Developing and Implementing a Policy to Deal with

Dis*rup*tive Staff

by John-Henry Pfifferling, Ph.D.

Disruptive behavior by any member of the oncology team can sabotage professionalism and has clinical, operational, and economic consequences. The interdisciplinary team becomes less productive and creative. At best, work is not as exhilarating as it could be. In the worst-case scenario, working becomes filled with anxiety.

When caregivers tolerate disruptive behavior from a member of the oncology team, the patient is the loser. Patients with cancer are dealing with intense fear and feelings of isolation. If their caregivers are emotionally unavailable and distracted by the behavioral ups and downs of a colleague, that sense of isolation will be intensified. The possibility also exists that important clinical information will be missed because the attention of the staff is not where it should be.

Cancer caregivers cannot develop strong therapeutic teams without a policy for dealing with disruptive behavior. The delivery of cost-effective, humane cancer treatment requires the healing or removal of disillusioned, angry, or "disruptive" professionals from direct patient care.[1]

While no single definition of disruptive behavior exists, most authorities agree such behavior undermines practice morale, increases staff turnover, sabotages effective teamwork, increases the risk of ineffective care, and causes distress to peers, staff, patients, or others in the practice.

Disruptive behavior includes bullying, abusive language, shaming others for negative outcomes, criticizing team members in front of others, and threatening a team member with retribution, litigation, violence, or job loss.

Members

(See case studies on page 20). Disruptive individuals rely on intimidation to accomplish their goals and refuse to honor cultural differences. A disruptive staff member may also violate personal boundaries or refuse to comply with clinical practice standards.

The consequences to the disruptive individual may be severe,[2] including loss of privileges, employment, and employability. He or she may be at increased risk of lawsuits from disgruntled colleagues and patients, or become "isolated" from colleagues and experience increased workloads because other team members will not provide assistance and support.

CAUSES OF DISRUPTIVE BEHAVIOR

Working in the field of oncology creates stress on its own, irrespective of what might be happening in a colleague's personal life. Cancer care practices are stages on which an inordinate number of dramas are played out. Suffering, loneliness, intractable pain, and "bad things happening to good people" are all part of an oncology staff's daily lives. This stress may aggravate pre-existing personality traits so that, for example, distrust evolves into hypercritical behavior or perfectionism.

Oncology practices need to acknowledge the stress inherent in dealing day after day with the needs of critically ill and dying people, and should offer their staff members ways to deal with these stressors.

Do not assume that an alleged disruptive professional has a psychiatric or psychological problem. Disruptive behavior can also be caused by stress syndromes or physical diseases, such as poorly-controlled diabetes, thyroid disorders, undiagnosed tumors, hearing loss, and so on.

Cultural differences are also worth exploring. For instance, personal space boundaries are smaller in the South than in the northern part of the country. A practitioner from a southern state may unknowingly offend northern coworkers without meaning to by standing "too close" to them.

PREVENTIVE STRATEGIES

Preventing disruptive behavior is as important as learning how to manage the problem once it occurs. Hiring outside experts to teach interpersonal skills and conflict management is a good investment for any oncology facility. The most cost-effective way to prevent disruptive behavior is to address the root causes of the behavior. One valuable method to help professionals cope with occupational stress is to get them to participate in facilitated staff support groups. Support groups have proved to be one of the best ways to prevent burnout and keep behavioral problems from becoming toxic.

Unfortunately, physicians tend to be so fearful of self-disclosure among peers that they don't take advantage of such groups, even litigation support groups. When oncologists don't receive the natural relief and revitalization provided by collegial support, this lack of respite may result in unresolved distress and resentment being discharged on their staff.

The problem needs to be addressed in your work culture. Clear messages should be communicated to your physicians that, within the confines of the cancer program or practice, self-disclosure, expressing fears, and asking for support will be considered healthy behaviors and will be met with caring and concern.

DIFFICULTIES IN HANDLING DISRUPTIVE BEHAVIOR

In spite of these efforts, there will always be people whose personal problems make difficulties between them and their coworkers.

Since many disruptors refuse to acknowledge the harmful impact of their behavior on others and do not respond to timely, private, and direct feedback, confrontation usually becomes necessary. Most people don't want to confront a disruptive individual because they are afraid the disruptor's anger will escalate or, if the disruptor is high in the institutional hierarchy, that the disruptor will abuse his or her power and terminate the confronter's employment. Fear of an increased workload if the disruptor is fired also encourages tolerance.

Tolerating disruptive behavior usually results in a higher turnover rate in the clinic staff and a poorer quality of patient care. For the sake of the patients alone, each workplace must create and implement standardized ways of dealing with individuals that cause problems for the practice.

DEVELOP PROFESSIONAL BEHAVIOR GUIDELINES AND POLICIES

A cancer program that focuses on professionalism and sets up positive standards of behavior lets staff members know what is expected of them. These standards should focus on both interpersonal and professional/practice expectations, and should be reviewed by the staff members who will be expected to comply with them. The agreed-upon standards should also be clearly communi-

Author's Note: Although the case studies refer specifically to disruptive physician behavior, the strategies outlined in this article can be applied to all members of the health care team.

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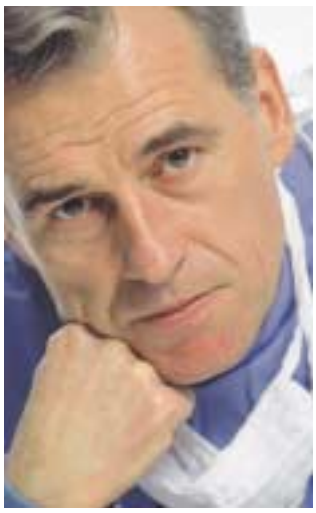

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cated to all members of the staff, including new staff when they arrive, and should be enforced fairly and on a regular basis.

The following is a partial list of reasonable professional behavior guidelines for staff members. Add to them according to the values of your practice culture. Staff members should: [3]

- Comply consistently with practice standards for professionalism
- Communicate with colleagues clearly and directly, displaying respect for their dignity
- Support policies promoting cooperation and efficient teamwork
- Use conflict resolution and mediation skills to manage disagreements
- Address concerns about clinical judgments with team members directly and in private
- Address dissatisfaction with practice policies through appropriate grievance channels
- Routinely offer and accept constructive feedback.

In a cancer center, the first step in developing a disruptive behavior policy is to decide what behaviors are considered disruptive, what consequences should be imposed on people who indulge in these behaviors, and how the consequences will be enforced. Answering the following questions will help you define what kind of policy your practice wants to implement.

- What single incident or patterns of behavior warrant use of the policy?
- Who should be responsible for initiating contact with an allegedly disruptive person?
- What consequences are available for dealing with disruptive individuals at each level in your staff hierarchy, and in what order do you want to apply them?
- How will you consistently enforce these consequences?
- Will you use performance appraisals as opportunities to discuss interpersonal behavior?
- In the hospital setting, how will you work with disruptive independent contractors, such as contract radiation oncologists?
- In the practice setting, is there an equitable professionalism policy for all staff members?
- Does your policy allow and reinforce mediation?
- Does your policy allow and fund efforts to find rehabilitation resources?
- Is the existence of outside resources for rehabilitation known to allegedly disruptive staff members?
- Are consistent rules in place to handle an alleged or verified disruptor who refuses help?
- After rehabilitation, is there a policy in place for re-entry transitioning?
- Has your grievance policy been reviewed by your legal counsel and interpersonal skills correction experts?
- Is there enough money so that the practice can defray the cost of corrective services if they become necessary?

The answers to these questions will help shape a sound disruptive behavior policy. Many of our clients have found it helpful to read sample policies from similar practices or cancer care centers when they are trying to establish their own standards, but do not assume that another practice or center's policy can automatically be transferred to your facility. Your definition of professionalism and policy transgressions is a culturally intimate decision. Just make sure the policy deals with behavioral expectations, methods of confrontation, the grievance process, assessment tools, treatment choices, sanctions, and re-entry into the system.

When fair disruptive behavior policies exist, disruptive professionals are helped to correct their behavior through a variety of mechanisms, including peer counseling, reading, support groups, and outside professional help. They usually respond to these aids and become functioning members of the practice once again.

SAFEGUARDS

Any system, no matter how well set up, is open to abuse. In our work, we have seen too many cases where disruptive behavior policies were used by jealous economic competitors, estranged spouses, or angry partners to harm innocent individuals. We were once involved in a case where a hospital administrator manipulated an investigative board to force a powerful, competing physician off the staff. It is not at all uncommon for litigious physicians to use the threat of a lawsuit to thwart or delay confrontation about their behavior.

Talk to your risk manager and legal counsel to develop a good disruptive behavior assessment policy with adequate due process protection.[4] Whether you add up incident reports or interview complainants, make sure your process is fair.

If necessary, call in outside help. We recall several cases where serious allegations were made and outside assessment discredited the allegations.

Outside assessments can occur on site or off site. Our organization, the Center for Professional Well-Being (CPWB), is a 501(c)3 non-profit educational organization devoted to promoting well-being among

The AMA's Policy E-9.045 on Physicians with Disruptive Behavior

1. Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect, patient care constitutes disruptive behavior. This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team. However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

2. Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness (or equivalent) committee.

3. In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements:

- Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.
- Describing the behavior or types of behavior that will prompt intervention.
- Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.
- Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
- Including means of monitoring whether a physician's disruptive conduct improves after intervention.
- Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.
- Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
- Providing clear guidelines for the protection of confidentiality.
- Ensuring that individuals who report physicians with disruptive behavior are duly protected.

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health care professionals through educational, consulting, and advisory programs and services. Visits are made to groups and practices, and services and programs are tailored to the needs of clients. Off-site programs include retreats, lectures, seminars, and consulting services. CPWB assesses and helps remediate "disruptive" behavior using a supportive, non-psychiatric, skills development model. Among other services, we offer seminars and workshops on anger management, assertive communication, conflict resolution, and medical partnership relationship building.

At CPWB, we usually collect data on site when major discrepancies exist between the stories of the complainant and the alleged disruptor, or the denial of the alleged disruptor is so great that a neutral party must be called in to mediate.

An equitable and effective grievance procedure must be structured into the framework of your policy, and both sides of a problem must be explored.[4] If a physician believes his or her outburst was triggered by the administration's intractable resistance to legitimate requests for equipment, this allegation must be looked into and corrected.

Treating each alleged case of disruptive behavior as a special entity is no longer acceptable. Many risk managers can relate stories replete with aggravation, staff anger, unexpected job turnover, and threatened litigation. The problem is pervasive and emotionally and financially costly.

Of course facility leaders must investigate and correct the aggravating aspects of their cancer program or practice that promote frustration and acting out; but the best way cancer care centers can prevent or reduce difficult behavior on the job is by creating and enforcing strong, positive professional behavior standards and crafting fair disruptive behavior policies to manage, confront, and rehabilitate people who interfere with the healthy functioning of a work group.

Within professional groups one must 1) define reasonable and competent interpersonal behavior; 2) offer educational opportunities to improve communication, increase interpersonal skills, and learn how to manage conflict; and 3) fairly assess, offer feedback, confront, and attempt to correct interpersonal deficiencies when they cause problems in the workplace.

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THREE CASE STUDIES

Case 1

Dr. Perfect is a well-respected oncologist, who has been in practice for 10 years. She and her partners rarely communicate except in the context of work-related decisions. She is gradually becoming more fatigued, ostensibly from dealing with death, dying, and loss issues on a daily basis. She tells anyone who asks about her, "All my patients have bad outcomes. How do you want me to feel?" Dr. Perfect discounts her patient's successes when they do well, and also discounts the patients who tell her they appreciate her efforts and expertise.

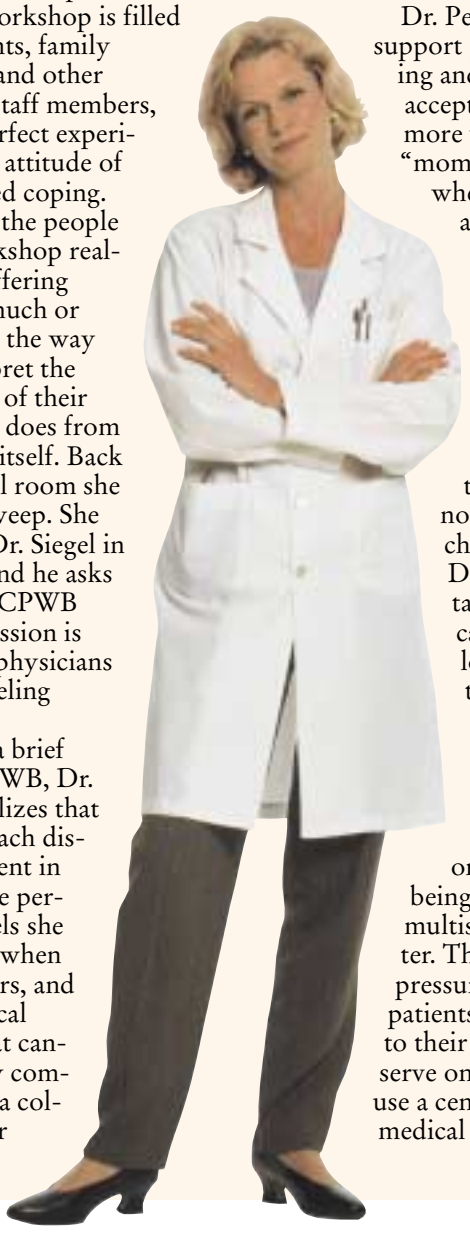
Dr. Perfect is constantly tired (from her apparent failures), and often gets angry with her patients if they don't agree with her or try to discuss her treatment plans. Her staff says her expectations are unrealistic and her anger seems to be "generic." Dr. Perfect's anger seems ever-present, even when her staff does well, and she always seems to be on the edge of raising her voice to everyone—her staff, her nononcology colleagues, and her patients and their family members.

The practice staff is fearful of confronting Dr. Perfect because she is the practice's senior and founding partner. Since the practice is in a rural area, the staff has few other job opportunities. The anger level among staff members is escalating, and seemingly slight incidents provoke outbursts.

At Christmas, a young patient with non-Hodgkin's lymphoma presents Dr. Perfect with a copy of *The Healing Companion* by Jeff Kane, and Bernie Siegel's *Love, Medicine and Miracles.* She tells Dr. Perfect, "You really need to read these books because I'm concerned about you." Dr. Perfect's husband finds the books at home, and after reading them himself convinces her to attend one of Dr. Siegel's workshops.

The workshop is filled with patients, family members, and other oncology staff members, and Dr. Perfect experiences their attitude of nonresigned coping. Somehow, the people at the workshop realize that suffering comes as much or more from the way they interpret the experience of their illness as it does from the cancer itself. Back in her hotel room she begins to weep. She runs into Dr. Siegel in the hotel and he asks her to call CPWB "whose mission is caring for physicians who are feeling depleted."

After a brief visit to CPWB, Dr. Perfect realizes that she takes each distressing event in her practice personally, feels she is a failure when death occurs, and has a medical partner that cannot display compassion to a colleague. Her anger is a symptom of burnout, and unresolved and unsupported grief. Looking back, she realizes that *a patient*, in spite of her illness, had showed her compassion and caring, and she sees that patient as a model for reaching out in spite of her own overwhelming situation.



Dr. Perfect decides to attend support group facilitator training and retrains herself to accept "permission" for more vacations. Her "moment of clarity" happens when she realizes that her anger came from her unrealistic expectations and the way she discounted her own needs. Anger, she now realizes, is almost always a teacher.

After she returns to her practice, the staff notices a profound change in her attitude. Discussions about mental health days, sabbatical planning, using locum help, and neutralizing the burnout trajectory are now commonplace.

Case 2

An eight-physician oncology practice is being incorporated into a multispecialty medical center. The practice is being pressured to see more patients, refer more patients to their diagnostic colleagues, serve on more committees, and use a centralized electronic medical record system. The

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physicians feel they are losing their autonomy but are powerless to stop the process.

Frustrations are building. Each doctor has his own income expectations and obligations, but more and more dollars are being siphoned out of their incomes to pay for the administrative demands of the "Big House." The staff is forced to take sides and reacts by dreading going to work and using so much sick leave that chaos permeates the practice. At home, the doctors' irritability and accusations even start affecting how they treat their children and pets.

Because the group is so splintered, presenting a united front to the medical center administration is not possible.

A senior member of the group hears a CPWB associate lecture at grand rounds on physician collegiality and practice quality of life. After weeks of discussion, a CPWB team is invited to address the practice. Before meeting with the group, CPWB sends a survey to the practice's doctors and their spouses and asks everyone to describe the problems in the office individually. The results are anonymous.

The oncology offices are closed and a Center facilitator meets with the group at a member's home to summarize the dysfunctional communication issues expressed in the surveys. The spouses meet with the facilitator after the physicians are done. The next morning, physicians and spouses meet as a group, and the spouses have the opportunity to express their feelings about the part of the conflict that "came home."

To reestablish effective communication, two partners volunteer for training in peer conflict management. Although the stressful work environment does not change, the practice uses its new skills to promote inter-partner respect and rebuild trust. Practice meetings are monitored for three sessions to ensure that issues are addressed and not personalities, and a follow-up retreat is planned for the future.

Case 3

Mrs. S came in for her routine scheduled follow-up visit for breast cancer. She had met with her oncology care team and indicated she understood a carefully outlined treatment plan. Because her primary oncologist was out of town attending a CME program, she was seen by another oncologist.

His first comments were brusque, "I recommend a change in treatment, and you need to follow my new regimen."

The patient indicated that this recommendation was delivered with an authoritative attitude and she felt that her primary care oncologist had been belittled. Mrs. S told her oncology nurse that the physician's behavior had left her with feelings of confusion, insecurity, and trepidation bordering on fear. Each staff member reacted differently to the patient. Some defended the changed regimen, others mollified the primary oncologist, and others tried to be diplomats.

We discovered that this physician (the founding and managing partner in the oncology practice) routinely changed associates' treatment plans when he had to cover for other partners' patients. The associates (newly hired, competent, and caring oncologists) failed to confront the managing partner. The staff was also divided, fearful, and unsure about how to confront the owner. Everyone retreated into feeling "FINE" [fearful, insecure, neurotic, and emotionally labile].

This "disruptive" physician appeared completely unaware of Mrs. S's disquiet and confusion. He regaled other staff members with stories about how he had discovered other "errors" this young associate had made, always behind her back, and used the inevitable vulnerability of junior physicians, their fear of personal failure, and his confidence that his staff would not confront him to successfully play his games. The effect of his behavior on patients was never one of his concerns.

When staff members gently requested clarification of the discrepant approaches, they were belittled with technical sophistry. He "never had time" to discuss the logic behind his actions or the differences in his treatment approaches. The young associates predictably retreated, since it was up to this senior physician to define their clinical competency.

Unfortunately, in this case the request for help to our intervention team came very late in the game. We were only able to help the scapegoated oncologist understand that her employer had severe psychological problems and help this young physician develop both an exit strategy and a preventive strategy for her next workplace.