UNIVERSITY RADIOLOGY

ACR2022
WASHINGTON, DC
April 24–27

Atrius Health

Disruptive Physician: Impact, Prevention and Management

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American College of Radiology Annual Meeting, Washington, DC

April 24, 2022

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Disruptive Physician: Scope of the Problem

- As two practicing physicians who have a combined 36 years of experience, the authors have witnessed disruptive behavior among our physician colleagues that was not addressed due its acceptance in the workplace culture and lack of a defined process to prevent and manage the problem.
- In this presentation, the authors investigate:
  - Types of disruptive behaviors
  - Causes and contributors to such behaviors
  - Impact on patient care and the workplace
  - Prevention
  - Management

Definition and Prevalence of Disruptive Behavior

- American Medical Association (n.d.): To “speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual’s ability to work with other members of the health care team, or for others to work with the physician”
  - "Abusive" is an interchangeable term for disruptive.
  - Characterized it as a style of interaction (AMA, 2000).
- The Joint Commission (TJC, 2012): “behaviors that undermine a culture of safety”
- Includes verbal or nonverbal behaviors, such as facial expressions or manners.
- 3-5% of physicians are affected (Leape & Fromson, 2006)
- 1635 physician executives were surveyed in 2004 for experience with disruptive behavior
  - 80% underreported disruptive physician behavior due to fear of retaliation or only reported severe infractions.
  - 95% encountered disruptive behavior regularly.
  - 70% reported repeated offenses by the same physicians (Weber, 2004).
- Disruptive behavior usually occurs when there is a perceived power imbalance
  - between physicians and nurses, physician assistants, or other support staff and
  - less commonly between other physicians, administrators and patients (Weber, 2004).

American Medical Association. (n.d.) *Physicians with disruptive behavior*. Retrieved June 20, 2021, from https://www.ama-assn.org/delivering-care/ethics/physicians-disruptive-behavior

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Disruptive Behaviors

Aggressive Behavior	Microaggressive Behavior	Passive-aggressive Behavior
• Yelling • Anger outbursts, such as throwing instruments or charts • Physical aggression • Threats, implied or direct, especially retribution for making or investigating reports, regardless of perceived veracity of report • Condescending language, tone, or body-language, such as eye-rolling • Bullying • Insulting and shaming of coworkers, especially publicly • Profane or disrespectful language; slurs • Inappropriate touching	• Invading one's space • Mocking • Name calling • Referring to a particular group in a negative way • Comments that undermine a patient's trust in other caregivers • Comments that undermine a caregiver's self-confidence in caring for patients • Gossip • Racial/ethnic "jokes" • Sarcasm • Off-color jokes	• Failure to adequately address safety concerns of patient care needs expressed by another caregiver • Ignoring phone calls/pages • Ignoring questions, warnings, suggestions, policies • Failure to respond to emails • Chronic tardiness

- Prevention and Management of sexual harassment is beyond the scope of this presentation.

Porto, G. & Lauve, R. (2006, July/August). Disruptive clinician behavior: A persistent threat to patient safety. *Patient Safety & Quality Healthcare*. https://www.psqh.com/julaug06/disruptive.html
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Causes and Contributors to Disruptive Behaviors

Intrapersonal	• Psychiatric
	  • Axis I
	  • Depressive disorders
	  • Bipolar
	  • Axis II
	  • Narcissistic personality disorder
	  • Paranoid personality disorder
	  • Passive aggressive personality disorder
	  • Substance Abuse
		• Personality Traits
		  • Highly skilled
		  • High achieving
		  • Intelligent
		  • Confident/Arrogant
		  • Intimidating
		  • Controlling and inflexible
		  • Self-centered
		  • Lacks empathy
		  • Lacks self-awareness

Interpersonal	• Diversity
	  • Age/Generation
	  • Cultural conflicts
	  • Gender and sexual orientation
	  • Religious conflicts
	• Leadership styles	

Organizational and Situational Factors	• Training • Stress and burnout • Environment/culture • Personal issues	

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Misuse of the Disruptive Label

- Investigations must ensure that the disruptive label is not misused prior to any intervention (Reynolds, 2012).
- Physicians with axis I mental health and substance abuse disorders should not be labeled as disruptive (Reynolds, 2012).
  - Symptoms of such disorders may manifest as disruptive behavior
  - Underlying disorder must be treated
  - Role of Medical Executive Committee (MEC) or Human Resources (HR) is to make the appropriate referrals for treatment
  - With treatment the behaviors will likely resolve.
- Disruptive label should NOT be applied:
  - To single or rare occurrence of disruptive behavior (Reynolds, 2012)
  - When criticisms are made in good faith (AMA, 2000; Gallegos 2016, Reynolds, 2012)
  - To silence individuals
  - Related to personal feelings about an individual
  - Related to jurisdiction disagreements (Reynolds, 2012)
- Prevention and Management of behaviors attributed to mental health disorders and substance abuse/alcoholism are beyond the scope of this presentation.

American Medical Association. (2000, June). *House of Delegates Proceedings, Annual Meeting*. Retrieved June 10, 2021, from https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00002%2F00000012

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Impact of Disruptive Behaviors on the Workplace

- Undermine the healthcare team's psychological safety
  - Psychological safety = "the belief that one will not be rejected or humiliated in a particular setting or role" and "an interpersonal climate characterized by trust and respect" (Edmondson & Roloff, 2009).
- Tolerating or ignoring disruptive behaviors is perceived as endorsement and negatively impacts the morale of those who are routinely professional (Rawson, et al., 2012).
- Increase the likelihood of medical errors as such behaviors can impair their clinical judgement and performance (Leape & Fromson, 2006).
  - Stymies critical communication among healthcare team (Zimmerman & Amori, 2011).
  - 7% reported intimidation playing a role in a medication error in the past year in a survey of 2,095 providers (ISMP, 2004).
- Contribute to increased stress, lower morale, and higher turnover among healthcare team members (Rosenstein & O'Daniel, 2005).
- Patients lose confidence and are less likely to ask questions or provide information (Grissinger, 2017).
- $593,150 (2012 inflation-adjusted to 2022 dollars) is the annual cost to a typical 400-bed hospital due to preventable events related to disruptive physician behaviors (Rawson, et al., 2012).

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Rosenstein, A. H., & O'Daniel, M. (2005). Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *American Journal of Nursing*, *105*(1), 54-65. https://doi.org/10.1097/00000446-200501000-00025
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Prevention of Disruptive Behaviors

- Have a code of conduct which defines acceptable behaviors and behaviors that undermine a culture of safety.
  - TJC requirement for accredited organizations to have a code of conduct (TJC, 2012).
  - Be universal, applying to all physicians and staff (Porto & Lauve, 2006).
  - Be specific (AMA, n.d., (d)).
    - Mitigates any pleas of ignorance by the offending physician.
  - Serve as guidance for physicians and administrators when there are grievances (Porto & Lauve, 2006).
- Code of conduct
  - Has references to policies, procedures, or regulations to allow it to serve as grounds for dismissal or termination (Porto & Lauve, 2006).
  - Include a non-retaliation clause (TJC, 2008).
  - During onboarding and annually thereafter, each physician be required to sign a statement of receipt and acknowledging the expectation of compliance. Non-compliance may lead to disciplinary actions including termination of employment or suspension of privileges (Leape & Fromson, 2006; Porto & Lauve, 2006).

American Medical Association. (n.d.) *Physicians with disruptive behavior*. Retrieved June 20, 2021, from https://www.ama-assn.org/delivering-care/ethics/physicians-disruptive-behavior

Porto, G. & Lauve, R. (2006, July/August). Disruptive clinician behavior: A persistent threat to patient safety. *Patient Safety & Quality Healthcare*. https://www.psqh.com/julaug06/disruptive.html

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Prevention of Disruptive Behaviors

- Routine performance monitoring mechanisms
  - 360-degree feedback system
    - Incorporates self-review; reviews from anonymized peer and staff chosen by the physician or management; and anonymized patient commentary (Leape & Fromson, 2006; Hammerly, et al., 2014).
      - B-29 is an example of a 360-degree feedback system that incorporates core competencies from the American Board of Medical Specialties and the Accreditation Council for Graduate Medial Education (Swiggart, et al., 2014).
    - Improves emotional intelligence and identifies discrepancies between a physician's self-perception and perceptions by team members (Hammerly, et al., 2014).
    - "Provide an early warning system that enables the physician and management to recognize and resolve conduct problems before more serious incidents occur" (Harmon & Lapenta, 2008).
- Voluntary and confidential reporting systems

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Prevention of Disruptive Behaviors

- Mentorship
  - Organization can publicize a pool of willing and qualified mentors to facilitate the process.
  - Ideally allow individuals to identify their own mentors rather have one be assigned. (Willis, et al., 2018).
- Professional development programs
  - Communication (Saxon, 2012)
  - Stress management
  - Time management
  - Diversity and inclusion
  - Conflict resolution
  - Implicit bias
  - Leadership (Willis, et al., 2018)

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Management of Disruptive Behaviors: General Principles

- Creating a culture of respect and courtesy is effective in reducing disruptive behavior (M. Howe, personal communication, June 17, 2021)
  - Reinforce positive behaviors
  - Create internal accountability through psychological safety
    - Feedback from the affected individual has more power than when coming from a 3rd party
- Consistent and progressive approach to management is necessary (Gallegos, 2016)
  - All discussions must clearly state the offending behavior and why it is a problem (M. Howe, personal communication, June 17, 2021)
  - Consider contributing factors (Rosenstein, 2016; Gallegos, 2016)
    - Management should make reasonable effort to reduce contributing factors
      - Patient overload, additional assistance, process improvements
- Document, Document, Document (McConnell, 2021)
  - Physician and manger must sign acknowledgement of discussion and plans
  - If the physician refuses to sign, the refusal with date and time must be documented
- Specific recommendations: anger management, diversity and sensitivity training (Rosenstein, 2016)
- Improvement plans should be specific to the individual and situation (Rosenstein, 2016; Gallegos, 2016)

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Management of Disruptive Behaviors: General Discussion Principles

- Discussion should occur in a private and professional setting (Holmes & Olsen, 2016)
  - Obtain assistance from people trained in facilitating and conflict resolution (Rosenstein, 2016)
  - Enlist a physician liaison to reduce potential tensions with nonphysician involvement (Holmes & Olsen, 2016)
  - HR can help with scripting and guidance (M. Howe, personal communication, June 17, 2021)
- Outline of talking points available for meeting (Holmes & Olsen, 2016)
  - Reduces deflection
  - Clearly delineate offending behavior, perceptions, why the behavior is a problem, and potential adverse events
- Allow the physician to respond and explain in their own words
- Code of conduct and anti-retaliation clause available for reference (Holmes & Olsen, 2016)
  - Allows clarification of expectations going forward
  - Clarifies zero-tolerance of retaliation

Holmes, J., & Olsen, L. (2016). *Dealing with disruptive physicians*. Medical Group Management Association. https://www.mgma.com/resources/human-resources/dealing-with-disruptive-physicians
Rosenstein, A. H. (2016). Human factors affecting disruptive physician behaviors and its impact on the business of medicine. *Journal of Business and Human Resource Management*, *2*(2), 1-10. http://crescopublications.org/pdf/jbhrm/JBHRM-2-012.pdf

Hickson, et al. Four Step Approach to Management of Disruptive Behaviors

- Step 1: "Cup of Coffee" conversation (Hickson, et.al., 2007)
  - Informal interaction with a peer or supervisor in quiet and private location
  - The initiator should state observed behavior and for allow response
  - Most physicians will self-correct at this stage
- Step 2: Awareness intervention and formal documentation begins
  - Pattern of behavior has been established through repeat offenses
  - Intervention conducted by authority figure and data is presented supporting the pattern of violations with support of the code of conduct
  - Recommendations are made: counseling, anger management, sensitivity training
  - 60% of physicians will show improvement at this point
- Step 3: Authority intervention
  - Occurs after the pattern continues
  - Conducted by authority figure
  - Performance improvement plans are created and documented
  - Evaluation and progress plans are set and documented
- Step 4: Disciplinary intervention
  - Pattern continues after previous interventions
  - Restriction of privileges or termination may occur

Hickson, G. B., Pichert, J. W., Webb, L. E., & Gabbe, S. G. (2007). A complementary approach to promoting professionalism: Identifying, measuring and addressing unprofessional behaviors. *Academic Medicine*, *82*(11): 1040-1048. https://doi.org/10.1097/ACM.0b013e31815761ee

Who Manages the Disruptive Physician?

- Approaches may differ from organization to organization
  - Depends on size and structure (M. Howe, personal communication, June 17, 2021)
    - More spread-out organizations may be addressed by local HR
    - Institutions may govern managing body: Human Resources (HR) vs. Medical Executive Committee (MEC)
  - Depends on employment status of physician (contract versus employed) may determine the managing body (Gallegos, 2018)
  - Depends on who files the complaint (e.g., staff member, another physician, supervisor) (Gallegos, 2018)
    - Staff reporters may trigger HR management while physicians may trigger MEC management (depending on organizational structure)
- Management by MEC
  - Moves slower due to appeals process and panel review
  - Health Care Quality Improvement Act (HCQIA) of 1986 provides legal protection for MEC's peer review process (42 U.S.C. § 11101 et seq) and the process is not discoverable in most cases (Gallegos, 2018)
- Management by HR
  - Moves quicker
  - Different rules may apply based on employment status (Gallegos, 2018)

Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq. https://www.ssa.gov/OP_Home/comp2/F099-660.html
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Conclusion

- Disruptive physicians can be difficult to manage.
  - Behaviors may be unintentional and not realized.
  - Physicians may become disruptive due to disengagement over time.
- Predetermined and consistent approach to prevention and management of disruptive behaviors demonstrates an organization's commitment to accountability and zero-tolerance.
- Continued work is needed to change the current cultural tolerance of disruptive behaviors.
  - Significant progress has been made.
  - Culture change is a slow process but will continue with increased recognition of causes and contributing factors; recognition of the impact on patients and worker wellbeing; and implementation of management techniques.