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"Human Factors Affecting Disruptive Physician Behaviors and its Impact on the Business of Medicine"

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Abstract

Healthcare is an extremely complex business. While there are many different modalities and entry points for health care delivery, for more serious illnesses it is the physician who takes primary responsibility for managing and directing care. In most cases the process works out well for all involved. But in some cases inappropriate disruptive physician behaviors can lead to significant problems related to the efficiency and quality of care. For many reasons individuals and organizations have a difficult time in addressing these types of behaviors in an effective manner. Gaining a better understanding of the human factor forces involved that influence attitudes and behaviors is a crucial step in developing appropriate strategies to deal with this serious issue.

Introduction

Published studies have reported that 3-5% of physicians (and nurses) act in a disruptive manner [1]. Disruptive behavior is defined as any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual harassment that can potentially negatively impact patient care. The types of offensive behaviors described in this category include yelling, abusive language, condescending, berating, undermining, disrespectful behaviors, or overt bullying, harassment, and intimidation. Direct physical abuse is reported to occur less than 5% of the time. Having a clear definition of disruptive behavior is crucial to developing appropriate policies and procedures that set the expectations for professional behaviors and hold non- compliant individuals accountable for their actions.

Causes

No physician starts out the day planning to be disruptive. It's just that things seem to get in the way. There are multiple different factors influencing the way physicians think, act, and feel. Table I divides these factors into two categories: Internal and External Forces. We recognize that it is impossible to apply a cause and effect relationship to each individual factor but instead we need to consider the interplay of each of these factors and their role in influencing emotions and reactions.

Table I: Influencing Factors

Internal Factors:	External Factors:
- Age and generation	- Training/ hierarchy
- Gender/ sexual orientation	- Health Care Reform
- Culture/ethnicity/ spirituality	- Stress and burnout
- Geography/ life experiences	- Work environment
- Mood/ personality	- Adverse events/ Litigation/ Personal issues/ debt

Age and generational issues are based on the values and perceptions reinforced by the current existing status of the social, economic, and political environment at the time in which the individual grew up. Differences in views as to work ethic, commitment, views of authority, and work life-balance are different for each of the groups (Millenniums <1980-1995>, Generation X <1965-1979>, Baby Boomers <1946-1964>, Veterans/ Traditionalists <pre 1946>) which under stressful situations may lead to conflict in the workplace environment. Many organizations have addressed this issue by offering programs that educate staff about generational differences and provide strategies to help them reach compromises during periods of conflict or disagreement [2].

Gender differences may also affect the way individuals react in stressful situations. Males are typically more assertive, task oriented, domineering, and under pressure tend to dig in. Women are more socially oriented and under pressure will look for consensus opinions to support their points of view. In the past these problems were exacerbated by the predominantly female nursing workforce and the predominantly male physician task force. While the percentages are changing, potential conflicts may still arise. Many organizations have addressed these issues by educating staff on sexual orientation including issues related to traits, equality, sexual orientation, tolerance, and harassment [3].

The next factor is diversity. With changing world demographics we are seeing a greater diversity in our patient and staff populations with a greater influx of foreign born or foreign trained nursing and medical staff with their own individual ethnic, cultural, and religious beliefs that affect values, thoughts, and behaviors as to feelings about religion and spirituality, hierarchy, authority, and communication styles. In difficult situations this can lead to misunderstandings in purpose and intent that may negatively affect communication efficiency, expectations, and outcomes. In this regard there is a big push toward training providers on cultural competency and/ or providing diversity training to help individuals better understand individual needs and values, address hidden assumptions or biases, and provide effective solutions for more effective communication [4].

All of these internal factors combined with genetics, socioeconomic factors, geographic influences, and other individual life experiences help to shape an individual's mood and personality. Strategies for improvement should focus on introducing a variety of different training programs designed to enhance personality and relationship management. These programs might include such topics as sensitivity training, emotional intelligence, diversity management, cultural competency, mindfulness, generational gap values, personality traits, conflict management, stress management, anger management, sexual harassment training, customer satisfaction, and improving overall communication and collaboration skills.

The external factors include current day circumstances that influence present state perceptions. For physicians one of the key factors starts with the training environment. Some equate this training to a fraternity/ sorority hazing type environment where individuals are harassed to the point of losing self- esteem. In some cases this can lead to severe cases of stress, burnout, and depression [5]. In response the trainees try to develop knowledge and technical competencies through exhaustive independent study. As a consequence there is no focus on developing personal skills or team collaboration mechanics which leads to a lower degree of sensitivity and emotional intelligence. This presents a definite liability in today's complex multi-spectrum health care environment so dependent on multidisciplinary collaboration. Fortunately, there are movements in place to try and deal with these training hazards At the front end Medical Schools are looking for more "well- rounded" applicants who have majored in something other than the traditional math and sciences. At the back end some of the more progressive Medical Schools are adding programs that focus on developing personal and team collaboration skills as part of the freshman year curriculum in an effort to enhance work relationships. Unfortunately one of the slow to evolve underlying problems is the traditional hierarchal health care structure with dedicated roles and responsibilities and set boundaries between the different health care disciplines.

Health Care Reform has added another level of disturbance to the force. Where physicians used to pride themselves on their ability to provide best practice care with autonomy and control, the introduction of new care restrictions, utilization controls, changing incentives, and performance accountability metrics based on a series of "questionable" variables has forced many physicians to reassess their positions and change models of care. Add to this the growing complexity of health care management, the frustrations of dealing with electronic documentation and other administrative requirements taking physicians away from face to face direct patient care, school debt, being involved in an adverse event, concerns about litigation, and other complicating workplace or personal issues, we can see how this can have a significant negative impact on physician attitudes and behaviors. As far as a remedy, it's unlikely that we'll be able to change the system. But what we can do is to provide more education to help the physician better understand why this is occurring, the intent, what the projected service impact will be, and then provide the necessary support to help physicians adjust and become more compliant in meeting these new objectives.

One of the unintended consequences of Health Care Reform is the growing amount of stress and burnout in physicians and its impact on their willingness to continue to practice medicine. Recent studies have shown that more than 50% of physicians report a significant amount of stress and burnout which has led to increasing irritability, cynicism, apathy, fatigue, disillusionment, dissatisfaction, and in some cases more serious depression, behavioral disorders, and even suicidal ideation [6]. As a result there is an increasing amount of physician dissatisfaction, where many physicians have either changed practice settings, joined different groups, or moved into salaried positions. Others have either left the profession entirely or chose early retirement.

So how do we deal with stress and burnout [7]? This is obviously a complicated issue. The process starts with raising physician awareness. Many physicians are unaware that they are working under stress and the physical and emotional toll it's taking on their livelihood. If they do admit that they are under stress, they accept it as being part of the job and rationalize that they have been working under stress all their lives. Even if they think they may need some outside help they are reluctant to ask in fear of concerns about their competency, confidentiality, discoverability, or a blow to their ego. If physicians are reluctant to admit or accept assistance, we need to look for the organizations that they are associated with to take a more pro-active stance in trying to encourage and provide support. These are significant barriers that need to be addressed before moving forward.

Solutions actually start at the Medical School level. There is a growing amount of evidence suggesting that high levels of stress, burnout, depression, and even suicidal ideation starts during the first year of medical school. This probably results from a combination of factors of having individuals driven by a strong competitive egocentric driven personality being dropped into an intensely complex bewildering hierarchal system without direction and a sense of nowhere to go. These problems are further exacerbated by a sense of physical and emotional exhaustion, stress, and fatigue, which can take a toll on physical and mental well- being. Fortunately many organizations are making a concerted effort to provide resources to help students adjust to the pressures in the academic environment [8].

Once a physician gets out into practice there are other day to day pressures that promote a stressful environment. As mentioned previously, many physicians are either unaware or reluctant to admit that they are under stress, and even if they do recognize it, that won't take any action. In this case we need to look for outside assistance from friends, peers, or the organizations in which the physician is associated with to help out. The most consistent approach is to provide pro-active support at the organizational level. Unfortunately, many physicians feel that their organizations don't support them. In a recent study conducted by Cejka Search and VITAL WorkLife, when asked if their organization did anything currently to help physicians deal more effectively with stress and/or burnout, 85% of the respondents said no [9]. So, in an effort to better address the issue of physician stress and burnout we need to (1) raise awareness, (2) motivate physician reactiveness, and (3) have the organizations take a more active role in providing support services to help physicians better adjust to the stress and pressures of today's health care environment.

Support can come from a variety of different directions. On one level the organization can provide training on stress management, time management, conflict management, business management, and other appropriate programs to teach basic skill sets on stress reduction. On a deeper level the organization can provide more personalized support services through Physician Wellness Programs, Wellness Committees, Physician EAPs (Employee Assistance Programs), or through individualized coaching or counseling. Some physicians may require more in-depth behavioral modification programs. Organizations need to approach these programs with the idea that they understand the physician's world, that they respect and value the physician's time and what the physicians do, and that they are here to help. They need to make an effort to promote customized individual support and be responsive to physician resistance, time constraints, and fears of confidentiality. To motivate physician action the focus needs to be on the goal of helping the physician do what they want to do, which is to practice good medical care.

Consequences

Despite all the evidence and concern about the physician behavioral turmoil in many cases it goes unresolved [10]. Depending on the circumstances, the combination of internal and external factors can result in inappropriate actions that lead to disruptive behaviors.

Unfortunately, many disruptive events either go unrecognized, go unreported, or are ignored for a variety of different reasons. The problem with this personal and organizational reluctance is the potential for bad things to happen to patients, staff, and the organization (Table II).

Table II: Reluctance and Ramifications

Organizational reluctance:	Risk of non- action:
- Awareness/ accountability/ tolerance	- Staff retention/ recruitment/ patient satisfaction
- Financial	- Staff/ patient satisfaction
- Hierarchy/ boundaries/ sacred saints	- Quality/ patient safety
- MD autonomy	- Medical errors/ care efficiency
- Code of silence/ fear of reporting	- Joint Commission accreditation standard
- Conflicts of interest	- Liability/ litigation/ fines/ penalties
- Structure?/ skill set?/ solutions?	- Reputation/ social media

One of the issues raised earlier was the importance of defining what disruptive behavior is and holding individuals accountable for their actions. Many individuals who act "disruptively" aren't aware that they are acting in an inappropriate non-professional manner. This is particularly true for physicians who are used to taking control, and "giving orders". Under times of stress they may yell and intimidate others and not even realize they are doing it. Even if they are aware they justify their behaviors as being necessary to direct patient care. The problem is that they are oblivious to the downstream negative consequences this may cause on care relationships, communication efficiency, task accountability, and patient care.

A second big concern is the issue of organizational tolerance. Many of the events involve very prominent physicians who bring a large number of patients and revenue into the organization. Many organizations are reluctant to address the issue in fear of antagonizing a physician to the point where they worry that the physician won't bring their patients into the facility. This is particularly true for smaller organizations where there may be shortage in supply of certain specialties. There is also the concern about crossing boundaries. Physicians work autonomously and in many organizational cultures physicians are viewed as "sacred saints" impeding the willingness to intervene. There is also a hidden "code of silence" where health care workers are reluctant to report disruptive behaviors. This lack of reporting is accentuated by potential conflicts of interest, concerns about lack of confidentiality, and/ or fears of retaliation. Many who do report are frustrated by the lack administrative support and the fact that despite reporting, the perception is that nothing ever changes, so why bother.

And lastly is the structure and skill set to deal with behavioral problems. Organizations have policies and procedures in place to address clinical competency but may not be well equipped to deal with behavioral problems. They need to have the right structure in place supported by individuals skilled in facilitation and negotiation techniques. Turning matters over to the Chief or Chairman of the Department may not lead to an effective resolution.

The Risks of Inaction

The risk of inaction can lead to downstream consequences that affect moral, culture, workplace atmosphere, and/ or lead to medical mishaps that have significant direct or indirect financial penalties [11] (Table III).

Table III: Economic consequences

I- Recruitment and retention- RN: $60,000 – 100,000/ additional opportunity costs

II- Patient satisfaction/ HCAHPS/ Reputation- Market share implications ($?)

III- Adverse events ("No pay" for adverse events initiatives)-

- Medication error: $2,000 to $5,800 per case/ > LOS 2.2-4.6 days

- Hospital acquired infection: $20,000 to $38,500

- Deep Vein Thrombosis: $36,000/ > LOS 4.2 days

- Pressure Ulcer: $22,000/ > LOS 4.1 days

- Ventilator Associated Pneumonia: 49,000/ > LOS 5.3 days

IV- Joint Commission Standard

V- Compliance issues ($?)-

- Impact on documentation and coding

- Impact on utilization efficiency (LOS/ resource efficiency/ DC planning)

- Impact on quality

- Impact on productivity and efficiency (down time/ waste/ delays)

- Communication inefficiencies ($4 million 500 bed hospital)

VI- Risk Management/ Malpractice: $521,560/ Lawsuits/ Fines: $25,000 - $100,000

On one level disruptive behaviors have been shown to have a significant negative impact on nurse satisfaction and retention [12]. Replacing a nurse can cost the organization anywhere from $60,000 to $100,000 for recruitment, training, and secondary opportunity costs. When it occurs in a public arena disruptive events can also lead to patient dissatisfaction which can negatively impact HCAHPS scores and other patient satisfaction pay for performance initiatives which can have a negative effect on reimbursement. Then there is the spillover effect on hospital reputation which may impact market share and contacting.

From a patient care perspective the biggest concern is the occurrence of preventable medical errors or adverse events. In addition to waste, duplication, and inefficiencies in management, lack of communication and collaboration can lead to task failures that result in medication errors, infections, delays in treatment, and other serious medical conditions which can increase lengths of stay and accrue significant non- reimbursable costs of care.

In response to the concerns about the impact of disruptive behaviors on patient safety in 2010 the Joint Commission added a new leadership standard requiring hospitals to have a disruptive behavior policy in place and to supply support for its intent as part of the leadership accreditation standards [13]. In order for hospitals to receive Medicare reimbursements, they need to pass the accreditation survey criteria requirements.

From a compliance perspective, non- compliant behaviors that adversely impact coding and documentation requirements, non- adherence to utilization protocols, and/ or not following best practice guidelines, policies, and procedures, can all have a significant negative economic and quality impact on patient care outcomes. It is estimated that the average yearly cost for a midsize hospital due to communication deficiencies is $400,000 [14].

From a risk management perspective more egregious cases can lead to litigation. Time, preparation, and malpractice awards can result in significant dollar amounts with average malpractice settlements averaging above a half a million dollars. In California there is the additional penalty of hospital fines (ranging from 25,000 – 100,000) for the occurrence of significant adverse events.

Addressing Disruptive Behaviors

Recognizing the multidimensional cause, nature, and extent of disruptive behaviors, it is clear that there is no one solution to resolve the problem. The ultimate objective is to prevent disruptive behaviors from occurring. If they do occur the organization and staff need to take immediate action to lessen the likelihood of any adverse incident involving staff or patient care. Depending on the nature and frequency of events, further interventions may be required to prevent repeated incidents. Table IV provides a list of recommended strategies. In addition to reducing the incidence of disruptive behaviors, this approach can also be used to improve the overall organizational culture, staff relationships, team collaboration, communication efficiency, physician engagement, and physician well-being.

Table IV: Recommended Strategies

1. Training re-design:
   - Applications/ MCAT testing
   - Revised curriculum
2. Organizational Culture/ Work environment:
   - Hiring/ On-boarding
   - Mutual alignment
   - Leadership commitment/ Structure and process
   - Encourage motivation/ address barriers/ set priorities
   - Engage Champions/ Catalysts/ Role models
   - Recognition and rewards
3. Education:
   - Awareness/ Responsibility/ Accountability
   - The business of healthcare
   - Expectations vs. reality
4. Relationship training:
   - Address factor influences: Generation/ Gender/ Culture/ Ethnicity
   - Diversity management/ Cultural competency/ sensitivity training
   - Personality profiling
   - Customer satisfaction
   - Stress/ Conflict/ Anger management
   - Emotional Intelligence
5. Communication skills/ Team collaboration training
6. Behavioral policies and procedures
   - Definition/ Accountability/ Incident reporting and review
   - Risk management
7. Intervention:
   - Prevention
   - Tiered approach: Informal/ Formal/Disciplinary
8. Staff support:
   - Administrative/Clinical/ Behavioral (EAP/ Wellness Committees/ Coaching/ Counseling)
   - Behavioral modification programs
   - Career guidance
9. Physician Well- Being:
   - Awareness/ Reflection/ Self- care/ Relaxation
   - Stress Reduction
   - Quadruple Aim
   - Mindfulness
   - Resilience
10. Physician engagement:
    - Input/ empathy/ responsiveness/ alignment
    - Recognition/respect

As discussed earlier, one of the earliest steps to take is to improve the process and criteria for medical school selection and enhance personal skill and team collaboration skills early on in their training curriculum.

From an organizational perspective, hiring and retaining the right people is key to success. Many organizations are recognizing the importance of the right "cultural fit" and are using more selective interviewing techniques to assure that new hires will work well with the mission and operational needs of the work environment. Once hired, there should be a comprehensive on-boarding process to first welcome the physician, and then explain organizational priorities and incentives working under the complexities of today's health care environment and the support available to help physicians negotiate through the maze of medical requirements.

Recognizing administrative concerns for financial viability, and clinical staff concerns about quality and safety, there needs to be a mutually agreed upon rallying point and alignment around best patient care. Organizational culture sets the tone. Strong and supportive organizational cultures have been shown to significantly enhance staff morale, satisfaction, motivation, and engagement which lead to behaviors that result in best patient outcomes of care [15]. Having a strong, committed, and respectful leadership, an effective structure and process in place manned by skilled individuals, a willingness to address and respond to individual concerns and barriers that pose a potential disturbance in the force, establishing priorities, and enlisting the help of key individuals who act as champions and catalysts to help promote a positive work environment are the key ingredients to a successful culture. In today's multitasking pressure filled here's what you need to do world, always remember to take a step back and take time to recognize physicians and staff for their efforts and say thanks for a job well done.

Another crucial step is to make an effort to educate staff about what's going on, what we need to do in response, and how it might impact individual roles and responsibilities. Proving educational sessions on the evolving health care environment, value based care, system redesign, performance based accountabilities, and the business implications of clinical practice, will help set realistic expectations by giving physicians a better understanding of what's happening and how it might affect their individual practice.

Providing training to enhance relationship management is crucial. Under an umbrella of increasing complexity and accountability, more segmentation between specialty and discipline specific tasks and responsibilities, and a greater focus on care responsibilities that extend across the entire spectrum of care, it is crucial for all members of the health care team to work well together to provide best patient outcomes. In order to accomplish this, we need to gain a better understanding of the factors affecting individual values, perceptions, and behaviors. Offering educational and training programs on such topics as diversity management, cultural competency, sensitivity training, emotional intelligence, generational values, personality assessments, and customer satisfaction may prove extremely valuable. Additional programs on conflict management, anger management, and stress management may also be of benefit depending on individual circumstances.

Beyond addressing disruptive behaviors is the need to improve overall communication and team collaboration skills. Physicians are typically not the best communicators. There are many barriers that get in the way [16]. First, they look at patient management as a one way dictatorial process. They're trained to work autonomously, to take control, and give orders. Communication gaps are further accentuated by a bureaucratic health care hierarchy, a teaching focus on gaining knowledge and technical competency rather than personal skill development, segmented, siloed, and discipline specific priorities which focus more on the organ or disease rather than the patient, and an overriding strong ego that resists outside advise, interference, or involvement. In today's complex health care world improving communication skill sets should be a number one priority.

There are many different types of communication skills training programs available. The focus is getting the physician in synch with effective two way communication. Crucial points emphasized include a proper introduction and acknowledgement, making time and patience, exhibiting positive body language and verbal tone, enabling trust, avoiding distractions or conflict, reflective listening, being sensitive to the other's values, needs, and desires, providing clarification and understanding, and setting appropriate expectations. In a demanding hectic environment, taking the time to listen, understanding, responding, and explaining is the key to gaining compliance and a successful interaction and outcome [17].

A further extension of communication is to teach team collaboration. One of the most effective programs in health care is the TeamStepps program. The focus of the training program is to teach team members how to (1) anticipate and assist, (2) build trust, respect, and commitment, (3) understand your role and roles of others, (4) reinforce accountability and task responsibilities, (5) avoid/ manage conflict or confusion, (6) assertiveness and need to speak up, (7) follow up discussions, and (8) thanks for a job well done.

In order to hold individuals accountable for their behaviors the organization needs to have a code of conduct policy in place that outlines non-professional behaviors and the ramifications of non-compliance. The policy must be backed by an effective incident reporting system where each complaint is evaluated on its own individual merits with recommendations given for appropriate follow up action. In order for the program are effective individuals needed to be willing to report. Barriers to reporting include fear of whistleblower retaliation, a double standard of reluctance to apply consistent reprimands when it involves physicians, and the sense that they report and report and nothing ever changes. On the incident evaluation side, determinations need to be made by trained individuals functioning without personal bias or conflicts of interest with recommendations passed on to an individual or committee who has the appropriate facilitation skills to foster accountability and resolution. When patient quality or safety is of concern many of these issues fall under a risk management protocol.

When it comes to intervention the first intervention is prevention. As discussed previously, taking a pro-active approach in trying to get a better understanding of behavioral characteristics, and teaching basic principles about behavioral management can certainly reduce the predilection for behavioral problems. For recurring issues early intervention has a much greater potential for success than waiting until a bad incident occurs where the interaction take on more of a remedial tone [18].

Interventions can occur at several different levels. In all cases it's crucial to intervene at the appropriate time and place with the intervention conducted by someone skilled in the arts of facilitation and conflict management.

The first intervention is real time. If somebody is acting inappropriately the recipient needs to be assertive in addressing their concerns in a respectful professional manner.

The next series of interventions are post-event interactions. Hickson and his group at Vanderbilt University have come up with a four phase process for intervention that includes informal, awareness, authority, and disciplinary actions [19]. The informal interaction is often described as the "cup of coffee" approach where you take the physician aside, describe the series of events, and ask for their opinion.A good facilitator will listen to what the physician has to say, ask if they thought that their action was appropriate, address their concerns and rationalizations, reframe the issue to bring behaviors into context, ask them to think about the impact it had on the other person(s) involved, and what they could have done differently to ease the angst of the situation. When the situation is addressed under the guise of raised awareness, most physicians will self- correct.

For repeat offenders or when the incident is of a serious nature there needs to be a more formal intervention. The physician needs to recognize the ramifications of non-compliance with the code of behavioral standards and the organization needs to reinforce the importance of a zero tolerance policy with the potential of disciplinary action. In some cases the recommendations may be made for anger management, conflict management, or diversity training, and in more serious cases the need for individualized counseling. Always keep in mind the underlying possibility of drug or alcohol abuse. Depending on the nature of the problem, some physicians may be required to attend an outside behavioral modification program.

In the more extreme cases where physicians are resistant to follow recommended actions the only recourse may be sanctions or termination of privileges. Having served as an expert witness on both sides of the picture (representing hospitals, representing individual physicians)health care organizations need to have a clear line of documentation as to the issues, follow due process, adhere to the bylaws and HCQIA requirements, be consistent with similar types of cases, document follow up discussions, comply with the rights of the physician to be heard, provide specific recommendations designed to resolve problems, and state the capability to reapply once the issues are addressed and resolved [20].

When possible the focus of any intervention should be on trying to help the physician better adjust to the situation by offering assistance and career guidance rather than punishment. The primary focus should be on positive physician support.

If the physician is overwhelmed by administrative requirements and time constraints, the organization needs to recognize this issue and provide appropriate support. From an administrative and logistical perspective reducing on- call scheduling or productivity requirements, and/ or reducing committee responsibilities will help reduce some of the administrative load. Offering administrative assistance by providing help with documentation and compliance with electronic medical records through additional training, staff support, or using "scribes" will help ease physician frustrations in this area. From a clinical perspective using Physician Assistants, Nurse Practitioners, or Case Coordinators to help cover some basic medical necessities will free the physician up to concentrate on more complex patient management issues. From a behavioral perspective, providing services to help the physician better adjust to the pressures of medical practice, organizations can offer services through Wellness Committees, Employee Assistance Programs, individualized coaching and counseling sessions, or other services offered though Human Resources, Medical Staff Services, or outside referral services.

As mentioned previously stress and burnout are a major problem affecting physician satisfaction and overall well- being. Motivation for physician well- being needs to be linked with the physician's primary goal and aspirations to provide best practice care. They need to recognize, understand, and accept the fact that emotional and physical well- being affects their levels of energy, purpose, and the joy of being a physician[21]. This all starts by getting the physician to understand the importance of good health and the negative consequences of ill- health on performance that impacts family, friends, colleagues, staff, and ultimately patients. They need to understand the importance of relaxation and recreation, adequate sleep, regular exercise, and good nutrition. They need to try and avoid stressful situations, be able to set limits, and be comfortable in saying no. They also need to be willing to accept outside advice. One of the most important components is to teach them techniques to support self- reflection, self- preservation, and the importance of time off and relaxation to achieve inner peace. Many organizations are introducing the concepts of mindfulness and mediation training programs for physicians as a way to promote self-refection, purpose, and fulfillment, and enhance physician resilience [22, 23]. For most physicians the recognition is there but it becomes a secondary priority to the daily grind. We need to aggressively promote and support the importance of physician well- being and get then to commit to make it happen.

The final phase is to enhance physician engagement [24].Engaged physicians are more satisfied, energetic, and less likely to behave in an unprofessional manner.Part of their frustration is the lack of physician input. With growing frustrations from outside intrusions and having someone else telling them what they need to do, physicians react negatively when they don't have a voice.

Input can be gathered from several different sources. These include surveys, discussions at Town Hall or Department meetings, specialized task forces, or better yet, one on one conversation with administrative and clinical leaders. Allowing input diffuses some of the frustrations particularly if there are expressions of empathy and understanding of the physician world. Input must be followed by responsiveness. It's not that you'll be able to solve every problem, but at least you can provide an explanation and coordinate next steps on achieving mutually aligned objectives. There is a strong correlation between physician engagement, physician alignment, physician well-being, physician satisfaction, physician motivation, improved relationships, and improved outcomes of care. And always remember to visibly show respect and thank physicians for what they do.

Conclusion

Physician disruptive behaviors can have a significant impact on staff relationships, care efficiency, and clinical outcomes of patient care. There are multiple influencing deep seated internal and real time external forces at play which influence moods, perceptions, biases, values, priorities, and attitudes that impact behavioral output. For a number of different reasons, physicians have a unique set of circumstances that affect their persona and by nature of the business are under increasing levels of stress that may perpetuate burnout and depression that further aggravate the potential for disruptive actions. Most physicians are usually unaware of the consequences of their actions. Rather than taking a remedial approach to behavioral management we need to look at physicians as being precious resource and proactively provide the appropriate administrative, clinical, and behavioral support in an effort to help them better adjust to the pressures of today's health care environment. Early intervention is the key. A combination of cultural understanding and support, education, relationship training, and communication skillsdevelopment will help improve work dynamics. Some physicians will require additional personalized coaching or counseling and in rare instances require more intense behavioral modification interventions. Efforts need to be made to support and enhance physician well- being. Lastly, we need to make a conscious effort to provide opportunities for physician input and discussion in an effort to improve physician energies, engagement, satisfaction, and compliance with best practice care initiatives. We can't leave it up to the physician to take action. We need to get out there and try to help them be the physician they really want to be.

References

1. Rosenstein, A., O'Daniel, M. "A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety" The Joint Commission Journal on Quality and Patient Safety Vol.34 No.8 August 2008 p.464-471.

2. "Executive Dialogue: The Multigenerational Workforce: Management Implications and Best Practices" Hospitals and Health Networks October 2013.http://www.hhnmag.com/articles/5899-executive-dialogue-the-multigenerational-workforce.

3. Jagsi, R., Griffin, K., Jones, R., Perumalswami C,et. al. "Sexual Harassment and Discrimination Experiences of an Academic Facility" Journal of the American Medical Association Vol.314 No.6 August 11, 2015 p.555-556.

4. Curtis, E., Dreachslin, J., Sinioris, M. "Diversity and Cultural Competence Training in Health Care Organizations: Hallmarks of Success" Health Care Management Vol.26 No.3 July-September 2007 p.255-262.

5. Mata, D., Ramos, M., Bansai, N., Khan R, et al. "Prevalence of Depression and Depressive Symptoms among Medical Residents: A Systematic Review and Meta-analysis" Journal of the American Medical Association Surgery Vol.314 No.22 December 8, 2015 p.2373-2383.

6. Shanafelt, T.Hasan, O. Lotte, N., Drybye N, et al. "Changes in Burnout and Satisfaction with Work- Life Balance and the General US Working Population Between 2011-2014" Mayo Clinic Proceedings Vol.90 No.12 Dec. 2015 p.1600-1613.

7. Rosenstein, A. "Physician Stress and Burnout: What Can We Do?" American College of Physician Executives Vol.38 No.6 November/ December 2012 p.22-30.

8. Salles, A., Liebert, C., Greco,R. "Promoting Balance in the Lives of Resident Physicians: A Call to Action" Journal of the American Medical Association Surgery Vol.150 No.7 July 2015 p.607-608.

9. 2014 Physician Stress and Burnout Survey Cejka Search and VITAL WorkLife www.VITALWorkLife.com/survey/Stress.

10. Rosenstein, A. "Taking a New Approach to Reduce the Incidence of Physician Disruptive Behaviors" Hospital Practice Vol.43 No.4 November 2015 online p.221-225.

11. Rosenstein, A. "The Economic Impact of Disruptive Behaviors: The Risks of Non- Effective Intervention" American Journal of Medical Quality September/October 2011 Vol.26 p.372-379.

12. Rosenstein, A. "The Impact of Nurse-Physician Relationships on Nurse Satisfaction and Retention" American Journal of Nursing, Vol.102 No.6, June 2002, p. 26-34.

13. http://www.jointcommission.org/assets/1/6/Leadership_standard_behaviors.pdf.

14. Agarwal, R., Sands, D., Schneider, J. "Quantifying the Economics Impact of Communication Inefficiencies in U.S. Hospitals" Journal of Health Care Management Vol.55 No.4 2010 p.265-282.

15. Shanafelt, T., Gorringe, G., Menaker, R., Storz, K. et. al. "Impact of Organizational Leadership on Physician Burnout and Satisfaction" Mayo Clinic Proceedings Vol.90 No,4 April 2015 p.432-440.

16. Rosenstein, A. "Physician Communication and Care Management: The Good, the Bad, and the Ugly" Physician Executive Journal Vol. 38 Issue 4 July/ August 2012 p.34-37.

17. Joshi, N. "Doctor, Shut up and Listen" NY Times January 4, 2015 http://www.nytimes.com/2015/01/05/opinion/doctor-shut-up-and-listen.html?_r=0.

18. Rosenstein, A. "Early Intervention Can Help Prevent Disruptive Behavior:" American College of Physician Executives Journal. Vol. 37 Issue 6 Nov/ Dec 2009 p.14-15.

19. Hickson, G., Pichert, J., Webb, L., Gabbe, S. "A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors" Academic Medicine Vol.82 No.11 November 2007 p.1040-1048.

20. Rosenstein, A., Karwaki, T., Smith, K. "Legal Process and Outcome Success in Addressing Disruptive Behaviors: Getting it Right" Physician Leadership Journal May/ June 2016 p.46-51.

21. Rosenstein, A. "Understanding the Psychology behind Physician Attitudes, Behaviors, and Engagement as the Pathway to Physician Well- Being" Journal of Psychology and Clinical Psychiatry Vol.5 No.6 May 2016 p.1-4.

22. Beach, M., Roter, D., Korthuis, P., Epstein R, et al. "A Multicenter Study of Physician Mindfulness and Health Care Quality" Annals of Family Medicine Vol.11 No. 5 September/ October 2013 p.421-428.

23. Epstein, R., Krasner, M. "Physician Resilience: What it Means, Why it Matters, and How to Promote it" Academic Medicine Vol.88 No. 3 March 2013 p.301-303.

24. Rosenstein, A. "Meeting the Physician's Needs: The Road to Organizational-Physician Engagement" Trustee June 2015 p.19-22.

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