"The Impact and Consequences of Disruptive Behaviors: What Do We Need to Do"

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Lifeline Physician Operators Forum
October 3, 2015
Houston, TX

1

Case Example

Dr. DeSade is a General Surgeon who has been in practice for 25 years. He has an excellent reputation as being a skilled competent technician but is also known for his strong direct domineering personality. Over the past several months Dr. DeSade appears to be more "on edge". He has become less patient, more irritable, frequently yelling, making condescending remarks, and intimidating staff and colleagues to the point that that no one wants to work with him. Nurses frequently resist calling him in fear of getting reprimanded on the phone. When they do have an emergency he does not return calls in a timely manner putting patient safety at risk. One day in an intense moment during a procedure he screamed at the nurse for not having the right equipment and then went on to question where she was trained and if she knew what she was doing. He ignored her during the rest of the procedure. After the procedure the nurse tried to discuss the situation with Dr. DeSade but he said he didn't have time. She tried to page him later but he did not return her calls.

2

Addressing Disruptive Behaviors ….

She tried to discuss the episode with her nursing supervisor but the supervisor downplayed the event saying that he didn't mean it and that no harm was done.

There have been several other episodes like this with Dr. DeSade in the past but the number of incidents has recently escalated. He has had several "informal" conversations with members of the staff but they make no impact. He repeatedly complains about inefficiencies in staffing, scheduling, and concerns about competency in the OR. He resents the fact that someone has called him disruptive and would like to know who this was.

The organization has tried several times to talk with Dr. DeSade but have not made any progress. In moving forward, what do you think the next steps should be?

3

Learning Objectives

- Gain a better understanding of the nature and significance of disruptive behaviors and its negative downstream impact on organizational culture, staff and patient relationships, process flow, patient safety, and quality of care.
- Discuss the benefits of implementing appropriate education, training, and behavioral modification programs to better understand and modify behavioral traits to enhance communication and team collaboration.
- Discuss the importance of providing an effective early intervention program to help providers better adjust to the pressures of today's health care environment and improve staff and physician satisfaction and engagement.

4

Concern

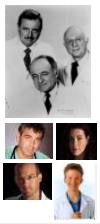

Science Times
The New York Times
Arrogant, Abusive and Disruptive – and a Doctor

USA TODAY
"Disruptive" doctors rattle nurses, increase safety risks

5

What's Happened to Our Image of Physicians?


1950s-1960s


1970s-1980s


1990s-2000s


2014+

6

Spectrum of Behaviors

Fully engaged: collaborative

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Engaged: participative

↓

Non- compliant

↓

Passive aggressive

↓

Disruptive

↓

Destructive

PHYSICIAN

- Overt
  - Course of action
  - Short term
  - Mal-intent?
- Noncompliance
  - Protocols
  - Charting
  - Availability
  - Communication

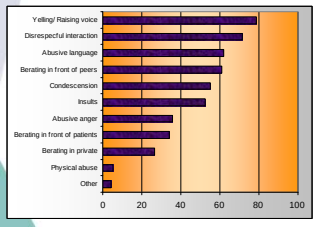
NURSE: Horizontal hostility

- Passive aggressive
  - Behind the scenes
  - Cliques
  - Middle management

7

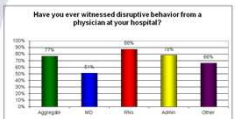
Definition:

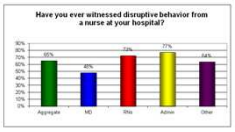
"Disruptive behavior" is defined as any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual harassment that can potentially negatively impact patient care.

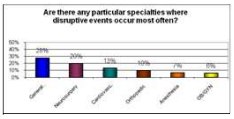


8

Who/ Where/ Frequency/ Impact








The Joint Commission Journal on Quality and Patient Safety

Leadership

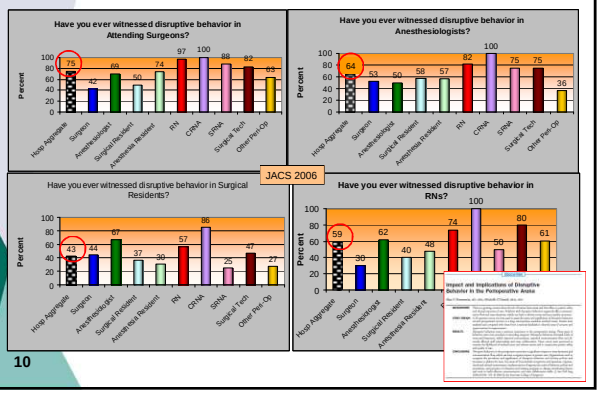
A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety

3-5% of staff exhibit disruptive behaviors

30-50% of staff are poor communicators

9

Peri-operative Assessment



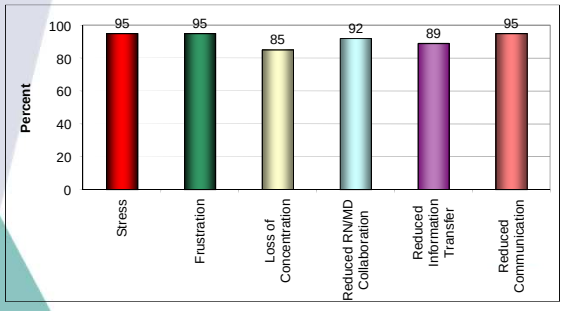
10

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	☐	☐	☐	☐	☐

11

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



12

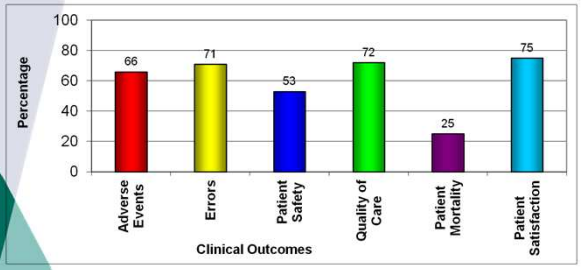
How Often Do You Think There Is a Link Between Disruptive Behavior and the Following?

	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

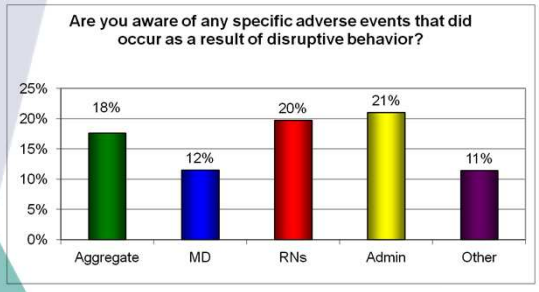
13

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



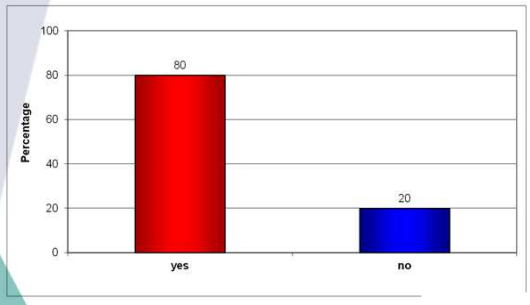
14

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



15

Could These Specific Adverse Events Have Been Prevented?



16

Comments:

- **Most nurses are afraid to call Dr. X when they need to, and frequently won't call. Their patient's medical safety is always in jeopardy because of this.**
- My concern is that the new nurses are afraid to call about patient problems and issues that truly need to be addressed in a timely manner impacting outcomes.
- Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended
- **Poor communication post-op because of disruptive reputation resulted in delayed treatment, aspiration and eventual demise**
- **MD was told twice that sponge count was off. She said "they will find it later". Patient had to be re-opened**.
- When patient brought to unit for GI bleeding patient saw MD yelling at nurses. Patient asked if that was his doctor. Yes. Patient refused treatment and was transferred to another hospital. I am retiring early and never recommend someone becoming a nurse
- "Are you aware of any specific adverse events ….?" Yes. Death as a result of disruptive behavior. Staff nurses advocated for better patient care but MD would not willing to listen to reason. As a result patient died. The doctor chose to undo all the help that various staff had been working on for weeks to get this patient the help so badly needed.
- Yes, many incidents are preventable if both parties are willing to listen to each other, but many doctors are unwilling to accept a nurse's opinion just as some nurses are unwilling to listen to the opinions of LVNs, techs or CNAs, and it may have to do with the entrenched pecking order that exists at most hospitals.
- **The disruptive behavior from nurses is much more upsetting because I expect that behavior from the surgeons NOT the nurses b/c I rely on them as my peers (RN)**

17

Call to Action

- Organizational reluctance:
  - Awareness/ tolerance/ desire
  - Financial
  - Hierarchy/ boundaries/ sacred saints
  - MD autonomy
  - Code of silence
  - Conflict of interest
  - Structure?/ Skill set?
- Risk of non- action:
  - Staff/ patient satisfaction
  - Staff retention/ recruitment
  - Quality and patient safety
  - Care efficiency/ medical errors
  - Fines/ Liability/ Litigation
  - Joint Commission standard
  - Reputation (media/ blogs)

American Journal of Medical Quality September 2011

18

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
- Personal issues

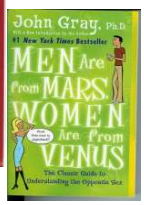
⇨ Behavioral health/wellness:

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

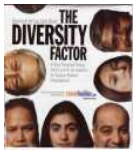
19

Internal Factors

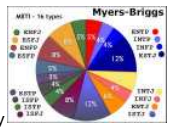
Age & generation



Gender



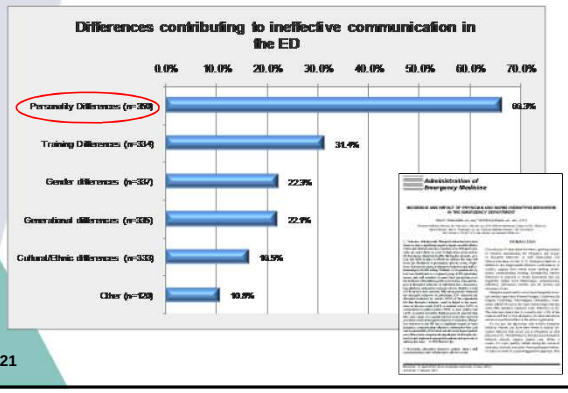
Culture & Ethnicity



Life/ Personality

20

Survey Results



21

Structured 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

22

External Factors:

Training

Reform

Stress & Burnout

23

Structured Training: Physician Management

- Medical School admissions
- Curriculum re-design
- Business education
- Job selection
- On-boarding
- On-going education
- Resource support
- Work-life balance
- Career management

24

Concerns and Consequences

Physicians/ Staff

- Decreasing job satisfaction
- Feelings of irritability, moodiness, cynicism, apathy
- Sleep disturbances, fatigue
- Negative impacts on physical health
- Negative impacts on emotional health (anxiety, depression, behavioral disorders)
- Behavior/ performance liability
- Patient safety issues
- Patient satisfaction
- Career issues

Organization

- Culture and morale
- Increased turnover, recruitment and retention challenges
- Poor care coordination/ productivity/ compliance
- Disruptive behaviors
- Patient safety and quality issues related to poor responsiveness, ineffective communication, judgment errors causing adverse events
- Patient satisfaction/ reputation
- Penalty/ liability

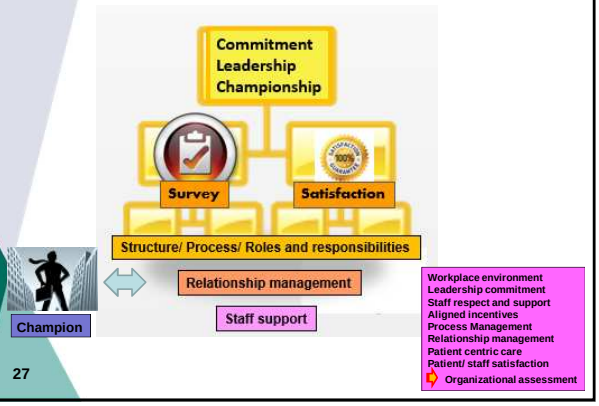
25

Recommendations: Ten Point Plan

1. Organizational Culture/ Work environment:
   - Leadership commitment/ structure and process
2. Education
   - Education: Responsibility & accountability
3. Relationship training
   - Diversity/ Sensitivity/ Stress/ Conflict management
   - Emotional Intelligence/ Customer satisfaction
4. Communication skills training
   - Scripting/ Listening/ Team collaboration
5. Policies and procedures
6. Reporting mechanisms
7. Intervention
   - Tiered approach
8. Staff support
   - Administrative/ Clinical/ Behavioral
9. Physician engagement
10. Thank you
    - Job satisfaction

26

Organizational Culture



27

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

28

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

29

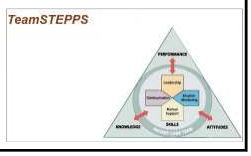
Potential Communication Barriers

- History (demographics/ values/ attitudes/ personality)
- Training/ Hierarchy
- Environment
- Awareness and sensitivity/ E.I./ Cultural competency
- Command and control
- Focus (Organ vs. disease vs. patient)
- Time/ priority/ Difficult conversations
- Segmented care: ED ⇨ On-call Attending ⇨ Consultant ⇨ Hospitalist ⇨ Primary Care MD
- Fatigue/ stress/ burnout
- Frustration/ Dissatisfaction
- Receptivity/ acceptance

30

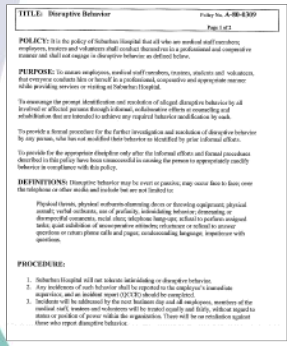
Team Collaboration Skills (TeamStepps)

- 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



31

Code of Ethics/ Behavior Policy


TITLE: Disruptive Behavior

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 assure 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 working at Suburban Hospital.

To encourage the prompt identification and resolution of alleged disruptive behavior by all involved or affected persons through collateral, 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 disciplines 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 modes and include but are not limited to:

Physical threats, physical/ workstation-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:

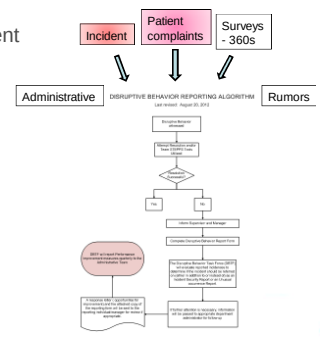
1. Suburban Hospital will not tolerate intimidating or disruptive behavior.
2. Any incidences of such behavior shall be reported to the employee's immediate supervisor, and an incident report (QCCR) should be completed.
3. Incidents will be addressed by the next business day and all employees, members 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.

Agreement
All staff
Definition
Standards
Expectations
Compliance
Ramifications
Follow up

32

Reporting Disruptive Behaviors

- Zero tolerance policy
- Non-punitive environment
- Confidentiality
- No repercussions
- Reporting vehicle
  - Consistency
  - Non- biased evaluation
  - Action oriented
  - Provide feedback
- Barriers
  - Confidentiality
  - Retaliation
  - Impact?



33

Intervention Strategies/ Staff Support

- Prevention
  - Cultural assessment
  - Raise awareness/ understanding/ Emotional Intelligence
  - Education/ Training/ Motivation/ Support
- Pre-event early intervention
  - Hiring/ On- boarding/ On going assessment/ discussion/ resolution
  - Pro- active support
    - Administrative (scheduling/ capacity management/ Scribes)
    - Clinical (NPs/ PAs/ Care coordinators)
    - Behavioral (Relationship training/ Coaching and Counseling/ Wellness Committees/ Physician Employee Assistance Programs (EAPs)/ Behavioral modification programs
- Trend based intervention (4 tiers)
  - Coffee time
  - Coaching/ Counseling
  - Behavioral modification
  - Enforcing compliance

34

Physician Engagement

Meeting the Physician's Needs

Boards can improve engagement through support, recognition and education

What Makes a Physician Feel Engaged?

Element of Engagement	Important to Feeling Engaged	Trios of Current Practice
Respect for my competency and skills	9.0	7.9
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	8.3	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

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 those efforts.

To foster physician alignment, hospitals and systems have implemented a variety of strategies, including adopting best practice guidelines and protocols, standardizing supplies, providing aggressive case management interventions, implementing computer-assisted alerts and reminders, and

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.

Link to personal/ core values
- High quality care
- Improved care efficiency
- Improved productivity
- Improved outcomes

Improve relationships
- Physician input
- Physician participation
- Organizational responsiveness
- Reduced stress
- Recognition

Improve satisfaction

Improve well-being

Satisfaction: Wants and Wishes

Physicians:

- Good patient care
- Happiness/ success/ respect
- Work-life balance
  - Work hours/ control
  - Rest and relaxation
  - Wellness activities
- Thank you
- Administrative support
  - Respect and concern
  - Input and understanding
  - Scheduling/ work flow
  - Clinical
  - Financial
  - Behavioral

Organizations:

- Mission/ Culture/ Morale
- Reputation
- Recruitment and retention
- Less disruption/ productivity
- Compliance
- Communication and collaboration
- Conflict resolution
- Quality/ Safety
- Professional behaviors
- Patient/ staff satisfaction
- Physician satisfaction/ success

36

Solutions

- Recognize increasing complexity/ change/ care re-design
- Physicians/ Nurses/ Staff a precious resource
- Just trying to do their job
- Stressed/ fatigued/ frustrated/ angry/ burnt out
- Reluctant to seek outside help
- Listen to what they have to say
- Provide pro-active empathetic operational, clinical, behavioral support
- Improve communication, collaboration, conflict management, and relationship skills
- Hold accountable/ intervene/ support/ counsel
- Focus on physician/nurse/ staff/ patient satisfaction
- Recognize and reward

37

Questions?

Teaching Doctors to Be Nicer

New Accreditation Rules Spur Medical Schools to Beef Up Interpersonal-Skills Training

By Laura Landro

IN HER SECOND YEAR as a resident at Indiana University School of Medicine, Michelle Eliff had a "rude awakening" about the medical profession.

It wasn't the chaos of the emergency room or the grim work of caring for dying patients that came as a shock. It was the callous behavior of the doctors she observed in the hospital. "No one told me what it would be like to perform an autopsy on a baby who died from child abuse, while doctors in the room laughed with gallows humor," says Dr. Eliff, now a temporary faculty member.

Medical educators call it the "hidden curriculum"—the negative messages medical students get in from-the-trenches residency training that seem to contradict everything they had been taught about ethical behavior, compassionate care and professionalism. Researchers say the most powerful influence on future physicians is the behavior they observe on a day-to-day basis in the medical-school environment. And what they often learn is how to be cold, intimidating, inflexible, narrow-minded and disrespectful of subordinates and patients.

Medical schools have long acknowledged the problem. In the past few years, there has been a movement to add courses on professionalism, empathy and communication skills. But there is mounting evidence that the new curriculum hasn't been effective. Paul Haidet, a professor at Baylor College of Medicine and an internist at the Houston VA Medical Center, has helped measure such efforts at 14 medical schools and says his surveys show the coursework is routinely undermined by what students are watching doctors in action.

New standards from the Accreditation Council for Graduate Medical Education are spurring medical schools to move more aggressively than ever to change their culture. Starting next year, the council will require programs to demonstrate how effective they are in teaching students six basic "competencies," which include compassionate care, ethical behavior and professionalism along with mastery of medical knowledge and technical skills. The accreditation council, which certifies 7,800 medical residency programs in the U.S., has traditionally accredited schools so long as the programs' structure had the potential to educate residents.

But the council began developing the new standards several years ago in response to growing criticism—much of it from the medical profession—that residents weren't adequately prepared to practice in the rapidly changing health-care environment, where patients are demanding better communication, and concerns about slipshod care, medical errors and patient safety are eroding their trust in doctors. "We have to prepare the next generation of doctors differently—they can't be bad walking textbooks," says David Leach, the ACGME's executive director.

A number of medical schools including Indi...

Please Turn to Page D6, Column 1

Actors posing as patients help a student at Indiana University School of Medicine learn to deliver bad news and show sensitivity.

ahrosensteinmd@aol.com

38