A growing number of organizations recognize that disruptive behavior may compromise patient care. Numerous reports of disruptive physician behavior in the media and literature demonstrate its negative effect on patient care and other staff. The problem is so significant that, in July 2008, The Joint Commission issued the Sentinel Event Alert 40, “Behaviors that undermine a culture of safety” (1). The American Medical Association’s Report of the Council on Ethical and Judicial Affairs defines disruptive behavior as “a style of interaction...that interferes with patient care...[and] that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care” (2). Several types of behavior can create distress or negatively affect morale in the work environment. The following are examples of disruptive physician behavior:

- Profane or disrespectful language
- Yelling, berating, or insulting others
- Throwing instruments, charts, or other objects
- Bullying, demeaning, or intimidating conversations
- Criticizing other health care providers or organizations in front of patients or other staff
- Sexual comments or innuendo (3)
- Insidious intimidation, such as sarcasm, nonverbal gestures, or passive–aggressive behavior (4)

Yelling, insulting others, or a refusal to carry out duties are among the most common types of behaviors reported. The targets of such behavior are often coworkers with less status than the offending individual as exemplified by the relationships between staff physicians and nurses, residents, or medical students (5). A consequence of these behaviors is corruption of teamwork.

Best estimates suggest that a small number of physicians (3–5%) are responsible for most of the reported disruptive behavior (5). Although relatively few physicians exhibit these behaviors, 95% of physician executives reported knowing of “disturbing, disruptive and potentially dangerous behaviors on a regular basis” (6). One study concluded that many disruptive physicians began to show evidence of such behavior as medical students (7), highlighting the potential importance of recognizing behavioral patterns early in career development.

Ultimately, disruptive behavior may have a negative effect on patient safety and quality of care by causing others to avoid the disruptive physician. Staff may refrain from asking the disruptive physician for help or clarification and hesitate to make health care-related suggestions about patient care. Additionally, patients who witness the behavior may lose confidence in the physician as well as the institution.

Several factors contribute to a reluctance to systematically confront disruptive behavior. These include financial concerns, such as losing physician referrals, threats to take one’s practice to another hospital, and fear of retribution (eg, lawsuit for antitrust or defamation of character) (8). Nevertheless, institutions and practices should develop a multifaceted approach for dealing with disruptive behavior. It is essential that the administration fully support and show commitment to addressing and correcting disruptive behavior. An effective approach, for example, would include the components described as follows.

**Establishing a Code of Conduct**

The Joint Commission requires that a code of conduct be established that “defines acceptable, disruptive, and inappropriate behaviors” (9). When establishing a code of conduct, institutions should stipulate behavioral
standards and the consequences for failure to comply. Specific examples of unacceptable behavior should be included to provide guidance for leadership, employees, and staff in determining what constitutes disruptive behavior. As required by The Joint Commission, a process for managing disruptive and inappropriate behaviors should be created and implemented (9). At initial appointment and each reappointment, each medical staff member should acknowledge acceptance of both the behavioral standards and the consequences of failure to comply, as detailed in the code of conduct, consistent with provisions contained in the medical staff bylaws. A training program about the code and attendant behavioral expectations may be included as part of this approach.

Instituting a Monitoring and Reporting System

A monitoring system may be considered. Systematic review could include regular surveys of staff, focus groups, peer and team member evaluations, and direct observation to detect incidents of disruptive behavior (3). Implementing a confidential system for reporting also could include routine confidential evaluations and formal analysis of complaints from patients, coworkers, or others. These evaluations should be provided in a confidential manner to the appropriate administrative individual, such as the chair of the department of obstetrics and gynecology or the chief of staff for resolution. The individual in question should be notified and given an opportunity to respond to the complaint.

Educating, Reporting, and Training

A concerted effort should be made within each organization to educate the entire staff (ie, medical, nursing, and ancillary staff) about patient safety exposures that are associated with disruptive and inappropriate behaviors. The importance of reporting these behaviors should be emphasized as a mechanism to eliminate these behaviors and increase patient safety. Confidentiality of reporting should be emphasized to ensure privacy and reduce potential fears about retribution (10). Additionally, leaders of both the medical and nursing staff should undergo specific training in intervention techniques to help counsel individuals in their respective disciplines who exhibit disruptive or intimidating behavior.

Establishing a Resolution

Any complaints should be handled in a confidential manner with interventions designed to assist in behavioral change whenever possible. Complaint resolution should be consistent with medical staff, departmental, or other institutional policies and procedures. Appropriate steps should be taken to resolve the problem. Disciplinary actions should be appropriate to the type of infraction and frequency of behavior, including any mitigating factors. Each institution should establish thresholds for taking action that depend on the severity of the behavior. Some actions may merit zero tolerance. All attempts to address disruptive behavior should be clearly and thoroughly documented. The department chair or appropriate leader should be informed of individuals with persistent problem behaviors and should be responsible for establishing an appropriate response. The response may include some or all of the following steps:

- Face-to-face meeting with the physician exhibiting disruptive behavior
- A follow-up meeting (if the problem is still unresolved), resulting in a behavioral contract setting forth any disciplinary actions that may be taken if the disruptive behavior persists
- Formal counseling
- Administrative hearing
- Summary suspension for egregious behavior

Assessment and treatment programs that are tailored to the individual should be made available as necessary. Special attention should be given to the possibility of substance abuse or psychiatric diagnosis, which can contribute to disruptive behavior. At least initially, these programs should attempt to enable the individual to continue or resume practice.

Conclusion

Disruptive physician behavior creates a difficult working environment for all staff and threatens the quality of patient care and, ultimately, patient safety. Colleagues often find confronting these individuals difficult. Therefore, it is important that clear standards of behavior are established and all staff are informed of such standards, as well as the consequences of persistent disruptive behavior. Confidential reporting systems, as well as assistance programs for the offending physician, should be established. A clear hospital-wide policy and procedure relating to disruptive behavior should be available to all physicians and uniformly enforced by hospital administration.

References


