Continuing Education Webinar

Incivility and Intimidation:
A Recurrent Threat to Perinatal Safety

Audio Options:
• Broadcast Audio: Please ensure computer volume and speakers are enabled
• Dial-in #: 1-303-248-0285  Access Code: 5041508
• All participants will automatically be placed in “listen-only” mode.

This webinar will be recorded and available on the NPIC/QAS website www.npic.org.

NPIC/QAS is a non-profit membership organization of perinatal centers across the United States. Our Perinatal Center Data Base (PCDB) has collected over 12 million inpatient perinatal discharges since it was established in 1985. NPIC/QAS is dedicated to the improvement of perinatal health through comparative data analysis, health services research, and professional continuing education.

If you would like more information on NPIC/QAS please email mservices@npic.org.
Nurse Planner:
Carolyn L. Wood, PhD, RN, Clinical Nurse Consultant

Purpose/Goal(s) of this Education Activity:
The purpose/goal(s) of this activity is to enable the learner to expand knowledge on the management of disruptive behaviors between healthcare team members.

Objectives:
- Recognize the components and spectrum of disruptive behavior
- Examine how disruptive behavior can affect the organization and increase risk for errors in the management of obstetrical patients
- Explore how organizations in conjunction with medical staff leadership can eliminate disruptive behaviors
1.0 Contact Hour:
This activity has been submitted to Northeast Multistate Division (NE-MSD) for approval to award contact hours. Northeast Multistate Division (NE-MSD) is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

1.0 AMA PRA Category 1 Credit™:
Accreditation: Women & Infants Hospital is accredited by the Rhode Island Medical Society to sponsor intrastate continuing education for physicians. Women & Infants Hospital designates this online educational activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity has been approved for 1.0 Risk Management Credit.

American Society for Healthcare Risk Management (ASHRM):
This meeting has been approved for a total of 1.0 contact hours of Continuing Education Credit toward fulfillment of the requirements of ASHRM designations of FASHRM (Fellow) and DFASHRM (Distinguished Fellow) and towards CPHRM renewal.

Content Code: 1 - Clinical/Patient Safety
Education Type Code: 1 - Educational Program
Dec 7, 2016
Larry Veltman, MD, DFASHRM, FACOG

Dr. Veltman practiced obstetrics and gynecology in Portland for 30 years. He was Chair of the Department of Ob/Gyn, Providence St. Vincent Medical Center in Portland, Oregon for 9 years. He was Chair of the Professional Liability Committee of the American College of Obstetricians and Gynecologists and was Vice Chair of ACOG’s Committee on Patient Safety & Quality Improvement. Dr. Veltman is certified in professional healthcare risk management. He currently serves on the Board of NPIC/QAS. He has published articles and given presentations on teaching risk management to physicians, achieving patient safety in obstetrics, vaginal birth after cesarean section, and patient safety aspects of disruptive and intimidating behavior.

**Learning Objectives:**

Upon completion of this activity, participants should be able to:

- Recognize the components and spectrum of disruptive behavior
- Examine how disruptive behavior can affect the organization and increase risk for errors in the management of obstetrical patients
- Explore how organizations in conjunction with medical staff leadership can eliminate disruptive behaviors

**Media used for activity:**

- Live event – webinar
- Archived event – electronic

**Method of Participation:**

- Participants are required to attend the live event through webinar format.

**Estimate time required for completion:**

- One hour

**Date of original release:**

- December 7, 2016

**Activity termination date:**

- 1 Year after date of original release

**Scope of Practice:**

- This activity is appropriate for the current and future scopes of practice for attending physicians and other clinicians and Allied Health professionals involved in perinatal care.

**Core Competencies:**

- Medical Knowledge and Patient Centered Care

**Accreditation:**

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**Disclosure:**

- Larry Veltman, MD, DFASHRM, FACOG has no relevant financial relationships to disclose.

- No other persons responsible for the planning or implementation of this activity have any financial interests to disclose.

**Policy on Privacy and Confidentiality:**

To obtain the Women & Infants Continuing Medical Education Policy on Privacy and Confidentiality, call the WIH CME office at 401-274-1122, ext. 4-2383.

**Further Information:**

For more information regarding this program please email education@npic.org or call 401-274-0650.
Disclosures and Successful Completion of this Activity

No commercial support has been provided for this activity.

No one involved in planning or presenting this program has a conflict of interest.

There will be no discussion of off-label usage of any products.

In order to successfully complete this activity and receive 1.0 Contact Hour(s) or 1.0 AMA PRA Category 1 Credit™, you must attend/watch the webinar and return the completed post-test/evaluation to NPIC/QAS.
Incivility and Intimidation: A Recurrent Threat to Perinatal Safety

National Perinatal Information Center
Larry Veltman, MD, FACOG
December 7, 2016
We’re Back!

Disruptive Professional Behavior: A (Not So) Hidden Threat to Patient Safety

National Perinatal Information Center
Larry Veltman, MD, FACOG

May 8, 2013
Setting The Stage

• An obstetrician says to a newly hired nurse caring for his patient, “Let me talk to a real nurse.”
• An anesthesiologist tells a laboring woman’s nurse, “I’m going to bed; it’s now or never for her epidural.”
• A nurse on the night shift does not notify a physician about an abnormal fetal heart tracing because she was reprimanded for calling another physician the night before with similar concerns.
• A nurse rolls her eyes and walks away from another nurse’s request for help saying, “She’s not my patient.”
Here Is What I Think You Know...

• A few physicians and nurses ...

• Eliminating this behavior is frustrating...

• A threat to patient safety...

• Leadership issues...

• The organization suffers...
Incivility, Disruptive, and Intimidating Behavior

- Spectrum
- Errors
- People
- Elimination
We know it when we see it

"Damn it, nurse! I didn't ask for a twenty. I asked for a ten and two fives."
The Spectrum of Disruptive Behavior (QuantiaMD/ACPE 2011)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Have encountered</th>
<th>Most concerned about</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrading comments or insults</td>
<td>59%</td>
<td>51%</td>
</tr>
<tr>
<td>Discriminatory behavior</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Inappropriate joking</td>
<td>40%</td>
<td>17%</td>
</tr>
<tr>
<td>Incompetence</td>
<td>27%</td>
<td>26%</td>
</tr>
<tr>
<td>Physical assault</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Profanity</td>
<td>41%</td>
<td>19%</td>
</tr>
<tr>
<td>Refusal to cooperate with other providers</td>
<td>57%</td>
<td>54%</td>
</tr>
<tr>
<td>Refusal to follow established protocols</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Retaliation</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Spreading malicious rumors</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Throwing objects</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Yelling</td>
<td>54%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Our Best Benchmarks

• Survey of 2124 nurse and physician executives
• 97.4% saw disruptive behavior in their organization
  • Most commonly “several times” a year (30% said “weekly”)
  • Refusal to work together – 38.4%
  • Refusing to speak to each other – 34.3%
  • Physical abuse (throwing) – 18.9%
  • Degrading comments and insults – 84.5%
  • Yelling – 73.3%
• 70% said it was recurrent problem with the same few physicians, 2-5% of the medical staff (2004)
• Disruptive healthcare professionals:
  • 45.4% physicians; 6.8% nurses; 47.9% even mix of MDs and RNs
The Disruptive Physician

Equal opportunity impairment

- Time in practice
- Race, ethnicity, gender
- Specialty
- Place of training
- Often “good” doctors (good clinicians)
The Disruptive Physician: Behavioral Themes

- It is personal and usually angry
- Uses “patient care comes first” to justify behavior
- Always right about the medicine
- Insulting and power based
- Rare to have insight into effects of behavior
- Goes undercover for various lengths of time; can be turned on and off
- Litigious
- Disrupts the smooth operation of the organization through subverting policy, innuendo, gossip, non compliance – “stirs the pot”
How Does This Behavior Evolve?

• In training programs, modeling teachers, attendings, and television
  • “You haven’t had a good day unless the nurses are mad at you.”
  • “I’ll tell you what. Why don’t you go home, go to medical school and then come back so we can discuss the right way to treat her.”

• We don’t always know how we come across

• Poor anger management skills

• Failed expectations for perfection

• New wave of physician frustrations
  • Decreased autonomy, decreased reimbursements, mergers and practice acquisitions, increased government regulations, poor business acumen, EHR
What Else Could the Behavior Mean?

• Sign of other impairments (drugs, alcohol)
• Sign of diminished competence, dementia
• Sign of stress
• Sign of mental illness
The Cascade of Disrespect: Incivility

- “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect.”

- “rude and discourteous behavior, displaying a lack of regard for others.”

(Pearson, Andersson, and Wegner (2001))
The Cascade of Disrespect

Begins with INCIVILITY

- May be precipitated by stress
- Lack of insight how incivility affects others
  - We don’t always know how we come across
- Lack of accountability

The Cascade of Disrespect

If the process and the cycle is unchecked:

• May accelerate to INTIMIDATION, BULLYING, and, rarely, VIOLENCE

• May select targeted individuals
  – Power based
  – Inexperienced, unassertive, passive personalities are often targets
  – Less often peers

• May become pervasive and normalized in the organization
How Incivility, Intimidation Threatens Patient Safety and Effects the Organization

• Increase stress within the healthcare team
• Decreases willingness to communicate
• Decreases overall vigilance
• Inhibits nurses and pharmacists from questioning orders or patient care plans
• Contributes to nursing shortage
• Expensive for the organization
The silent organizational pathology of insidious intimidation

By Theresa Zimmerman, RN, JD, ARM, CPHRM, DFASHRM, and Geri Amori, PhD, ARM, CPHRM, DFASHRM

While organizations are valiantly striving to address acts of disruption among physicians and nurses, a silent and yet equally disruptive pathology is spreading through the veins of the organization. This behavior is found among all ranks and responsibilities, from the C-suite to the housekeeping staff. It occurs daily and is rarely reported. It continues because its nature is such that it is difficult to measure, the victims often feel helpless, and the perpetrators are often those in positions that are not normally perceived to be as essential to the flow of patient care. Nonetheless, this insidious intimidation chills communication, reduces morale, and ultimately harms patients. Organizations that desire a culture of safety and comfort must address this behavior through individual coaching, education of all staff, a willingness to tackle system frustrations that amplify and perpetuate the behavior, and establish processes for dealing fairly and firmly with the behavior.
Figure 1 — Verbal abuse and mean job satisfaction, organizational commitment, and intent to stay.
The Cost of These Behaviors

- Recruitment and Retention
  - 1% Turnover in nurses = $300,000/year

- Adverse Events
  - $17 – 29 billion x 17% = $289 – 493 million/year

- Malpractice Costs
  - $521,560 per case; fines $25,000 – $100,000

- Communication Inefficiencies
  - $4 million / 500 bed hospital/year

- Other hidden costs
  - Harassment suits, disciplinary proceedings and lawsuits from providers, damaged reputation, adverse publicity, decrease patient satisfaction, stress and increase chance for additional errors

Decreased Willingness to Communicate

• Why don’t some speak up?
  – “I don’t want to be called stupid.”
  – “What if the doctor yells at me?”
  – “I know I will pay for it.”
  – “What if I’m wrong?”
  – “In my culture we do not question men, especially physicians.”
Impact of Past Events

• How did my last interaction with that individual go?

• How does what I observed amongst my peers effect my future actions, opinions, behavior, relationships?
Impact of Observation

**Observing Rudeness** – Witnessing rudeness reduces observers performance, creativity, citizenship behaviors, and actually decrease concern for others in the organization.

Disruptive Behavior and Adverse Outcomes

(American J. of Nursing, January 2005)

17% (249) Adverse Event As A Result of Disruptive Behavior
What About Perinatal Care?

Is Incivility an Underlying Threat to Safety in Obstetrics?

By Larry Wolkow, MD, FACOG, CPHRM

A resident is called stupid and a fool when she makes a minor error during surgery.

An obstetrician says to a newly hired nurse caring for his patient, “Let me talk to a real nurse.”

An anesthesiologist tells a laboring woman’s nurse, “I’m going to bed; it’s now or never for her spiritual.”

A nurse on the night shift does not notify a physician about an abnormal fetal heart tracing because she was reprimanded for calling another physician the night before with similar concerns.

A nurse rolls her eyes and walks away from another nurse’s request for help, saying, “She’s not my patient.”

Disruptive behavior? Perhaps these examples do not meet everyone’s threshold. However, few would deny that incivility characterizes these awkward interactions, which all occurred in labor and delivery. In 2007, a study of disruptive behavior in labor and delivery units on the West Coast of the United States found that 60% of nurses reported that disruptive behavior was currently occurring on their unit (Valman, 2007).

Also in 2007, the American College of Obstetricians and Gynecologists (ACOG) issued a Committee Opinion on disruptive behavior, which concluded, “Disruptive physician behavior creates a difficult working environment for all staff and threatens the quality of patient care and ultimately patient safety” (ACOG, 2007).

In 2008, the Joint Commission issued a Sentinel Event Alert #40: “Behavior that Undermines Cultural Safety.” New standards set by the Joint Commission require organizations to define “acceptable and unacceptable and inappropriate behaviors” (EP 4) and to create and implement a process for managing those behaviors (EP 5). In addition, interpersonal skills and professionalism should be addressed in the educational process of the medical staff (The Joint Commission, 2008).

Has anything changed since the Sentinel Event Alert or since the ACOG Committee Opinion on disruptive behavior? Does incivility “come with the territory” of perinatal care? Do we still have behaviors that undermine a culture of safety? One might answer vaguely, “It depends.” Yes, most organizations have complied with the Joint Commission standards with written policies and a code of conduct that defines the spectrum of disruptive behavior and lists measures to eliminate such behaviors from the organization. And some organizations have attempted to raise the consciousness of medical staff leaders about unprofessional behavior through additional presentations and training. And there have been some successes in removing high-profile practitioners who demonstrate chronic disruptive behaviors.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0320</td>
<td>Stomach Careful, Baby Post, Cervix 7-8cm, 1/2</td>
</tr>
<tr>
<td>0340</td>
<td>PB 8-9cm, ER card</td>
</tr>
<tr>
<td>0355</td>
<td>Uncontrollable urge to push</td>
</tr>
<tr>
<td>0350</td>
<td>Baby crowning</td>
</tr>
<tr>
<td>0353</td>
<td>Controlled RN Del. of Viable female &amp; Nuchal cord X2</td>
</tr>
<tr>
<td>0356</td>
<td>ER here</td>
</tr>
<tr>
<td>0356</td>
<td>ER here</td>
</tr>
<tr>
<td></td>
<td>Average 8-9</td>
</tr>
</tbody>
</table>
Have There Been Specific Adverse Outcomes As A Result of The Behavior?

- Yes = 13 (42%)
- No = 18 (58%)

Professionals Exhibiting Disruptive Behavior (Total number of responses = 34)

Horizontal Violence
Nurse Against Nurse

“We eat our young.”

**Overt:** Name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip, shouting, blaming, put-downs, raising eyebrows, etc.

**Covert:** Unfair assignments, eye-rolling, ignoring, making faces (behind someone’s back), refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, etc. (Kathleen Bartholomew)

Bartholomew, K. Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young, HCPro, Inc. 2006
“One of the nurses is just plain mean.”
“She terrorizes everyone including the physicians.”
“We’re all afraid of her.”
“She has a way of making you feel small or incompetent.”
“The nurse manager knows but won’t do anything since she picks up a lot of the needed shifts.”
“That just gives her more time to cause trouble and no one else wants to pick up the shift to work with her.”

Simpson, James & Knox (2006) JOGNN
What Can the Organization Do?

• **Disruptive Physician Behavior:**
  
  • **Team effort**: Medical staff, administration, Board, HR (no weak links)
  
  • **Responsibility**: Medical staff leadership
  
  • **The power**: Medical staff leadership, by-laws
  
  • **Elimination of the behavior**: The goal of the organization
“We know it’s wrong, and we really want to do something about it, but...”

• At what point and with what formality do we intervene?”

• Can we really change disruptive behavior?”

• Will I (we) be protected if there is a lawsuit?

• How can we eliminate it and make it “stick”
When Shall We Intervene?

• Intervene early

• Do you have a tiger by the tail?

• It is okay to be informal at the onset, but stay ahead of the curve or you risk a chronic problem
Levels of Intervention

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Collegial, informal, usually the department chair, letter of expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>“Collegiality at the edge”, may involve several people, requirements, warnings, recommendations for assessment, letter in file</td>
</tr>
<tr>
<td>Level 3</td>
<td>Formal, statement of one more event will involve disciplinary action</td>
</tr>
<tr>
<td>Level 4</td>
<td>Disciplinary action</td>
</tr>
</tbody>
</table>
Can We Really Change Behavior?

It Is Easy To Become Cynical

ALICE, I'VE BEEN ASKED TO COUNSEL YOU ABOUT YOUR ABUSE OF CO-WORKERS.

THE THEORY IS THAT I CAN ALTER YOUR PERSONALITY BY TALKING TO YOU.

IF YOU FEEL A TINGLE, THAT'S PROBABLY YOUR DNA CHANGING.
When Can We Really Change Behavior?

How Frequent is the Behavior?

- Frequent
  - How Deeply Entrenched is the Behavior?
    - Change is easier
  - Change may be difficult or impossible

- Infrequent
  - Response to a Particular Situation
  - Expression of an Individual’s Character

How Deeply Entrenched is the Behavior?
Dear Peggy,

My sincere apologies for being a "bad cat." There is no excuse for being rude. I have not raised my voice to a nurse in close to 20 yrs. I'm sorry I lost it with you.
Are You Protected?

Health Care Quality Improvement Act of 1986:

“...any person who participates or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State... ”
Eliminating Disruptive Behavior

1. Administration, the Board, medical staff leadership (MEC), and HR all announce zero tolerance…and means it.

2. Have effective bylaws, a disruptive behavior policy, code of conduct, and behavioral contracts.

3. Use/create established reporting mechanisms.

4. Establish a hierarchy of responsibility.

5. Train leadership in an effective intervention style.

6. Make appropriate referrals.

7. Deny privileges.
Eliminating Disruptive Behavior: #1 - Zero Tolerance

• In conjunction with the administration AND the Board, the medical staff announces zero tolerance for disruptive behavior and prepares to enforce the policy
• Best verified with a behavioral contract signed with appointment, reappointment, or employment
• It applies to new professionals (part of orientation)
• And it applies to established professionals:
  – Even if the physicians is a big producer
  – Even if he/she is a medical staff leader
  – Even if it has been tolerated for years
Are There Organizational Interventions To Reduce Incivility?
Assessment Tools

• WIS – workplace incivility scale
• CWBG – counterproductive workplace behavior checklist
• Nursing Incivility Scale
  (Journal of Nursing Measurement, Vol. 18, 2010)
• Straightforward Incivility Scale
• Safety Culture Assessment Checklist
  (Joint Commission Big Book of Checklists)
VHA Civility Scale

• Q1 (Respect): People treat each other with respect in my work group.

• Q2 (Cooperation): A spirit of cooperation and teamwork exists in my work group.

• Q3 (Conflict Resolution): Disputes or conflicts are resolved fairly in my work group.

• Q4 (Coworker Personal Interest): The people I work with take a personal interest in me.

• Q5 (Coworker Reliability): The people I work with can be relied on when I need help.

• Q6 (Antidiscrimination): This organization does not tolerate discrimination.

• Q7 (Value Differences): Differences among individuals are respected and valued in my work group.

• Q8 (Supervisor Diversity Acceptance): Managers/Supervisors/Team leaders work well with employees of different backgrounds in my work group.
CREW
Civility, Respect, Engagement in the Workforce

Civility, Respect, Engagement in the Workforce (CREW)
Nationwide Organization Development Intervention at Veterans Health Administration

The Journal of Applied Behavioral Science
CREW

The mechanism of change believed to be at work during CREW interventions is that, for the intervention period...organizations commit to giving time, attention, and support to having regular (weekly) workgroup-level conversations about civility.
Figure 1. Interaction of time and intervention for civility.
Eliminating Disruptive Behavior: #2 - Bylaws, Policy, Employment Agreements

Medical Staff membership (employment) dependent on:

“Ability to work harmoniously with others...”

“...allow(ing) the hospital and medical staff to operate in an orderly manner...”

“Behavior that ‘affects or may affect the quality of patient care.’”
Code of Conduct Policy

• Define the spectrum of behavior
• Define which medical staff leaders will take responsibility
• Defines the level of formality
• Defines necessity of documentation
• Defines the scope of disciplinary options when the behavior continues
• Contains behavioral contracts, code of conduct
Eliminating Incivility/Intimidation:

#3 – Documentation/Reporting

You have to write it down!
You have to report it!

- Date, time, patient, witnesses, others
- Circumstances that precipitated behavior
- Factual objective description of behavior
- Consequences (actual or potential)
- Action taken to remedy situation
Reporting Challenges

• What you need:
  – Maximize accessibility
  – Minimize anxiety
    • What will happen to the report?
    • Who else will see it?
    • Do I jeopardize myself, my career, my colleagues?
    • Can I get into legal trouble?

• A written policy “what the consequences of reporting could be; and what rights, privileges, protections, and obligations (regarding reporting) people may expect”.

(Dekker, S., Just Culture. Restoring Trust and Accountability in Your Organization. CRC Press. 2016.)
CORS℠

The Joint Commission Journal on Quality and Patient Safety

Safety Culture

Using Coworker Observations to Promote Accountability for Disrespectful and Unsafe Behaviors by Physicians and Advanced Practice Professionals

Lynn E. Webb, PhD; Roger R. Dmochowski, MD; Ilene N. Moore, MD, JD; James W. Pickens, PhD; Thomas F. Catron, PhD; Michelle T. Troyer, BS; William Martinez, MD, MS; William O. Cooper, MD, MPH; Gerald R. Hickson, MD

Table 1. Co-Worker Observation Reporting System℠ (CORS℠) Characteristics Associated with Successful Initiatives for Improving Safety and Quality

<table>
<thead>
<tr>
<th>Does this project have sufficient levels of</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
</tr>
<tr>
<td>1. Committed leadership prepared to address reports of behaviors that undermine a culture of safety?</td>
</tr>
<tr>
<td>2. Project champion(s) entrusted with key data, and have a history of persevering and inspiring others to overcome barriers to achieving aims?</td>
</tr>
<tr>
<td>3. An engaged implementation team of leaders with clinical practices similar to those of recipient professionals, and who are willing to undergo a half day of training, able to communicate potentially distressing information nonjudgmentally and confidentially?</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>4. Clearly articulated organizational values and goals (mission and values statements, and professional conduct policies) that are aligned with program intent?</td>
</tr>
<tr>
<td>5. Enforceable policies that address expectations for professional conduct and professional accountability?</td>
</tr>
<tr>
<td>6. Model for tiered interventions (Figure 2, page 156) for sharing coworker concerns and addressing patterns?</td>
</tr>
<tr>
<td>7. Resources appropriate and sufficient to create, improve, and sustain best-practice processes for collecting, reviewing, aggregating, and sharing concerns (for example, software, personnel, training), plus wellness and assistance for both the professionals who are the subjects of reports and those who are witnesses and victims of reported events?</td>
</tr>
<tr>
<td>Systems</td>
</tr>
<tr>
<td>8. Measurement and surveillance tools for capturing, reviewing, coding, analyzing, and tracking data?</td>
</tr>
<tr>
<td>9. Reliable processes for reviewing and delivering data, ensuring including timely review and delivery, individualized and peer-based comparative data analyses, and trending?</td>
</tr>
<tr>
<td>10. Multilevel training for leaders and other professionals, including unprofessional behaviors’ impact on safety, evidence base, skills practice and feedback, and how to implement, manage, and sustain?</td>
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</tbody>
</table>
Eliminating Disruptive Behavior: #4 - Hierarchy of Responsibility

- Department directors
- Medical director/Chief of staff
- Medical executive committee
- Credentials committee
- Board of trustees
- Physician’s well-being committees may be ineffective and frustrated with this problem
Eliminating Disruptive Behavior:
#5 – Training for Intervention

For early intervention…scripts

For the medical staff leadership, training is critical:
- Intervene early, control environment and numbers
- The focus is *always* on the **behavior**
- Have quotations, times, dates, specifics
- Be firm, not angry, use scripts
- Know what you want to have changed; work toward specific behavioral agreements or contracts
- Make sure the message sinks in
- “In most instances, behavioral change occurs with consequences, not with gaining insight” (Kent Neff, MD)
Eliminating Disruptive Behavior: 
#6 - Referrals

Appropriate referrals:

– Anger management
– Psychiatric evaluation and treatment
– Professional assessment programs
  • [www.fsmb.org](http://www.fsmb.org) – Directory of physician and remedial education programs
– In-house ongoing monitoring after assessment
# 7 - Denying Privileges

Can disruptive behavior alone be grounds for denial of privileges, or must compromise of patient care be demonstrated?
Legal Decisions

- **Georgia**: “A doctor’s ability to work with others…is a factor that could significantly influence the standard of care his patient received”

- **New Jersey**: “A hospital may adopt a bylaw providing that the inability of a doctor to work with nurses and other doctors as a ground for denying or terminating staff privileges…”

- **Oregon**: “Member who, because of personality or otherwise, is incapable of getting along, could severely hinder the effective treatment of patients”
The Disagreeable Physician: Disruptive or Disputative?

• The disruptive physician will claim he or she is disputative (a champion for patient safety)
• The court may have to help make the distinction:
  – Yunus v. Department of Veterans Affairs
  – Wieters v. Roper Hospital, Inc (No. 01-2433 (4th Cir., Feb. 27, 2003))
Checklist For Management of Disruptive Behavior

- Does the medical staff have code of conduct and sexual harassment policy?
- Are the medical staff bylaws adequate to provide authority to take necessary action including mandating a psychiatric examination?
- Do your chief of staff and administrator talk regularly to share ideas on how to handle problem personalities?
- Does the administration provide leadership training for your present and potential medical staff leaders to enable them to develop effective communication and management skills to deal with disruptive behavior?

Modified from Mary Powers Antoine, Esq.
Checklist For Management of Disruptive Behavior

☐ Does the hospital have adequate insurance and resources to cover outside consultants?

☐ Does the medical staff take a proactive role in educating medical staff members about disruptive behavior? Do they establish a link with this behavior and patient safety?

☐ Do you have a good health law attorney (not necessarily your favorite malpractice defense attorney)?
Thank You for Your Attendance and Participation!

Larry Veltman, MD
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Participants are encouraged to ask questions and share comments.

- Please use the chat box for questions or comments.
- Questions and comments are visible only to presenters.
- Questions will be answered in the order in which they are submitted.
- Should there not be enough time to address your question(s), please email education@npic.org so we may follow-up with you.
Thank You for Attending!

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