Disruptive Clinicians

And

Enterprise Risk Management

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INTRODUCTION

Disruptive clinicians have been a chronic and severe problem in the health care delivery system since collective care giving began. This article first defines and describes: (i) enterprise risk management (ERM); (ii) disruptive clinicians; (iii) the root causes of disruptive behaviors; (iv) the negative impacts and risks created when hospitals fail to effectively deal with disruptive clinicians; and (v) the current state of how many hospitals and related parties attempt, often unsuccessfully, to manage disruptive clinical behavior. Secondly, this article will suggest that disruptive clinical behavior may only be effectively addressed when it is viewed as part of a larger problem: the prevailing existing clinical culture. Finally, the authors recommend that using an enterprise risk management discipline to truly transform a hospital’s culture is necessary to achieve and maintain real, meaningful, substantial and enduring constructive changes.

ERM DEFINED

ERM may be succinctly defined as: “[a] discipline that engages professionals in the practice of identifying, managing, controlling, and monitoring all risks to the organization. ERM is an ongoing business decision-making process instituted and supported by the health care organization’s board of directors, executive administration and medical staff leadership.”1 ERM must also include all of an enterprise’s constituents in a directed, inclusive and continuing collaborative process, which creates standards of best practice in every risk domain, in order to meet the institution’s goals, strategic vision and consensus risk tolerances.

DISRUPTIVE CLINICAL BEHAVIOR DEFINED

Disruptive clinical behavior typically means aberrant, extraordinary behavior, which causes damage to clinical healthcare facilities and their constituencies. Historically, disruptive behavior was narrowly defined to encompass only the most aggressive forms of behavior involving acute physicality, screaming, temper tantrums, overt and gross sexual harassment and significant rule-breaking. In the last fifteen to twenty years, however, the ranges of behaviors that comprise disruptive clinical behaviors have expanded to not only include aggressive behaviors, but also passive-aggressive conduct and passive behavior which lead to a loss of clinical teamwork, collaboration and mutual respect.

The issue of disruptive clinicians took center stage after a series of academic studies, articles and events exposed the wide ranging negative effects that the breadth of disruptive behaviors has on the successful delivery of clinical care, including the danger of increased risks and the substantial untoward impact on health care institutions. The Joint Commission (TJC) in July 2008 issued a sentinel alert regarding disruptive clinicians. Following that sentinel alert, in January 2009, TJC issued several new directives\(^2\) to their accredited institutions creating new requirements to address disruptive clinicians. TJC mandated that each accredited hospital must develop a code of conduct, which would define acceptable, disruptive and inappropriate behaviors and which would require each of those institution’s leadership to create and implement a process to manage behavior. TJC requires that a facility’s code of conduct (i) provide a means to educate all healthcare team members, so that all clinicians are held accountable for compliance with the code’s standards; (ii) imposes a zero tolerance standard for conduct that violates the code; and, (iii) requires its hospitals to create a system to detect and receive reports of disruptive behaviors as well as a disciplinary process to address infractions. TJC also changed

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\(^2\) The Joint Commissions’ Code of Conduct may be found at: http://www.jointcommission.org/assets/1/18/TJC_Code_of_Conduct_09.pdf
its standards for provider credentialing to include an evaluation of interpersonal skills, communication skills and professionalism. There were many comments to TJC’s new directives. Most notably, the American Medical Association (AMA) suggested an alternative code of conduct. According to the AMA: “[a] disruptive physician is best described as someone who undermines practice morale, steals from productive activities, intimidates or threatens harm to others and disproportionately causes distress to others in the work environment.”

TJC’s and the AMA’s codes of conducts (although somewhat different) are primarily directed at specific negative behaviors, as are most other disruptive clinician solutions which are currently in use. These current approaches address the problems posed by disruptive clinicians most often by cataloging several specific negative behaviors that would constitute a violation of the codes. While targeting the individual disrupter may be a good strategy for creating bright lines for discipline, this does not accurately capture or remediate the broadest range of disruptive behaviors. Disruptive behavior should be more expansively defined. Disruptive clinical behaviors are part of a continuum of behaviors which: “interferes with the orderly conduct of hospital business...[including] behavior that interferes with the ability of others to effectively carry out their duties or that undermines the patient’s confidence in the hospital or another member of the healthcare team.”

There are many identified disruptive behaviors, which are often grouped into differing categories, including aggressive, passive-aggressive and passive. Examples of aggressive behaviors include: “anger outbursts, profane/disrespectful language, throwing objects,

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3 The American Medical Association Code of Conduct may be found at: [http://www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf)

4 Grena Porto, RN, MS, ARM, CPHM and Richard Lauve, MD, MBA, CPE, FACPE, *Disruptive Clinician Behavior: A Persistent Threat to Patient Safety*. Patient Safety and Quality Healthcare (July/August 2006), which may be found at: [http://www.psqh.com/julaug06/disruptive.html](http://www.psqh.com/julaug06/disruptive.html).
demeaning behavior, physical aggression, sexual comments or harassment, and racial/ethnic jokes.” 5 Examples of passive-aggressive behavior include: “derogatory comments about institution, hospital, group, and refusing to do tasks”. 6 Examples of passive behavior include: “chronically late, not responding to call and inappropriate or inadequate chart notes.” 7 Disruptive behaviors vary in type, severity, frequency, patterns and root causes.

ROOT CAUSES OF DISRUPTIVE BEHAVIORS

There are a number of explanations as to why disruptive behaviors occur. Many studies and commentators focus on physicians and the causes of their disruptive behavior. In other studies, nurses’ disruptive behavior is often explained as a consequence of frustration with an inequitable system and having to be subordinate to physicians who do not respect their contributions and responsibilities.

Physicians have historically been trained to be at the top of the clinical hierarchy. They are trained to be effective clinical performers, with an almost singular focus on the development and execution of their clinical knowledge and skills. As a general rule, they are rarely trained in communication methods, interpersonal social skills or clinical personnel management. During school and residency, they were taught they were the “captain of the ship,” but lacked any formal training outside of their clinical competency to work effectively with their crew. As the delivery of health care services within hospitals has grown more complex, task specialization and the number of persons a physician is required to interact with, have increased exponentially.

5 Martha E. Brown, MD, Michael R. Callahan, Esq., Julian L. Rivera, Esq., Lawyer or Psychiatrist? Handling “Disruptive” or “Impaired” Physician Cases. Presented at the American Bar Association’s Physician-Legal Issue Conference, (June 10, 2010), which may be found at: http://www.kattenlaw.com/lawyer-or-psychiatrist-handling-disruptive-or-impaired-physician-cases-06-10-2010/.
6 Ibid.
7 Ibid.
Today’s clinical environment requires a physician to navigate within a broad social clinical network in order to perform effectively. Except for clinical experiences, with a few progressive exceptions, medical education has not formally addressed the skill sets needed to be successful in this more complex social environment.

At the same time they have had to face growing complexities and considerably greater interactions with more specialized personnel in the clinical delivery process, physicians are also required to comply with many more rules and procedures, including sexual harassment standards, hostile workplace restrictions, drug and pharmacy controls, billing and compliance rules, clinical practice guidelines, greater documentation requirements and a myriad of other standards. Today, physicians certainly have more controls and external pressures, impinging on their former relatively autonomous status. While physicians are usually highly functioning individuals focused on clinical care, only some are innately prepared to successfully face the challenges presented in today’s clinical environment - others are not.

Physicians have historically enjoyed power in healthcare institutions due to their being at “the apex of the clinical hierarchy” and as a consequence of being the primary source of referrals and revenues for hospitals. Although disruptive behaviors have long been a concern among healthcare workers, they have often gone unchecked, or even worse, accepted as part of the system. By not addressing these behaviors, organizations silently supported them and reinforced them.”

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9 Ibid.
The culture of tolerance and adaption to disruptive behavior for highly valued physicians is still a prevalent inhibition to reducing this type of behavior. It leads to a reactive cycle that bolsters bad behavior. “Reasons for not reporting these behaviors include intimidation, fear of conflict, perceived lack of reporting confidentiality, fear of being labeled a troublemaker, and concern that nothing ever seems to change in the organization. Intimidating treatment of healthcare clinicians, lack of confidence, and an unresponsive administration all contribute to a difficult situation for frontline healthcare staff and set the stage for catastrophic patient care in present and future institutions.”\textsuperscript{10}

Often, disruptive behavior is intentional and used to the disrupter’s advantage. “The behavior is exhibited in a clinical microsystem, and the behavior gains some reward ...for the physician....”\textsuperscript{11} “The instrumentality might be a surgeon getting the operating room he prefers, the hospitalist getting undisturbed rest because nurses avoid him, the intensivist never having to deal with the family of the patient...”\textsuperscript{12} The hospital’s failure to promptly and meaningfully address these concerns reinforces, perpetuates and expands the use of disruptive behavior – both by that provider and others.

Another common factor that underlies disruptive behavior may be a disruptive provider’s mental health. “Neff reports in his sample of physicians initially reported for disruptive behavior that the incidence of psychiatric illness is quite high.”\textsuperscript{13}


\textsuperscript{12} Ibid.

\textsuperscript{13} Ibid. See also, K.E. Neff, Responding to the Disruptive Physician, CME: Behavioral and Emotional Problems, Vol. 2004, Texas Medical Association (1997).
Nurses’ sources of disruptive behavior could very well be a result of their subordinate role in the traditional clinical setting and also due in part to gender bias. “Unlike physicians, nurses have historically lacked power in the healthcare setting; this lack of power has been theorized to play a role in disruptive behavior in nurses.”14 “Nursing has been described as an oppressed group because the profession is primarily female and has been under a dominance of a patriarchal system headed by physicians, male administrators and marginalized nurse managers.”15

Disruptive behavior can also manifest itself when expectations are not met - this could occur with facility personnel and their perceived quality, inefficiency or personality or “when equipment or staff is not available or orders are not carried out in a timely and correct manner.”16

CONSEQUENCES OF DISRUPTIVE BEHAVIOR

In the article, Silence Kills,17 several sources and consequences of disruptive behavior were highlighted. The studies the article relies upon support the thesis that disruptive behavior materially impacts patient safety. The article identifies seven crucial concerns, all of which include disruptive behaviors, as the source of that increased danger to patients. The seven areas of crucial concerns include: broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect and micromanagement.18 Broken rules focuses on “clinicians taking shortcuts, which could be dangerous to patients.” Mistakes include “people who have trouble or

18 Ibid.
fail to follow directions and failing to get help when needed.” Lack of support can be found in “clinical colleagues who are reluctant to help, impatient, or refuse to answer questions.”

Incompetence is “seen among colleagues but due to a culture, which does not support, encourage or provide an effective means of reporting incompetence, many providers continue with those inadequacies unaddressed.” Poor teamwork includes “providers who gossip, are in cliques which divide teams or teammates who try to look good at others expense.” “Disrespect includes condescending, insulting, rudeness, yelling, shouting, swearing or name-calling.” Finally, Silence Kills talks about micromanagement “where clinicians abuse their authority, pull rank, bully, threaten or force their point of view.”

Profound consequences stem from disruptive behaviors. Studies show that 67% of respondents link disruptive behaviors and adverse events and 71% found the same link with pharmaceutical errors. “In one study 64% of the pharmacists surveyed reported that they had assumed a medication order was correct rather than interacting with a particular physician to confirm that order (Institute of Safe Medical Practices, 2009).

Health care workers’ well being is often adversely impacted by disruptive physicians. “[B]eing a victim of disruptive behaviors include tiredness, headaches, gastro-intestinal complaints, and feelings of sadness.” According to another study, “[p]sychological and

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19 Ibid.
behavioral disturbances, such as stress and frustration can compromise nurse-physician relationships resulting in decreased concentration, collaboration, communication and information transfer.”

Another known consequence of disruptive behaviors is staff turnover. Numerous studies have confirmed that staff retention and recruitment is materially adversely affected by disruptive behavior and ineffective institutional responses to remediate the source of those behaviors.

**CURRENT STATE OF INSTITUTIONAL TREATMENT OF DISRUPTIVE BEHAVIOR**

Despite a wealth of studies, TJC’s focus, AMA’s focus and numerous publications and seminars focused on raising consciousness around this problem, most institutions are not effectively reducing its root causes. While it is true that many institutions have adopted codes of conduct describing wrongful behaviors with specificity, created reporting mechanisms and refined their disciplinary processes to address outliers, most hospitals’ focus has still remained on the sole individual and his or her behavior. Frequently, hospitals fail to adequately examine or address why the behavior occurred in the first place. Often the stimulus for disruptive behavior actually points to something amiss in the clinical process or a breakdown in the clinical social network found in today’s more complex clinical environment. Addressing the behavior failure alone will not fix the underlying process or social network failure which stimulated the inappropriate response.

To effectuate complete corrective action, a hospital must address both concerns: first, the disruptive behavior and secondly, the remediation of the underlying process or environment

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failure, which was the stimulus of the disruptive behavior. Failure to address both sides of the equation will either induce additional disruptive behavior or cause an accommodation to a flawed process or social clinical network, further frustrating the clinicians and compromising patient safety.

Disciplining a provider, without understanding why they acted in a disruptive manner, will also mask those providers who need, at a minimum, interpersonal development, better social skills and a means to effectuate change not only within themselves, but with the clinical team members with whom they interact. Other providers will need coaching of their behavior in a team setting and strong education to overcome their individual deficiencies. Other providers will need psychological and/or psychiatric interventions to enable them to continue to be productive contributors to the hospital and its constituencies.

Credentialing processes and hiring methodologies have not sufficiently evolved to adequately assess a provider’s social skills, communication skills and professionalism. Assessments for quality initiatives, although relatively nascent, are underway, which measure certain clinical processes and outcomes (e.g. PQRI, OPOE). Yet little similar measurement and benchmarking have occurred on clinicians’ social skills, communication skills and professionalism.

Few institutions are concentrating on substantially reorganizing their clinical care processes away from the “captain of the ship” paradigm to a collaborative, non-hierarchical, best practices collegial and multi-disciplinary model. Essentially, there is no profound cultural shift, but rather, remediation of outliers of a slowly transitioning culture.

As previously stated, the current state primarily identifies and proscribes unacceptable disruptive clinical behavior. To be effective, the stimulus for that disruptive behavior must also
be understood and remediated whenever a disruptive clinical behavioral circumstance occurs. Those two steps are important, but are still merely reactive to an occurrence. This two-step reactive approach is similar to the traditional risk management approach. In a traditional risk management approach, an adverse event occurs or a clinical process failure is identified after it was observed being utilized. Subsequently, the incident is reviewed for its root causes, to determine what occurred and why. Often, where warranted, peer review and similar subsequent actions are taken with regard to culpable caregivers involved in that adverse outcome. Most often, the traditional approach to risk management merely mitigates the particular adverse event and takes appropriate actions regarding the culpable providers. The more developed traditional risk management approach would also routinely incorporate changes to the clinical processes, which have a broader impact on all caregivers.

The next evolutionary step in risk management is to employ an ERM approach. Conceptually, traditional risk management is reactive and event driven. In broad terms, ERM is proactive, prophylactic and system-redesign oriented. Traditional risk management is part of the historical individualistic clinical model. ERM, however, is a discipline that uses methods to cause a hospital or clinical care delivery system to make consensus driven changes throughout the enterprise that ultimately results in an evolution in the clinical culture to better reflect the collective structure of today’s complex healthcare environment.

**EMPLOYING ERM TO TRANSFORM THE CULTURE**

One means of stimulating a more collaborative team approach is through utilization of a comprehensive disciplined ERM process. As a response to disruptive clinicians, many hospitals’ governing boards have already adopted changes in bylaws, approved codes of conduct and begun other aspects of implementing TJC’s required steps for maintaining accreditation.
An ERM approach, however, would start with a hospital’s governing board. The governing board would initiate a comprehensive analysis and assessment to be made of every aspect of an institution’s clinical care delivery system. That analysis and assessment would consider each risk domain. A specific hospital’s analysis and assessment would look at the hospital’s current state, identify its strengths and weaknesses, benchmark current practices against industry best practices, identify known risks and measure occurrences of those risks.

An institution’s risks domains include: operational, financial, human capital, strategic, legal/regulatory and technology. The operational risk domain consists of a hospital’s processes, systems and how people interface with each of those components. The financial risk domain consists of a hospital’s financial condition, financial resources, sources and levels of profitability, cash position, reserves and access to capital and insurances. The human risk capital domain is comprised of a hospital’s human capital risks relating to its employees, agents, and medical staff members, clinical and non-clinical leadership. It includes performance and assessment mechanisms, hiring, privileging, engagement processes, risk mitigation strategies to prevent labor shortages, recruitment effectiveness, avoidance tactics relating to negligent hiring, negligent engagement, negligent retention, ineffective credentialing, talent management and avoidance of other human capital risks. The strategic risk domain is comprised of a hospital’s strategies for market share, differentiation, branding, reputation, growth and overall business strategy and mission. The legal and regulatory risk domain includes policy and procedures for monitoring and ensuring compliance with all governmental laws, regulations, rules and orders. The technology risk domain includes all aspects of the enterprise to make sure that technology is suitable to meet the needs of the hospital, is secure, and properly maintained and operated.
A hospital governing board that desires to use an ERM discipline to address the problems associated with disruptive clinicians should be advised in detail of the multi-factorial, industry known causes and effects of that behavior on all of hospitals’ risk domains. Building on that information, the governing board’s next step would be to obtain hospital-specific data. That would require the governing board to direct several multi-disciplinary groups to study each of their respective areas of practice and assess them against the risk domains. All directly and indirectly affected constituencies in the hospital would participate in their most relevant multi-disciplinary group. Those groups’ studies would have to focus on how to meet the acceptable risk tolerances set by the governing board for each respective area’s risk domains. This would be accomplished by incorporating best industry practices to improve a hospital’s existing risk domain profiles. Additionally, multi-disciplinary internal reviews of each and every process impacted by disruptive clinicians, which are unique to that hospital’s risk domains, should lead to consensus-based specific process improvements within the hospital.

The governing board would then clearly identify, adopt and articulate the strategic value of recognized necessary enterprise-wide changes. The governing board would cause the hospital’s leaders, and each of the hospital’s constituent groups, to change course and collaboratively set new standards and expectations to meet the hospital’s new strategic vision.

A compelling, empirically-based case for migrating to a new paradigm of a collaborative, collective, mutually respectful, non-hierarchical clinical delivery system is well-founded and supported by many studies and publications. A true cultural transformation will require ERM’s disciplined process mapping. The transformation will also compel constituencies to continually cross traditional role boundaries, rationally realign responsibilities and functions and extensively utilize inclusive collaborative processes. The ERM improvement process not only advances the
hospital towards its goal of cultural transformation but its effective execution would also serve as a model of how the new culture can work.

A hospital’s code of conduct should be developed by consensus among the hospital’s various constituencies. It should broadly and specifically define and mandate the most desired and acceptable behaviors. That code of conduct should also define and proscribe broad and specific behaviors and processes. Facilities should monitor by both established methods and by new means. Transparency of results and means of measurements should be established and followed. Surveys, education, training and cross-functional team group meetings and workgroups outside of the production environment should be created and continuously utilized.

Several avenues to ensure reporting of process and personnel dysfunctions must become the hospital’s cultural norm. Reporting both areas of concern or areas with less than optimal functioning or disruptive personnel must not only be strongly encouraged, but measurably facilitated.

A neutral and confidential multi-disciplinary process for intervention with disruptive clinicians would also be developed, implemented and maintained through a collaborative process among the hospital’s numerous constituencies. Best practices require a facility to intervene promptly and apply equally any appropriate remediation actions to any clinical provider, regardless of his or her relative economic or clinical status within the hospital.

Whenever a disruptive behavior occurrence happens, there should be a complete analysis of the breakdown of the team process or hospital process, which stimulated the disruptive behavior. This approach is no less important than a root cause analysis of a clinical adverse event and should be separate from dealing with the remediation of the disruptive behavior itself.

**CONCLUSION**
ERM should be deployed to transform clinical cultures in a structured manner, and must be based on a fully engaged governing board's understanding of the substantial value to be derived from that strategic shift. A strong institutional commitment must be made and widely articulated to build consensus and stimulate fundamental, empirically-based change in processes, personnel, social clinical organization and policies. These progressive processes and policies must be continually measured - their results should be transparent and be cross-constituency driven. The end result should be a much safer environment for the hospital, its leadership, medical staff, nurses and its patients while also substantially diminishing the root causes of disruptive clinical behavior.
Other Sources:


3. Jana Deen, RN, JD, CPHRM, Setting the Standard for Professional Behavior, Catholic Health Partners, (December 17, 2008), which may be found at: http://www.cahps.ahrq.gov/content/community/events/files/T-6-S-Deen-Final_fwp.pdf.


