) in routine clinical practice, particularly in primary care,[3,4] where accessibility and adherence to and implementation of MBIs in health systems may be enhanced.[5,6] MBIs are considered complex interventions because their implementation takes into account behavior change in patients and health professionals, as well as their adaptation to setting and culture.[7]

Our objective was to perform, for the first time, a meta-analytic review of RCTs to investigate the application and efficacy of MBIs in primary care patients. We had several initial hypotheses[8]: (1) the number of well-designed studies in primary care is greater than that in other levels of care, because most patients receive long-term assistance here; (2) the clinical impact of MBIs in primary care patients is greater than that at other levels of the health system, because such patients adhere more to mindfulness programs; (3) the range of health conditions addressed by MBIs is larger in primary care (including health promotion in at-risk population and

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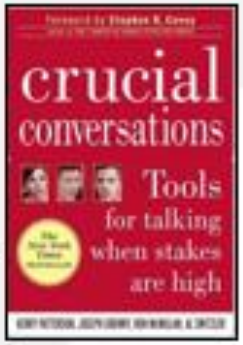
Communication Skills Training

Communication priorities:

- MD to MD
- MD to staff
- Staff to staff
- MD/ Staff to patient and family

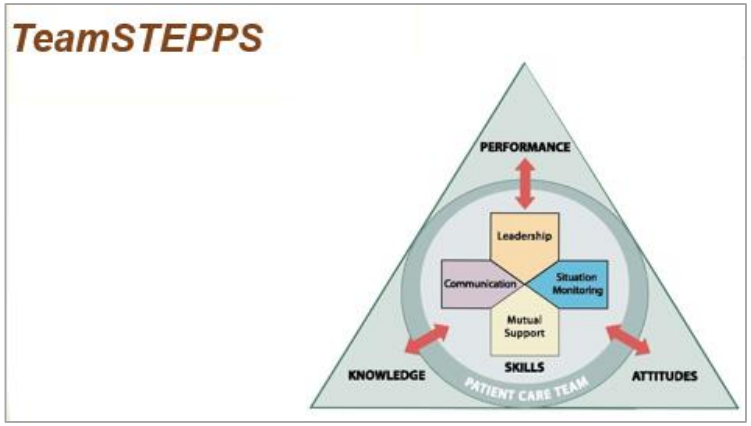
Communication skill sets:

- Scripting (SBAR/ Quint Studor)
- Team training (Crew Resource Management)
- Assertiveness (Crucial Conversations)
- Basic communication skills (AIDET/ REFLECT/ STARS)
  - Introduction/ Acknowledgement
  - Engage/ Time/ Attentiveness/ Concern
  - Verbal tone/ Posture/ Avoid conflict or distractions
  - **Reflective listening**/ solicit input
  - Empathy/ comfort/ trust/ safe environment
  - Explanation/ set expectations/ create enablers
  - Follow up



Team Collaboration Skills (TeamStepps)

- Anticipate/ Assist
- Build trust, respect and commitment
- Understand your role and roles of others
- Reinforce accountability and task responsibilities
- Leadership/ Assertiveness
- Check lists
- Avoid/ manage conflict or confusion
- Discussion/ briefing … debriefing
- Enhanced communication
- Job well done



Code of Ethics/ Behavior Policy/ Reporting

TITLE: Disruptive Behavior Policy No. A-80-0309

Page 1 of 2

POLICY: It is the policy of Suburban Hospital that all who are medical staff members; employees, trustees and volunteers shall conduct themselves in a professional and cooperative manner and shall not engage in disruptive behavior as defined below.

PURPOSE: To ensure employees, medical staff members, trustees, students and volunteers, that everyone conducts him or herself in a professional, cooperative and appropriate manner while providing services or visiting at Suburban Hospital.

To encourage the prompt identification and resolution of alleged disruptive behavior by all involved or affected persons through informal, collaborative efforts at counseling and rehabilitation that are intended to achieve any required behavior modification by each.

To provide a formal procedure for the further investigation and resolution of disruptive behavior by any person, who has not modified their behavior as identified by prior informal efforts.

To provide for the appropriate discipline only after the informal efforts and formal procedures described in this policy have been unsuccessful in causing the person to appropriately modify behavior in compliance with this policy.

DEFINITIONS: Disruptive behavior may be overt or passive; may occur face to face; over the telephone or other media and include but are not limited to:

Physical threats, physical outbursts-slamming doors or throwing equipment; physical assault; verbal outbursts, use of profanity, intimidating behavior; demeaning or disrespectful comments, racial slurs; telephone hang-ups; refusal to perform assigned tasks; quiet exhibition of uncooperative attitudes; reluctance or refusal to answer questions or return phone calls and pages; condescending language; impatience with questions.

PROCEDURE:

1. Suburban Hospital will not tolerate intimidating or disruptive behavior.
2. Any incidences of such behavior shall be reported to the employee's immediate supervisor, and an incident report (QCCR) should be completed.
3. Incidents will be addressed by the next business day and all employees, members of the medical staff, trustees and volunteers will be treated equally and fairly, without regard to status or position of power within the organization. There will be no retaliation against those who report disruptive behavior.

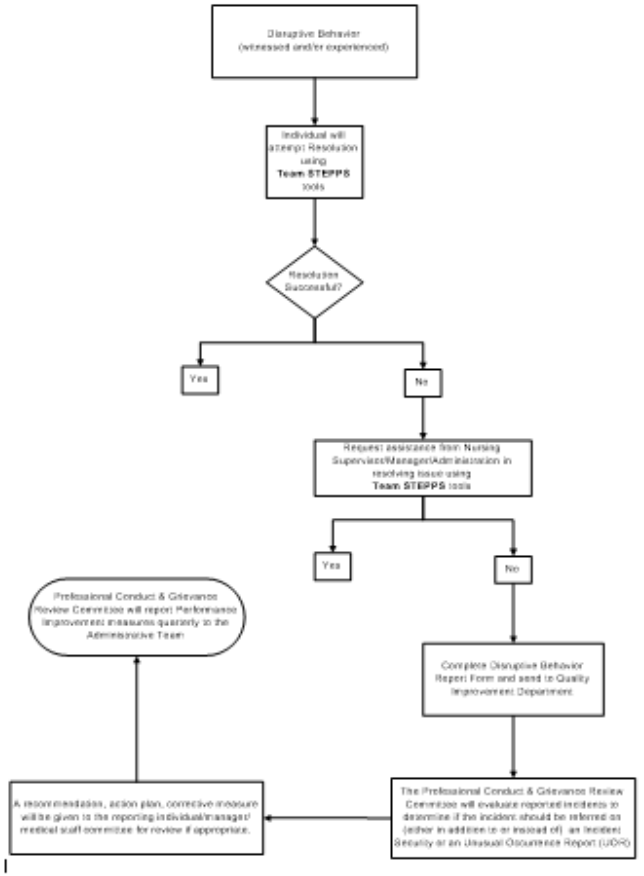
Incident

Patient complaints

Surveys - 360s

Rumors

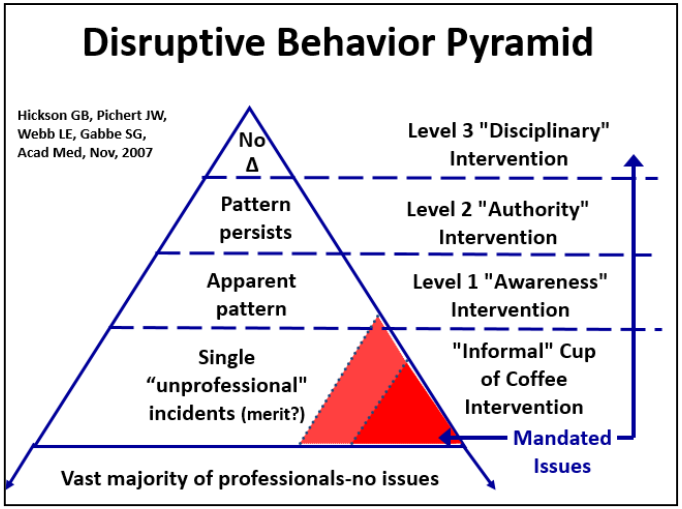
DISRUPTIVE BEHAVIOR REPORTING ALGORITHM



Last revised: December 17, 2015

Intervention Strategies

- Prevention
  - Cultural fit/ Cultural assessment
  - Education/ Training/ Assistance
- Pre-event early intervention
  - On- boarding/ On going assessment/ Resolution
  - Pro- active support: Address frustrations and irritations
- Real time
  - Assertiveness/ Code white
- Trend based intervention (4 tiers)
  - Informal
  - Awareness
  - Authority
  - Disciplinary



Resource Support

- Motivation/ Empathy/ Opportunity
- Staff support:
  - Administrative (scheduling/ capacity management/ EMR)
  - Clinical (NPs/ PAs/ Care coordinators)
  - Behavioral:
    - Education and training
    - Wellness Committees
    - EAPs
    - Mentoring/ Coaching/ Counseling
    - Behavioral modification programs

Motivation: Wellness/ Happiness/ Clinical Care

Physician wellness: a missing quality indicator

Jean E Wallace, Jane B Lemaire, William A Ghali

Lancet 2009; 374: 1714–21
See Editorial page 1653

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When physicians are unwell, the performance of health-care systems can be suboptimum. Physician wellness might not only benefit the individual physician, it could also be vital to the delivery of high-quality health care. We review the work stresses faced by physicians, the barriers to attending to wellness, and the consequences of unwell physicians to the individual and to health-care systems. We show that health systems should routinely measure physician wellness, and discuss the challenges associated with implementation.

Introduction

"Healthy citizens are the greatest asset any country can have."

Sir Winston Churchill

Physicians are important citizens of health-care systems, and evidence indicates that many physicians are unwell. Physicians who are affected by the stresses of their work may go on to experience substance abuse, relationship troubles, depression, or even death.[1–4] Results of emerging research show that physicians' stress, fatigue, burnout, depression, or general psychological distress negatively affects health-care systems and patient care.[1,2] Thus when physicians are unwell, the performance of the health-care system can be suboptimum. The corollary is that physician wellness might not only benefit the individual physician, but also be vital to the delivery of high-quality health care.[1,2]

We use the term wellness to capture the complex and multifaceted nature of physicians' physical, mental, and emotional health and wellbeing. Much research reports physicians' distress or ill health in terms of burnout (when individuals feel emotionally overwhelmed by the demands of their job), emotional exhaustion or withdrawal, fatigue, depression, anxiety, suicide, substance abuse, or impairment. We also consider the positive side of being well.[1,2] Shanafelt and colleagues[4] noted "Wellness goes beyond merely the absence of distress and includes being challenged, thriving, and achieving success in various aspects of personal and professional life."

Traditionally, health-care organisations assess programme performance from several patient-based indicators of the quality of care received (panel 1). By considering the relation between physician distress and patient perceptions of care, we have the opportunity to draw attention to physician wellness. Unfortunately, such indicators of quality of patient care and quality within health-care systems often seem to overlook or ignore the issue of physician wellness. But expansion of assessments to explicitly include physician wellness could lead to improvements in wellness.

In this Review, we present evidence from published reports to underscore the extent to which physicians face stressful working conditions. We discuss how and why physicians are unwell, and supply possible explanations for the profession's poor record of self-care, a practice that is difficult to revoke because of individual, professional, and organisational barriers. We review the potential consequences of self-neglect by physicians, both individually and at the level of health-care systems. We also address why health systems should routinely measure physician wellness as an indicator of health-system quality in view of the growing recognition that suboptimum physician wellness adversely affects system performance. We discuss some of the measurement and operational challenges associated with implementation of this missing quality indicator, and raise several issues that will need to be addressed to achieve the desired outcomes of improved physician wellness and system quality.

Risk of physician ill health

Practising medicine is stressful to many physicians. For example, authors of a Canadian study reported that 64% of physicians feel that their workload is too heavy, and 48%

Search strategy and selection criteria

We searched Medline and the Cochrane Library for review articles (January, 1985–July, 2009) and original articles (January, 2004–July, 2009) using several search terms to capture: physician demographics (eg, internship and residency, health personnel, medical staff, women physicians, medical students, general practitioners, internist, pediatrician, surgeon); wellness indicators (eg, burnout, suicide, fatigue, impaired or psychological distress, stress or wellbeing, work hours, work shifts, workload, anxiety, cognition, depression); negative medical consequences of physician impairment (eg, professional or diagnostic errors, fatigue, medical errors, sick leave, sleep deprivation, work schedule tolerance); and health-care organisational perspectives on physician wellness (eg, occupational health, personnel staffing and scheduling, personnel turnover). We focused on reports published in the past 5 years, but did not exclude frequently referenced and highly regarded reports published more than 5 years ago. We also searched reference lists of reports identified by this search strategy and selected those we judged relevant. Our reference list was modified on the basis of comments from peer reviewers. We identified an extensive number of studies, many of which could not be meaningfully acknowledged in this report; our report is not intended to cover all present knowledge of physician wellness. Therefore, we strategically selected a subset of high-quality studies that we judged to be most effective and relevant to draw attention to and support the central themes of this report.

PSNet
PATIENT SAFETY NETWORK

Perspectives on Safety Published February 2016

Relationships Between Physician Professional Satisfaction and Patient Safety

by ***Mark Friedberg, MD, MPP***

Perspective

As several authors have noted previously, there are good reasons to care about professional satisfaction among physicians.(1-3)

First, better professional satisfaction in any field (including more "joy in practice" [2] for physicians) is inherently good.

Second, some have warned that the United States faces a looming shortage of physicians. Better professional satisfaction could address impending shortages by improving recruitment among college students (which may not be necessary, given that medical school applications are on the rise) and encouraging fully trained physicians to spend more hours in practice per week and have longer careers. However, the accuracy of predicted physician shortages is unclear, as the Institute of Medicine pointed out in its recent report on graduate medical education reform.(4)

Third, greater physician professional satisfaction might lead to higher quality care and improved patient safety. This idea certainly has intuitive appeal. After all, who wouldn't feel uncomfortable receiving care from a burned-out, possibly depressed

Resiliency

Resiliency is the capacity to recover from difficulties, the ability to spring back into shape or the ability to withstand stress and catastrophe. Generally, resiliency improves with age as we are exposed to challenging situations and learn to solve problems. We can also deliberately enhance our resiliency by learning self-management skills and connecting with the meaning and purpose in our lives.

The look and feel of resilience: A qualitative study of physicians' perspectives

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Received: November 5, 2015 **Accepted:** December 20, 2015 **Online Published:** January 4, 2016
DOI: 10.5430/jha.v5n2p47 **URL:** http://dx.doi.org/10.5430/jha.v5n2p47

ABSTRACT

Some physicians can effectively cope and thrive in the face of potentially stressful job conditions, while others experience serious, negative consequences. This ability to be resilient may improve physician wellness and benefit health care organizations, yet little is known about what resilience means to physicians. This paper explores how physicians understand resilience both as they observe it in their colleagues and as they experience it themselves. Semi-structured interviews were conducted with 32 physicians practicing in Alberta, Canada. Two questions explored physicians' experiences of resilience or non-resilience, while two other questions considered what they observed in physician colleagues. Interview transcripts were independently coded by two authors and discussed to ensure agreement on the key themes. There were several similarities in how physicians described resilience or non-resilience in themselves and their colleagues related to control, positivity or negativity, boundaries and balance, coping, and support. There were also important differences in how physicians described their own experiences and their observations of colleagues. Participants' portrayals of themselves suggested being immune to stress and responsible for their success or failure in being resilient. Their depictions of colleagues, however, focused on professionalism, work performance, commitment to values, and experience or wisdom. There appears to be a difference in how physicians understand resilience in themselves compared to what they observe in their colleagues. Specifically, physicians may hold unrealistic and unachievable expectations for their own resilience. Initiatives aimed at improving physician resilience and wellness may be best served by raising awareness about more realistic expectations and self-appraisals.

Key Words: Physician resilience, Workplace stress, Culture of medicine, Physician wellness

Table 2. Key themes describing the look and the feel of resilience or non-resilience

	The Look	The Feel
Resilience	• Displaying positivity and optimism* • Maintaining boundaries or balance* • Having effective coping strategies* • Remaining in control* • Being committed to values and goals • Remaining calm and level-headed • Being expressive and friendly • Having work-related success • Having experience and wisdom	• Experiencing positive emotions* • Having balance in all aspects of their life* • Being able to cope* • Feeling in control* • Being immune to stress • Bouncing back from stressful situations
Non-Resilience	• Having negative emotional/personality qualities* • Lacking support systems* • Displaying poor job performance • Coping ineffectively • Having poor health or unhealthy behaviours • Lacking balance in aspects of their life	• Experiencing negative emotions* • Lacking support* • Feeling out of control • Being overwhelmed or stressed • Being burnt out or lacking energy

* This indicates the themes that were identified for both the look and the feel of resilience or non-resilience

Strategies to Help Physicians Build Stress Resiliency

1. Get an adequate amount of sleep.

This cannot be over-emphasized as sleep plays a pivotal role in how the body deals with stress (lack of sleep is in itself a stressor).

2. Get an adequate amount of daily exercise.

Exercise reduces anxiety, improves memory, and increases the production of neuro-protective chemicals in the brain.

3. Eat a healthy diet that includes a variety of plant-based foods.

4. Increase your positivity.

There is a link between sleep, stress, and positivity (the latter being the easiest to influence).

5. Practice mindfulness.

Research demonstrates that spending time in a calm, relaxed, and focused state builds the brain's ability to thrive in stressful situations. Additionally, it helps us gain greater self-control in threatening (real or perceived) situations. An easy way to learn mindfulness is by taking a few minutes to focus on our breath (which will also activate the parasympathetic nervous system).

6. Learn how to reframe and label distressing situations.

There is a direct link between our thoughts and our feelings. Much of the stress we experience is due to stressful thoughts, often causing a learned helpless and/or fearful response to certain triggers. Examples of stress-inducing thinking are: over-generalizing, black-and-white thinking, seeing things as worse than they are, making assumptions about what other people think about us, and believing we are helpless or powerless.

7. Plan ahead.

Much of stress is self-induced. Practice time management and priority setting to avoid procrastination and a buildup of stress.

All great points. The problem I run into is that physicians are either unaware that they're working under stress, or if they do feel like they can handle it themselves. They're "used to it". Then there' are the barriers of not willing to seek help because of ego, time constraints, reflections on competency, or concerns about confidentiality. In this regard we need for the organizations in which the physicians are affiliated with to step up and take a proactive role in providing programs and support that focus on improving physician well- being.

alan @ Thu, 2016-02-18 11:36 reply

Physician Engagement

Meeting the Physician's Needs

Boards can improve engagement through support, recognition and education

What Makes a Physician Feel Engaged?

Physicians' average score, 1-10 scale

Element of Engagement	Important to Feeling Engaged	True of Current Practice
Respect for my competency and skills	9.2	7.3
Feeling that my opinions and ideas are valued	9.1	6.5
Good relationships with my physician colleagues	9.1	7.9
Good work/life balance	9.1	6.7
A voice in how my time is structured and used	9.0	6.6
Fair compensation for my work	8.9	6.5
Good relationships with nonphysician clinical staff	8.9	8.0
A broader sense of meaning in my work	8.7	7.0
A voice in clinical operations and processes	8.7	6.3
Opportunities to expand my clinical skills and learn new skills	8.7	7.1
Opportunities for professional development and career advancement	8.6	6.6
Good relationships with administrators	8.4	6.4
Alignment with my organization's mission and goals	8.2	6.8
Working for leader in innovation and patient care	8.1	6.6
Participation in setting broader organizational goals and strategies	7.9	5.8

Source: Physician Engagement Survey, Physician Wellness Services and Cejka Search, 2013

By Alan H. Rosenstein, M.D.

As health care organizations take on accountable care and fixed-dollar reimbursements, boards are realizing the importance of physician engagement and alignment. Achieving performance goals, improving quality, safety and resource utilization in care, and increasing patient satisfaction all affect financial viability. Physicians are crucial to each of these efforts.

To foster physician alignment, hospitals and systems have implemented a variety of strategies, including adopting best-practice guidelines and protocols, and standardized orders; providing aggressive case management intervention; implementing computer-assisted alerts and remind-

SNAPSHOT

Physicians are frustrated and overwhelmed by the changes in care delivery. To support them and build engagement, boards and executives need to provide guidance and support at all levels of a physician's career.

20 JUNE 2015 Trustee

Trustee JUNE 2015 19

Focus on core values

Express concern and empathy

Provide education/ skills training

Opportunities for input/ involvement

- Surveys
- Exchange forum
- Responsiveness
- Address barriers

Motivate and inspire/ champions

Provide support

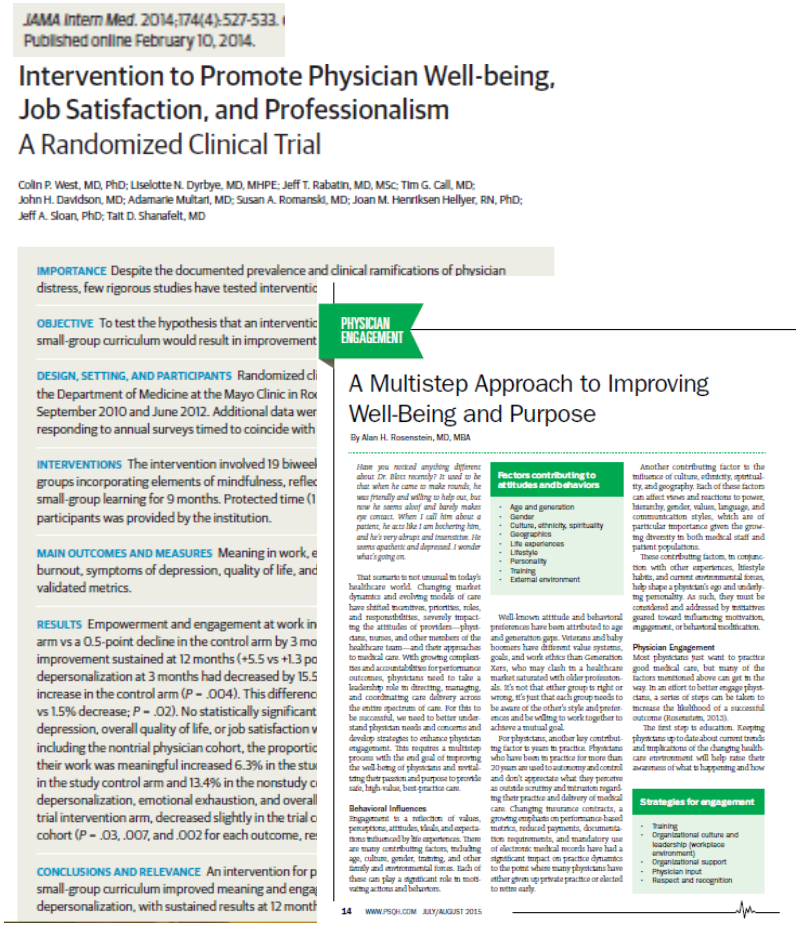
- Administrative: structure/ flow
- Clinical
- Behavioral

Show respect and recognition

- ➢ Improve well-being
- ➢ Improve physician satisfaction
- ➢ Improve care relationships
- ➢ Improve patient care
- ➢ Improve career

Physician Well- Being

- Understand importance
- Consider consequences
- Take care of self
  - Set expectations/ set limits
  - Avoid stressful situations
  - Sleep
  - Nutrition
  - Exercise
  - Relaxation
  - Meditation
- Accept advice/ support
- Behavioral compliance
- Change situation



JAMA Intern Med. 2014;174(4):527-533.
Published online February 10, 2014.

Intervention to Promote Physician Well-being, Job Satisfaction, and Professionalism

A Randomized Clinical Trial

Colin P. West, MD, PhD; Liselotte N. Dyrbye, MD, MHPE; Jeff T. Rabatin, MD, MSc; Tim G. Call, MD; John H. Davidson, MD; Adamarie Multari, MD; Susan A. Romanski, MD; Joan M. Henriksen Hellyer, RN, PhD; Jeff A. Sloan, PhD; Tait D. Shanafelt, MD

IMPORTANCE Despite the documented prevalence and clinical ramifications of physician distress, few rigorous studies have tested interventic

OBJECTIVE To test the hypothesis that an interventic small-group curriculum would result in improvement

DESIGN, SETTING, AND PARTICIPANTS Randomized cl the Department of Medicine at the Mayo Clinic in Ro September 2010 and June 2012. Additional data wer responding to annual surveys timed to coincide with

INTERVENTIONS The intervention involved 19 biweel groups incorporating elements of mindfulness, reflec small-group learning for 9 months. Protected time (1 participants was provided by the institution.

MAIN OUTCOMES AND MEASURES Meaning in work, burnout, symptoms of depression, quality of life, and validated metrics.

RESULTS Empowerment and engagement at work in arm vs a 0.5-point decline in the control arm by 3 mo improvement sustained at 12 months (+5.5 vs +1.3 po depersonalization at 3 months had decreased by 15.5 increase in the control arm ($P = .004$). This differenc vs 1.5% decrease; $P = .02$). No statistically significant depression, overall quality of life, or job satisfaction v including the nontrial physician cohort, the proportic their work was meaningful increased 6.3% in the stu in the study control arm and 13.4% in the nonstudy c depersonalization, emotional exhaustion, and overall trial intervention arm, decreased slightly in the trial c cohort ($P = .03, .007$, and $.002$ for each outcome, re

CONCLUSIONS AND RELEVANCE An intervention for p small-group curriculum improved meaning and engag depersonalization, with sustained results at 12 month

PHYSICIAN ENGAGEMENT

A Multistep Approach to Improving Well-Being and Purpose

By Alan H. Rosenstein, MD, MBA

Have you noticed anything different about Dr. Blois recently? It used to be that when he came to make rounds, he was friendly and willing to help out, but now he seems aloof and barely makes eye contact. When I call him about a patient, he acts like I am bothering him, and he's very abrupt and insensitive. He seems apathetic and depressed. I wonder what's going on.

That scenario is not unusual in today's healthcare world. Changing market dynamics and evolving models of care have shifted incentives, priorities, roles, and responsibilities, severely impacting the attitudes of providers—physicians, nurses, and other members of the healthcare team—and their approaches to medical care. With growing complaints and accountabilities for performance outcomes, physicians need to take a leadership role in directing, managing, and coordinating care delivery across the entire spectrum of care. For this to be successful, we need to better understand physician needs and concerns and develop strategies to enhance physician engagement. This requires a multistep process with the end goal of improving the well-being of physicians and revitalizing their passion and purpose to provide safe, high-value, best-practice care.

Factors contributing to attitudes and behaviors

- Age and generation
- Gender
- Culture, ethnicity, spirituality
- Geographies
- Life experiences
- Lifestyle
- Personality
- Training
- External environment

Behavioral Influences

Engagement is a reflection of values, perceptions, attitudes, ideals, and expectations influenced by life experiences. There are many contributing factors, including age, culture, gender, training, and other family and environmental forces. Each of these can play a significant role in motivating actions and behaviors.

Well-known attitude and behavioral preferences have been attributed to age and generation gaps. Veterans and baby boomers have different value systems, goals, and work ethics than Generation Xers, who may clash in a healthcare market saturated with older professionals. It's not that either group is right or wrong, it's just that each group needs to be aware of the other's style and preferences and be willing to work together to achieve a mutual goal.

For physicians, another key contributing factor is years in practice. Physicians who have been in practice for more than 20 years are used to autonomy and control and don't appreciate what they perceive as outside scrutiny and intrusion regarding their practice and delivery of medical care. Changing insurance contracts, a growing emphasis on performance-based metrics, reduced payments, documentation requirements, and mandatory use of electronic medical records have had a significant impact on practice dynamics to the point where many physicians have either given up private practice or elected to retire early.

Another contributing factor to the influence of culture, ethnicity, spirituality, and geography. Each of these factors can affect views and reactions to power, hierarchy, gender, values, language, and communication styles, which are of particular importance given the growing diversity in both medical staff and patient populations.

These contributing factors, in conjunction with other experiences, lifestyle habits, and current environmental forces, help shape a physician's ego and underlying personality. As such, they must be considered and addressed by initiatives geared toward influencing motivation, engagement, or behavioral modification.

Physician Engagement

Most physicians just want to practice good medical care, but many of the factors mentioned above can get in the way. In an effort to better engage physicians, a series of steps can be taken to increase the likelihood of a successful outcome (Rosenstein, 2013).

The first step is education. Keeping physicians up-to-date about current trends and implications of the changing healthcare environment will help raise their awareness of what is happening and how

Strategies for engagement

- Training
- Organizational culture and leadership (workplace environment)
- Organizational support
- Physician input
- Respect and recognition

Solutions

- Recognize the seriousness and significance of the issue
- Health providers a precious resource working under stressful conditions
- Raise organizational/ individual awareness and accountability
  - Solicit input: Surveys/ Town hall meetings/ discussion groups
  - Respond to issues and concerns that impact attitudes and behaviors
- Provide pro-active support: Satisfaction/ life balance/ health & wellness
  - Recognize reluctance to act
  - Structural/ administrative/ cultural/ clinical enhancements
  - Educational support/ relationship and communication skills
  - Emotional/ behavioral support (Wellness Committee/ HR / EAP….)
  - Satisfaction/ Career advice
- Address inappropriate behaviors:
  - Hold accountable/ intervene/ provide support
- Recognize and reward

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