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# Managing Disruptive Behavior

Balancing Patient Safety with the Rights and Dignity of Physicians

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## INTRODUCTION

One of the most difficult challenges facing medical staff leaders is overseeing professional conduct on the medical staff and confronting disruptive conduct when necessary to protect patients from potential harm. In addition, there is now a legal, regulatory, and accreditation mandate to eliminate professional conduct that may create a “hostile work environment” and place patients in potential jeopardy.

Unfortunately, although this seems straightforward, helping colleagues to modify chronic behavior traits that have been present for years is extremely challenging in a profession that has always valued the sanctity of professional autonomy and respect. Thus, balancing accountability to our patients and society with appropriate advocacy for our colleagues is a daunting task that will tax even the most experienced physician leader. This paper will not eliminate the inherent conflict in this challenge, but will provide a road map for approaching disruptive behavior that may have a detrimental effect on patients, staff members, and physicians if it is not properly addressed.

## THE PUBLIC MANDATE

According to CMS’ *Conditions of Participation (CoP)*, the organized medical staff is “accountable to the governing board for the quality of medical care provided to patients” (§482.22 CoP, A-0339), and “the medical staff must periodically conduct appraisals of its members” (A-0340). In addition, The Joint Commission adds in its 2009 leadership standards that: “A culture of safety throughout the hospital is created and maintained. Leaders use reliable and valid tools to evaluate the culture of safety on a regular basis. Leaders encourage transparency, teamwork and collaboration, a code of conduct, and processes to manage disruptive and inappropriate behaviors” (LD.03.01.01, EP 1-10).

Why is professional conduct linked to patient safety? According to The Joint Commission’s Sentinel Event Alert #40, there is irrefutable evidence that disruptive behaviors cause:

- Increased costs (e.g., costs due to complications, rework, liability, staff turnover, and loss of confidence)
- Medical errors and deaths
- Breakdown in communication and teamwork, which is the leading cause of sentinel events

Finally, creating a hostile working environment is against federal law. According to Title VII of the Civil Rights Act of 1991, “treating an individual in a demeaning, disrespectful manner may support a claim of discrimination.”

Thus, we as physician leaders now have a powerful and overwhelming mandate to address dysfunctional professional conduct concerns that have, in many cases, gone unaddressed for years.

## WHAT IS DISRUPTIVE BEHAVIOR?

According to the AMA, disruptive behavior is a “style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with or has the significant potential to interfere with patient care and to cause harm.” Thus, when identifying disruptive conduct, it is important to specifically link behaviors to their direct and indirect effect on patient care and the patient care environment. For example, when communication between a physician and nurse breaks down, will that nurse notify the physician in a timely manner if the patient’s clinical status changes in the middle of the night? And if that call does not occur, will the patient receive the timely care that he or she needs to survive?

Obvious examples of disruptive behavior include:

- Outbursts of anger or rage
- Throwing instruments or charts Inappropriate touching or sexual comments
- Repeated failure to respond to calls in a timely way

More subtle but equally destructive manifestations of disruptive behavior include:

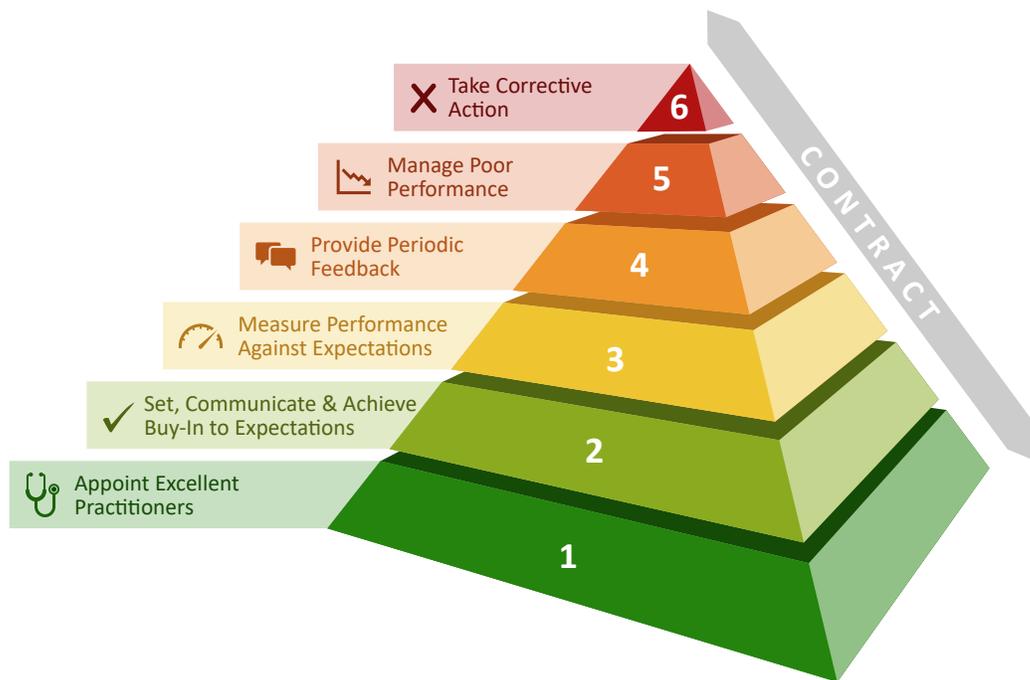
- Comments that undermine a patient’s trust in other physicians, the hospital, or the community
- Boundary violations, such as making critical comments about clinical performance in an area that a physician is not qualified to evaluate objectively
- Unethical or dishonest behavior, such as fraudulent documentation, casting aspersion on a colleague in bad faith, or misrepresenting the facts of a clinical case
- Difficulty working in collaboration with staff members, patients and their families, or other professionals or medical staff leaders

It is worth noting what disruptive behavior is not: It is not legitimate concerns regarding patient care and operations that are handled in a constructive manner through appropriate channels in the best interests of patients and the community. This may be difficult to separate from inadvertent disruptive conduct, and it is often a matter of judgment when an individual leaves the gray zone of good intentions and enters the unprofessional domain.

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# THE PERFORMANCE PYRAMID

The performance pyramid was created by the late Howard Kurz, MD, for the American College of Physician Executives as a part of his “managing physician performance course,” and we have found it to be the best approach to deal with any performance issue, regardless of whether it is behavioral.



The model is shaped like a pyramid with the assumption that focusing on the foundation layers will reduce the likelihood of dealing with the more problematic layers near the top. The area represented by each layer reflects the amount of time, energy, and resources that should be committed to that layer, with the ultimate goal being not needing to take corrective action. This is a more proactive and preventive approach to performance issues, which is the ultimate objective of every member of the medical staff. The following is a brief summary of how each layer works:

- 1. Appoint excellent physicians.** This is the credentialing and privileging layer; it is the foundation layer of the pyramid because the best way to address any performance issue is at the door. Once medical staff members recommend membership and privileges on behalf of a colleague, they now own any performance issues through the peer review process. Ironically, most medical staffs do a good job screening performance issues at initial appointment, but miss an important opportunity to address new or recurrent issues at reappointment.
- 2. Set, communicate, and achieve buy-in to expectations.** This is an often neglected layer and is the medical staff's opportunity to convey its expectations of performance clearly and succinctly and to ensure that individual members of the medical staff, particularly problematic members, “buy in” to the expectations in a convincing and sincere manner.

3. **Measure performance against expectations.** This layer exemplifies the aphorism that if you don't measure performance, you can't manage it. "Against expectations" emphasizes the need to create performance indicators that assess issues highlighted by leadership through its articulated expectations and not merely to choose indicators at random or because they are an accreditation, regulatory, or legal requirement.
4. **Provide periodic feedback.** Data do no good gathering dust in a drawer, and most conscientious physicians will utilize imperfect data to understand trends or patterns that may help them to modify and improve their performance, thus obviating the need for any leadership intervention.
5. **Manage poor performance.** This is the most challenging layer of the pyramid and leadership's last chance to assist and support a practitioner in making the performance improvements necessary to avoid corrective action. This is a pyramid within a pyramid and often starts with collegial interventions followed by informal then mandatory improvement plans, and concludes with a final warning. Physician leaders are encouraged to seek training to implement this layer, as the physicians who require this layer are often adept at avoiding, negating, or subverting their need to change.
6. **Take corrective action.** This is the recommendation that the board reduce part of a colleague's membership or privileges on the medical staff. Contrary to popular belief, this does not have to be an "all or nothing" approach, but, like "manage poor performance," may be implemented incrementally from one- or two-day timeouts to revocation of membership and privileges. Unfortunately, for the hardened and chronic offenders, this may be the only layer of the pyramid with sufficient clout to command their attention.

## APPLY THE PYRAMID TO BEHAVIORAL ISSUES

The following section includes specific implementation steps that you can take to apply the principles of the performance pyramid to behavioral issues. Not every step will work nor is appropriate for every case. These are options to consider based on specific situations encountered and personalities involved.

### 1. APPOINT EXCELLENT PHYSICIANS

As mentioned above, the best time to deal with behavioral issues is at appointment and reappointment. One of the tenets of good credentialing is to establish eligibility criteria for membership and privileges on the medical staff. Ideally, this should include behavior, character, and ethics. Whereas you cannot deny someone an application based on preexisting behavioral issues, the existence of eligibility criteria entitles leaders to thoroughly evaluate behavioral issues as a part of the application and reapplication process. If issues are encountered, it is helpful to have language in your bylaws or credentialing procedure manual that states that "an incomplete application is one that requires further information to confirm, clarify, or to establish current

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clinical competency and professional conduct.” This requires that the credentials committee or MEC determine when an application is complete so that it is not obligated to process an application and take action when issues of concern are raised and unresolved. It also entitles the credentials committee or MEC to send a more detailed questionnaire to address and resolve potential issues prior to completing an application. When encountered with a problematic applicant for appointment, we have found that digging deeper and eliciting specific information may cause the applicant to withdraw prior to undergoing closer scrutiny.

Invariably, you may request additional information and not receive it due to a reference’s liability concern. In this case, place the burden on the applicant and inform him or her that the application cannot be processed until the information is received, and that after 90-120 days (depending on your policy), the application, if deemed incomplete, will be considered voluntarily withdrawn. This is a nonreportable action to the National Practitioner Data Bank and also invites no due process rights under the Health Care Quality Improvement Act because the hospital is not taking any corrective action.

As mentioned earlier, these actions are often taken by effective credentials committees at appointment but are seldom applied at reappointment. This is an excellent time for leadership to sit down with a problematic practitioner and frankly discuss his or her willingness to change as a part of the reapplication process. It is permissible for the medical staff to modify its eligibility criteria for appointment for longstanding members as long as those standards are evenly applied for every applicant.

Remember, once you have let a colleague through the door, the performance issue is yours to manage and you are committing to expend the time and resources necessary to assess and improve this performance issue during the next two years.

## 2. SET, COMMUNICATE, AND ACHIEVE BUY-IN TO EXPECTATIONS

If we as medical staff leaders feel that professional conduct is an important component of quality performance, it is important to clearly communicate this expectation to our colleagues and obtain their support in return. This seems intuitive; however, many physicians who engage in disruptive behavior do not accept the medical staffs right to oversee their professional performance, much less their professional conduct. Thus, there is no point to measure conduct or hold others accountable if they do not support the medical staffs right and obligation to do so.

Several simple statements can crystallize the medical staffs expectations within the interpersonal and communication dimension of performance, such as:

- Treat all patients, families, colleagues, and staff members with respect and dignity, even during times of disagreement
- Address disagreements in a constructive and respectful manner through appropriate channels

Following an agreed upon short list of behavioral expectations, it is important for the medical staff to memorialize its commitment through creation of the following policies and procedures:

- Code of Conduct (for the medical staff and the organization as a whole)

- Sexual Harassment
- Impairment
- Mandatory Appearance
- Conflict Management

Many leaders ask why the medical staff should create its own documents in areas that are often duplicative of the hospital and governing board's policies and procedures. The medical staff should create its own approach for dealing with these challenging issues that balance its efforts to hold itself accountable while advocating and respecting fellow professionals in a way that is often not addressed in governance or HR policies and procedures.

These documents should be created by the medical staff through thoughtful debate and discussion so that they are not a product of management's efforts but rather represent the medical staffs point of view and unique perspective.

IF WE AS MEDICAL STAFF LEADERS FEEL THAT PROFESSIONAL CONDUCT IS AN IMPORTANT COMPONENT OF QUALITY PERFORMANCE, IT IS IMPORTANT TO CLEARLY COMMUNICATE THIS EXPECTATION TO OUR COLLEAGUES AND OBTAIN THEIR SUPPORT IN RETURN.

### 3. MEASURE PERFORMANCE AGAINST EXPECTATIONS

The best way to manage a performance expectation is to measure it through a medical staff performance indicator with two thoughtfully created targets. The indicator should be designed by a clinical department/service or a centralized peer review committee and approved by the MEC. It is important that the data collected be credible, which requires a careful validation process, particularly for behavioral issues in which observations are often based on subjective judgments.

Creating two targets accomplishes several goals. First, it separates exemplary from average performance and allows the medical staff to recognize excellence rather than merely screening for "bad apples." Second, it provides a basis to manage outlier performance by identifying individuals whose performance is different from their peers and require follow-up to explore the reasons behind this differing performance. Targets should move strategically over time to encourage "stretch goals" by the medical staff. These are realistically attainable goals that require effort to achieve.

An example of such an indicator with targets is as follows:

***Interpersonal and communication skills performance dimension: Number of validated behavior incidents***

- Green target 0/year
- Yellow target <3/year

These targets would not be randomly created but are based on how the medical staff would like to improve its performance over time.

## 4. PROVIDE PERIODIC FEEDBACK

Once the data are collected, practitioners should receive feedback every six months through a performance feedback report. This gives each individual the opportunity to modify and manage his or her own performance and gives leaders an opportunity to coach and support their colleagues toward mutually agreed upon goals.

Another advantage is that issues can be actively addressed prior to reappointment so that ongoing professional performance evaluation (OPPE, or the routine monitoring of individuals granted clinical privileges) is addressed through a performance improvement manner rather than the retrospective “bad apples” approach of the past. Ideally, the department or clinical service chair can work with individuals to develop informal or formal improvement plans to address specific performance issues in a measurable way.

Collecting data and providing constructive and timely feedback should serve as the foundation for a productive dialogue between leaders and their colleagues to enable individuals, departments, and the medical staff as a whole to reach mutually agreed upon performance goals over time.

IDEALLY, THE DEPARTMENT OR CLINICAL SERVICE CHAIR CAN WORK WITH INDIVIDUALS TO DEVELOP INFORMAL OR FORMAL IMPROVEMENT PLANS TO ADDRESS SPECIFIC PERFORMANCE ISSUES IN A MEASURABLE WAY.

## 5. MANAGE POOR PERFORMANCE

Unfortunately, there are a small number of individuals who either cannot or will not comply with performance expectations and choose to go their own way, and these individuals must be managed if they are to avoid corrective action. This is a painful and challenging layer of the pyramid because we often inadvertently support and reinforce these individuals’ dysfunctional behaviors because it seems easier than confronting them and risking the political and economic fallout that may ensue. This layer of the pyramid takes a personal and moral conviction that the risk of managing the problem and taking a hit is less than the risk of allowing it to escalate and to potentially cause others harm, including the physician in question.

The following general principles will serve as a framework to manage poor or marginal performance when the foundation layers of the pyramid fail or when there is a single egregious episode that demands this level of intervention at once.

## A. PRINCIPLE #1: TREAT OTHERS AS YOU WOULD WANT TO BE TREATED

Roger Fisher and William Ury, in their seminal book *Getting to Yes*, advise it is better to attack a problem together and not attack each other. No intervention should advertently place a professional or personal relationship in jeopardy. The purpose is to solve a mutual problem together, and this requires cooperation and trust.

## B. PRINCIPLE #2: TO BE UNDERSTOOD, FIRST SEEK TO UNDERSTAND (ST. FRANCIS OF ASSISI)

Paradoxically, when a physician acts out in a disruptive manner, he or she may be defending an important personal truth. Whereas the expression of his or her "truth" may not be effective, this key perspective should be addressed as an early and integral part of the process. This accomplishes several goals. First, an individual who feels listened to and understood is more likely to listen and be open to another's point of view. Second, understanding what is important to an individual is a great way to establish a mutual plan to attack a problem together.

## C. PRINCIPLE #3: "NEVER ASK ANYONE TO ACT IN SUPPORT OF YOUR VALUES UNTIL YOU HAVE GIVEN THAT PERSON ADEQUATE REASON TO DO SO" (CHARLES DWYER, PHD)

One of the keys to an effective intervention is to understand what is most important to that individual so important that he or she may be willing to change. It may be professional respect, economic survival, or personal satisfaction, to name a few. Once you have identified that person's "adequate reason," you may compel that individual to change enough to meet expectations.

## D. PRINCIPLE #4: PLAN YOUR INTERVENTION

This work is difficult, and most of us were never trained in how to do it. Further, the chronic offender is often more adept at defending his or her actions than we are at changing them. The acute offender will often express regret, self-awareness, and demonstrate a willingness and ability to change. The chronic offender, on the other hand, may have little motivation or interest in changing and may have little or no insight into the effect of the behavior on others. Therefore it is often best to perform this intervention with another more experienced leader.

These interventions should be seen as a series of carefully crafted escalating interventions designed to reduce variation from expectations.

The following is a brief summary of such a progressive intervention:

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- **Initial intervention.** This is the first focused intervention beyond merely providing constructive feedback. It should be collegial with an emphasis on mutual attentive listening and problem solving as well as understanding why the physician's behavior and performance is different from his or her colleagues. Ideally, a letter should be written describing the discussion with agreed upon commitments and signed by both the leader and the practitioner in question.
- **Second intervention.** This is less collegial, references the first intervention (with documentation), and is focused on the practitioner creating a voluntary action plan with measurable results (e.g., number of validated behavior reports) within a specified time frame. If the individual is unable or unwilling to do this, the intervention may automatically escalate to the third intervention. If the individual successfully completes the action plan, the intervention may revert to a purely collegial approach. In all cases, a positive and a negative consequence should be spelled out in writing and, again, ideally signed by both parties.
- **Third intervention.** This may result in the failure of the voluntary action plan and often results in a mandatory action plan created by the department/clinical service chair (with MEC approval) and with the possible assistance and support of a chief medical officer (CMO) or vice president for medical affairs (VPMA). Again, there should be a positive consequence for successful completion (e.g., voluntary action plan) and a negative consequence for failing to complete it (e.g., final warning) with all parties signing the agreement.
- **Final warning.** This is the final warning and should be a monologue and not a dialogue given by all relevant leaders, including the department/clinical service chair, the president of the medical staff, the CMO or VPMA, the CEO, and the board chair. It should specify in writing what behaviors may not continue with specific performance measures. This is the last intervention prior to corrective action, and the practitioner should also be given an opportunity for a successful outcome if he or she is at last willing to address the problem. The final warning is commonly called a "doc in the box" letter because it clearly defines the boundaries, or box, within which the physician is expected to remain and the consequences for stepping outside of the box.

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Roger Fisher and William Ury also point out that it is important to have at every intervention a BATNA (Best Alternative To a Negotiated Agreement) or a plan B if the intervention does not work out. Too often, inexperienced leaders repeatedly perform an unsuccessful intervention without any desire or ability to implement a more effective one or to understand what the consequence will or should be if the planned intervention fails.

## E. PRINCIPLE #5: PRACTICE YOUR INTERVENTION

This intervention is extremely difficult and fraught with

economic and political implications; therefore, it should be practiced, ideally with someone who has done many of these interventions before.

Important elements to consider in your intervention include:

- **Reference your leadership role and obligation.** Remember that along with the authority of your title comes an obligation to uphold medical staff bylaws and associated rules/regulations and policies.
- **Identify the issue in a nonaccusatory manner.** Here it is useful to cite objective data to define the problem. Keep the data quantitative and specific if you can. This will set the stage to create measurable goals later on.
- **Invite the physician to share his or her truth on the issue.** This will not deflect responsibility but rather create an opportunity for mutual problem solving and collaboration toward a beneficial solution.
- **Be persistent.** The individual may wish to deflect responsibility, deny the validity of the data, or try to threaten, cajole, or plead to avoid repercussions. Remember to have the correct facts on your side and the conviction that what you are doing is important.
- **Prepare for resistance.** Everyone defends themselves in a different way according to their personalities and what has worked for them in the past. It is helpful to anticipate the style of the practitioner and to create a plan for dealing with it so that you feel comfortable with a counter move. Always anticipate the unexpected and feel free to call a timeout if things get out of hand.
- **Don't conclude the meeting until your minimal objectives are achieved.** Without ownership and buy-in of the problem and commitment to change, there is no point to continue to manage this problem. Understand your "good enough" result and stick with it.

## F. PRINCIPLE #6: PERFORM YOUR INTERVENTION

This is the difficult part and may need to be accomplished with a support person. If this is your first attempt, you may wish to perform this intervention with a more senior and experienced leader.

Prebriefing and debriefing are excellent ways to gain fortification and constructive feedback. Many seasoned leaders and professionals spend years getting these interventions right, so don't feel bad if you're intimidated or discouraged. This is one of the most difficult tasks that a leader must do.

## 6. TAKE CORRECTIVE ACTION

Corrective action is defined as a loss of membership rights or privileges on the medical staff. Contrary to popular belief, it does not have to be all or nothing. For example, a healthcare entity is not obligated to offer a fair hearing and appellate review until corrective action has been in effect for greater than 14 days, and no report to the national practitioner data bank (NPDB) is required until corrective action has been in effect for greater than 30

days. Therefore, lesser timeouts may be imposed to let the practitioner have time to reflect on whether he or she would like to work with the medical staff toward mutual performance improvement goals. The organized medical staff is not for everyone and most members are unaware that membership on a medical staff obligates a mutual commitment to support the medical staffs efforts to oversee and improve the quality of care on behalf of the governing board.

Except for particularly egregious incidents, corrective action should only be taken as a final culminating step after each layer of the performance pyramid has been thoughtfully implemented and there appears to be no other alternative.

## CONCLUSION

The performance pyramid is the best model that we have found to address behavioral performance issues.

Most physicians who are disruptive have truths they are defending in a dysfunctional manner. This dysfunctional behavior has been inadvertently sanctioned through an overemphasis on the importance of technical skills and an undervaluation of the more abstract behavioral skills that elevates the physician from technician to healer. There is a clear public and professional mandate to eliminate professional conduct that neither supports the interests of patient safety nor represents the best of what the medical profession represents.

Our generation of physicians and physician leaders are charged with the task of eliminating dysfunctional and self-destructive behavior that may inadvertently harm patients and demeans our profession. Supporting a higher standard of professional conduct in a humane and supportive manner will be one of our lasting legacies to the next generation of healers and the patients whom they will serve.

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