Unprofessional behaviour and patient safety

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ABSTRACT

The vast majority of doctors behave to the highest professional standards, but a small number do not. Those who display unprofessional behaviour tend to do so recurrently and often go unchallenged, except in the most extreme cases.

In North America such behaviour is termed ‘disruptive’ and is receiving increased attention from regulators following a clear demonstration of a link with medical errors. In the United Kingdom a small number of the most serious cases will come to the attention of the National Clinical Assessment Service (NCAS) or the General Medical Council but little attention has been paid to lower profile behavioural disturbance. Disruptive behaviour has also been demonstrated by nurses, other clinicians and managers but it is the behaviour of doctors which has been most closely linked with patient harm.

In this paper we shall review the literature on disruptive behaviour by doctors and examine the evidence linking it to patient harm and unsafe working environments. We shall describe some of the programmes which have been developed in North America to deal with this and suggest ways in which these might be adapted for use in the UK.

Keywords: disruptive, patient safety, professionalism

Introduction

The 1999 Institute of Medicine report To Err is Human launched the modern patient safety movement (IOM, 1999). The main themes will be familiar to clinical leaders through the work of the Institute for Healthcare Improvement in the US, and the Safer Patients Initiative and the Patient Safety First Campaign in the UK. Most errors are committed by ‘good, hard-working people trying to do the right thing’ and to improve patient safety we should focus on designing systems which ensure a safe culture rather than trying to identify who is at fault (Wachter and Pronovost, 2009). The patient safety movement has promoted a ‘just culture’, which balances accountability with safety (Dekker, 2007) as a refreshing change to the traditional ‘blame culture’.

However, To Err is Human also recognised that individual professionals’ ‘dangerous, reckless or impaired’ behaviour can sometimes harm patients (p. 169). In 2008 the Joint Commission (the body which accredits hospitals for Government health insurance programmes in the US) became so concerned about ‘behaviours that undermine a culture of safety’ that it ruled that all hospitals should have a code of conduct for medical staff and mechanisms for addressing breeches of this (Joint Commission, 2008).

The most compelling reason for addressing disruptive behaviour has been the demonstration that it can directly harm patients (Institute for Safe Medication Practices, 2004; Rosenstein and O’Daniel, 2008) but there are other reasons. It contributes to poor team
working, difficult work environments, poor patient satisfaction and nurse recruitment problems, and poses a litigation risk (Hickson 2002; Joint Commission, 2008).

A variety of mechanisms have been developed which have helped organisations reduce the occurrence of disruptive behaviour and deal with it when it does arise (Hickson, 2007; College of Physicians and Surgeons of Ontario, 2008; Rosenstein, 2009).

**What is disruptive behaviour?**

Few would argue that throwing instruments in operating theatres, swearing or sexual harassment are disruptive but there is less agreement around ‘lower level’ behaviour.

Guidance from the College of Physicians and Surgeons of Ontario (CPSO) (2008) defines disruptive behaviour as:

> ‘When the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behavior interferes with, or is likely to interfere with, quality health care delivery. Disruptive behavior may, in rare circumstances, be demonstrated in a single egregious act (for example, a physical assault of a co-worker) but is more often composed of a pattern of behavior. The gravity of disruptive behavior depends on the nature of the behavior, the context in which it arises, and the consequences flowing from it.’

The College goes on to list verbal (insults, abusive language, outbursts of anger, inappropriate arguments) and non-verbal (refusal to comply with standards, failure to respond to calls, etc.) examples of disruptive behaviour (Box 1).

Swiggart and colleagues (2009) have found it useful to describe a spectrum of behaviours from aggressive through passive-aggressive to passive (Figure 1) and emphasise that passive and passive-aggressive behaviours can be just as detrimental to a safety culture as aggressive ones.

The Joint Commission (2008) regards disruptive behaviour as including:

> ‘Overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.’

It goes on to say that:

> ‘Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation and impatience with questions.’

All definitions recognise that disruptive behaviour occurs along a spectrum of intensity and frequency and that recurrent disruption by a small number of individuals is the most common pattern.

<table>
<thead>
<tr>
<th>Box 1 CPSO examples of disruptive behaviour (adapted)</th>
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<tr>
<td><strong>Inappropriate words</strong></td>
</tr>
<tr>
<td>- Profane, disrespectful, insulting, demeaning or abusive language</td>
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<tr>
<td>- Demeaning comments or intimidation</td>
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<td>- Inappropriate arguments with patients, family members, staff</td>
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<td>- Rudeness</td>
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<td>- Boundary violations with patients, family members or staff</td>
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<td>- Gratuitous negative comments about a colleague’s care (orally or in notes)</td>
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<td>- Censuring colleagues or staff in front of patients, visitors or other staff</td>
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<td>- Outbursts of anger</td>
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<td>- Behaviour that others would describe as bullying</td>
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<td>- Jokes or comments about race, ethnicity, etc.</td>
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<td><strong>Inappropriate actions/inactions</strong></td>
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<td>- Throwing or breaking things</td>
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<td>- Refusal to comply with known and generally accepted practice standards</td>
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<tr>
<td>- Use or threat of unwarranted physical force with others</td>
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<td>- Repeated failure to respond to calls or requests for information</td>
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<td>- Repeated and unjustified complaints about a colleague</td>
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<td>- Not working collaboratively or co-operatively with others</td>
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<tr>
<td>- Creating rigid or inflexible barriers to requests for assistance/co-operation</td>
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Factors underlying disruptive behaviour

Swiggart and colleagues (2009) have identified internal and external factors which may predispose individuals to disruptive behaviour, and similar characteristics have been highlighted in the UK by the NCAS (2009) (Boxes 2 and 3).

In some cases individuals have health problems (Leape and Fromson, 2006; NCAS, 2009); alcohol abuse, addiction, stress, depression, cognitive impairment, or physical illness may all play a part. Likewise, disruptive behaviour may be a manifestation of personal, family or financial problems (Swiggart et al, 2009).

Individuals who are seen as driven, perfectionist, focused or unassertive may be more inclined to behave in a disruptive way especially if the external work environment gives little support and has high demands. Most doctors referred to the NCAS are not antagonistic or disagreeable but unassertive, agreeable perfectionists (NCAS, 2009). Many perpetrators have very high levels of clinical skill and competence but may become socially isolated from their peers. They often have little insight into the effects of their behaviour on others and have poor influencing skills (Ephysician health.com).

Organisational culture may inadvertently promote aberrant behaviour especially if expectations are not
made explicit at the time of appointment and if issues are tolerated or managed inconsistently. Tolerance of lower level disruptive behaviour leads individuals to believe that it is acceptable, and creates a positive behavioural feedback loop reinforcing the belief that it achieves results. Problems can be exacerbated by poor or inconsistent mechanisms for responding to clinicians’ concerns (about patient safety, for example; Hickson, 2007).

How common is disruptive behaviour by doctors?

Clinical leaders, doctors, nurses and pharmacists commonly encounter disruptive behaviour. Most agree that this involves less than 5% of the medical workforce but that problems with these individuals are recurrent.

Of 1635 US physician executives (the equivalent of medical and clinical directors in the UK), nearly 80% encountered problems with doctors’ behaviour at least three to five times per year, and 35% encountered them at least monthly (Weber, 2004). Seventy percent of respondents reported that the problems usually arose with the same small group of individuals. There were similar findings in a survey of medical and nursing executives where two-thirds reported that problems between doctors and nurses arose at least monthly (Johnson, 2009).

Rosenstein and O’Daniel (2008) have collated the results from a series of surveys of 4530 nurses, doctors and other staff from over 100 US healthcare facilities. Seventy four percent of respondents had witnessed disruptive behaviour by doctors and 65% reported that this happened at least five or six times per year. Most respondents thought that only 2–4% of medical staff were involved. General and cardiac surgeons were thought the most likely to be involved.

The Institute for Safe Medication Practices (ISMP) (2004) surveyed over 2000 nurses and pharmacists. Most reported experiencing condescending language, impatience or refusal to answer calls and 22% had been the victims of strong verbal abuse on at least three occasions in the previous year. Most reported problems with less than five individuals in their organisations.

Less information is available from the UK, but of 1198 cases referred to the NCAS in 2007–2008, 56% involved behavioural concerns or misconduct (NCAS, 2009).

How do organisations respond?

Most clinical leaders and staff do not think that their organisations deal effectively with disruptive behaviour and many report a perception that doctors, especially those with a high value to the organisation, are treated more leniently than other staff.

Although just over 70% of American clinical leaders (Weber, 2004) reported that their organisations had a written code of conduct, over half of these thought it was applied selectively or not at all. Eighty percent believed that problems with doctors were either under-reported or only reported when a serious violation had occurred. Sixty three percent said that doctors were treated more leniently than other groups.

Sixty one percent of respondents to the ISMP survey (2004) thought that their organisations did not deal effectively with disruptive behaviour and 30% did not think that their manager would support them if they reported an incident.

The effects of disruptive behaviour on patient safety

Some behaviours contribute directly to medical errors. Pharmacists and nurses have reported reluctance to clarify safety concerns with some doctors because of behaviour and some have identified specific safety incidents which have arisen as a result.

Seventeen percent of respondents to the ISMP survey (2004) had felt pressurised to accept a medication order despite safety concerns on at least three occasions in the previous year; 13% had refrained from contacting a specific prescriber to clarify an order on at least ten occasions. Seven percent said that in the previous year they had been involved in a specific medication error where intimidation played a part.

Respondents to Rosenstein and O’Daniel’s surveys (2008) commonly indicated a reluctance to call or interact with certain doctors to clarify orders for fear of a hostile response. Fourteen percent of 4530 respondents reported that they were aware of a specific adverse event related to a disruptive behaviour episode. In a subset of 244 professionals working in a perioperative environment (Rosenstein and O’Daniel, 2006), 19% reported awareness of a specific adverse event which had occurred as a result of disruptive behaviour.
In addition to its direct contribution to medical errors, disruptive behaviour can undermine a culture of safety by its effects on team working and communication. Rosenstein and O’Daniel found a perception of a link between disruptive behaviour and adverse events (66%), medical error (71%), poor quality of care (72%), mortality (25%) and poor staff satisfaction.

Other effects of disruptive behaviour

Disruptive behaviour can also lead to reduced patient satisfaction, increased complaints, increased litigation risk, low staff morale and high staff turnover.

Hickson and colleagues (2002, 2008) analysed patient complaints in a practice of 645 doctors over six years and related these to the risk of litigation (a significant problem in the US). Most complaints were related to poor communication and behaviour, not clinical issues, and a small number of doctors generated a disproportionate share of complaints; 9% of doctors were responsible for 50% of complaints. Those with most complaints were also at highest risk of being the subject of legal action, irrespective of specialty.

Rosenstein and O’Daniel (2008) found that disruptive behaviour caused high levels of stress and frustration and a deterioration in the relationship between doctors and nurses. Thirty seven percent of respondents were aware of nurses who had left their hospital as a result of disruptive behaviour. Hickson (unpublished data) found that of those who had experienced disruptive behaviour, many felt angry and frustrated and some suffered adverse effects even after several months. Sixty eight percent had considered leaving their job and 36% expressed distrust of leaders as a result of having been targets of unprofessional behaviour.

Managing disruptive behaviour

Several approaches have been described for dealing with disruptive behaviour (Hickson, 2007; College of Physicians and Surgeons of Ontario, 2008; Swiggart et al, 2009) and the National Clinical Assessment Service has published useful materials on its website (www.ncas.npsa.nhs.uk). All approaches are modified to suit local regulatory arrangements, but they share some common themes. These include:

- making expectations explicit by having a code of conduct supported by appropriate policies
- ensuring robust Board support for clinical leaders in implementation
- support and training for those dealing with disruptive behaviour
- screening for health and personal issues
- proactive surveillance systems
- dealing consistently and transparently with infringements
- dealing with lower level aberrant behaviour early
- having a graduated set of responses (informal, formal, disciplinary, regulatory) depending on the severity of the incident
- making resources available to help those displaying and those affected by disruptive behaviour.

A code of conduct for doctors ensures that expectations are made explicit in advance and various templates are available which can be modified for local use (Hickson, 2007; College of Physicians and Surgeons of Ontario, 2008; Rosenstein, 2009). There is agreement that Boards need to be aware of the patient safety and other effects of disruptive behaviour and understand their responsibilities in this respect (Sandrick, 2009). In the US some Boards have appeared reluctant to challenge high revenue doctors and although the contractual situation is different in the UK, there may be some parallels.

The pyramid model in use at Vanderbilt University Medical Center (Hickson, 2007) is a useful one for ensuring that interventions are appropriate to the gravity of the behaviour (Figure 2).

For a single unprofessional act an informal approach between the individual and a suitably trained colleague is advocated (the ‘cup of coffee’ conversation). This has a structure designed to explore the individual’s insight into their behaviour, to draw attention to its effects and to ask them to reflect upon these. The important exception to this general rule is that if the single unprofessional act is so serious that it clearly warrants a formal or disciplinary approach.

If there is a recurrence of unprofessional behaviour and an apparent pattern is emerging then at Vanderbilt an ‘awareness intervention’ takes place conducted by a suitably trained clinical lead or department head. This is still a ‘developmental’ rather than disciplinary conversation and the possibility of illness or other external factors is explored. The intervention is designed to draw attention to an apparent pattern and to gauge the doctor’s interpretation of events.

If a definite pattern emerges then an ‘authority intervention’ occurs with an experienced clinical leader since at this stage there is enough evidence to be concerned about patient safety and other effects. This intervention involves identifying and documenting concerns and agreeing an action plan with measurable outcomes. There may be a requirement for behavioural or other interventions at this stage.
A continuation of unprofessional behaviour despite such an intervention or an unwillingness to comply with improvement plans means that the process moves to a disciplinary one which may ultimately involve the withdrawal of an individual's admitting privileges (or termination of their employment) and reporting to a licensing authority.

At Vanderbilt, this process is supported by a well-established training programme for clinical leaders and a proactive surveillance system involving analysis of complaints and clinical incidents. Hickson and colleagues (2007) have seen some success from this approach. They analyse complaints within specialty groups and benchmark against specialty colleagues. Those with higher levels of complaints are offered awareness, authority and if necessary disciplinary interventions; about 60% of those offered awareness interventions demonstrate a subsequent reduction in complaints and reduction in risk of litigation.

Most states in the US also have physician health programmes which deal with the small number of doctors who have serious health, addiction or similar problems. Such programmes usually involve comprehensive psychological evaluation followed by intensive therapeutic interventions. The programme for this group at Vanderbilt reports that 80% of those who undertake it show some improvement (Samenow et al, 2008; Swiggart et al, 2009). There are few such programmes at present in the UK, although there are plans to establish them (G Ashead, personal communication).

Practical suggestions for UK clinical leaders

There are important differences between the ways in which medicine is organised in North America and in the UK, where there are national appraisal systems, centralised registration, revalidation, the NCAS and national contracts for doctors.

Structures might vary between different types of organisation, between primary and secondary care and in the different countries of the UK, but we would suggest that clinical leaders consider the following steps:

- Quantify the extent of the problem in their organisations; helpful sources of information might come from an analysis of complaint and clinical incidents as well as their own experience of dealing with issues. Safety managers, HR departments, complaints managers, legal departments and senior nursing leaders might also have relevant information.
- Engage the Board and ensure their support; North American experience indicates that the whole Board and Executive team need to understand the importance of the issue. Presenting this as primarily a patient safety issue seems to have helped focus attention in the US. Directors of HR need to be prepared to participate in the process and support clinical leaders.
- Along with the Director of HR, establish a code of conduct for medical staff and policies for implementing this, including appropriate training. Existing approaches from North America could be modified to suit UK organisations.
• Ensure that expected behaviour is modelled by all those in authority in the organisation including Board and Executive team member, clinical leaders and other management colleagues.

• Use existing structures. An appraisal and revalidation infrastructure already exists and appraisers have professional responsibility, through medical directors, to the GMC. Individual doctors should already be collecting details of complaints, clinical incidents, outcomes from patient surveys and 360 degree feedback. Appraisers should ensure that any patterns are highlighted and that action plans are drawn up. In secondary care, existing mechanisms of support for pay progression and Clinical Excellence Awards could be linked to this. Only a small percentage of doctors will require formal referral to the NCAS but they also offer advice and guidance to clinical leaders dealing with less serious cases.

Conclusions

Most doctors adhere to the highest professional standards but a small number do not, and some recurrently display disruptive behaviour. Such behaviour contributes to an unsafe environment for patients and can directly lead to preventable medical errors. It also contributes to complaints, damages morale, creates difficult working environments and causes difficulty recruiting and retaining staff.

A small number of those displaying disruptive behaviour will be suffering from medical conditions or dependency and some will have family and other problems. Occasional unprofessional acts will be so serious that they require referral to the NCAS but they also offer advice and guidance to clinical leaders dealing with less serious cases.

REFERENCES


ADDRESS FOR CORRESPONDENCE

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Appendix 1

Helpful online resources

- UK National Clinical Assessment Service. www.ncas.npsa.nhs.uk. Links to materials on disruptive behaviour with video clip examples and link to sample code of conduct.
- The Center for Patient and Professional Advocacy at Vanderbilt. www.mc.vanderbilt.edu/centers/cppa. Extensive links to background literature, study outcomes and other resources.

Appendix 2

Case 1: Dr Jones
Dr Jones has been in his consultant post for a year and has a reputation for hard work and dedication. He is universally popular with patients and colleagues. He takes an active part in organising his department and is an enthusiastic teacher.

The Medical Director is surprised to receive a letter of complaint from the ward sister alleging that Dr Jones had a verbal outburst on the ward when he was asked to see one of his colleague’s patients (the colleague had taken leave at short notice). Dr Jones is alleged to have shouted at a nurse and stormed off the ward, refusing to see the patient.

Comment
Dr Jones appears to have behaved unprofessionally, but this seems to be a single act which is out of keeping with his previous behaviour. This might be the sort of incident which warrants an informal approach by the Medical Director or another colleague in the first instance. Undoubtedly the nurses and others involved should receive an apology and assurances that there will be no recurrence, but the meeting should also explore other issues. There may be concerns relating to taking on a new consultant post or there may be family or financial worries, especially if he has had to relocate for the job. He may feel that his colleague is not behaving fairly by taking leave at short notice and the Medical Director might need to help resolve this.

Case 2: Mr Black
Mr Black was appointed a few years ago with the reputation as a high-flier; he achieves excellent surgical outcomes and has an active research programme with a national reputation. However, some nurses refuse to work with him; it is said that he “expects the same high standards of others that he demands of himself”. The Clinical Director has had numerous informal meetings with him over the years about issues like off-formulary prescribing, refusal to follow hand washing policy, shouting at nurses when notes aren’t available and car parking. The complaints department is nearly always dealing with at least one complaint about his rudeness. The Medical Director is contacted by a surgeon who was working in an adjacent theatre and witnessed Mr Black throwing an instrument to the floor then shouting racial abuse at the scrub nurse.

Comment
If the circumstances are as reported then this immediately becomes a disciplinary issue, as it involves allegations of violent behaviour and racial abuse. The Medical Director should seek advice from the Director of HR; he may also find it helpful to discuss his concerns with the NCAS.

The pattern of previous unprofessional behaviour is common; earlier more formal intervention might have reduced the risks of progression to this stage.
Case 3: Dr Smith

Dr Smith has worked in a community setting for 25 years. He is considered pleasant and polite, but rather set in his ways. His prescribing habits are thought to be old-fashioned. Although he works with a multidisciplinary team, he always makes the final decisions himself. He is deeply disorganised; he is always late for meetings, and sometimes doesn’t turn up at all. He has never had a mobile phone, and refuses to get one, so is difficult to contact. He makes very brief notes when he sees patients and frequently forgets to write to GPs afterwards, which they find very frustrating. Numerous secretaries have tried to organise him but he appears to stubbornly resist.

Issues come to a head when a local GP practice make a formal complaint to his Clinical Lead about non-formulary prescribing and the lack of clinical letters.

Comment

Passive behaviour can be as much a risk to patient safety as more aggressive acts, but often does not attract the same attention. Prescribing irregularities and poor communication are significant safety risks, especially in community settings. When meeting with Dr Smith the Clinical Lead might want to ensure that any health problems are considered and that the job plan is reviewed. He should draw up a list of the various issues which may present risks, not just those identified in the complaint. 360 degree feedback may help inform the discussion; professional behavioural and HR support is likely to be required in drawing up and monitoring action plans. The approach is likely to require such an ‘authority’ intervention with clear plans for escalation if there is no progress.

Case 4: Dr Green

Dr Green has a reputation for being a bit short tempered, but is generally liked by her patients and colleagues. Over the years the Medical Director has had to deal informally with occasional minor behavioural issues.

A written complaint arrives from a patient alleging that she had been sent home from outpatients without being seen because her notes were unavailable. It transpires that this has happened fairly frequently over the last few months.

Dr Green meets with the Medical Director and admits to having sent a number of patients home because their notes weren’t available. She says that in some of her clinics notes have been missing for nearly half the patients. She has highlighted this to the departmental manager but been told that there is nothing she can do as internal audit figures show that the situation is getting better.

Comment

Refusing to see a patient because notes are unavailable could put the patient at risk, and would certainly inconvenience them; it could also damage the reputation of the hospital. This is unlikely to meet required standards of professional behaviour. However, there appears to be a very high percentage of missing notes in Dr Green’s clinics, which also creates risk. Dr Green has tried to get the issue resolved by going through accepted channels which appears not to have worked; the Medical Director now has a responsibility to try and help resolve the notes issue as well as dealing with the unprofessional behaviour.

Any intervention should aim at ensuring that patients who have been delayed receive apologies and are dealt with as soon as possible, and achieving an understanding by Dr Green of the correct approach to highlighting and resolving such issues in the future.