Disruptive Behaviors in Healthcare

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Abstract

Disruptive behaviors among healthcare members are a nationally recognized problem encountered frequently in healthcare institutions. Disruptive behaviors have a negative effect on concentration, communication, collaboration, and workplace relationships. Because of these negative effects, disruptive behaviors have been linked to compromised patient safety, adverse events, and patient mortality. To minimize the occurrence of these events, several strategies or policies have been mandated by some healthcare organizations. However, despite these mandates disruptive behaviors continue to be an escalating national patient safety concern. We aim 1) to describe the most common types of disruptive behaviors-their prevalence, frequency, and distribution in various sectors of healthcare; 2) to recognize the factors that drive disruptive behaviors and their consequences on patient safety; and 3) to illustrate the organizational processes used to address the general issue of disruptive practitioners. We believe that increasing the awareness of disruptive behaviors and understanding the organizational processes that healthcare institutions can have to minimize these behaviors has the potential to reduce the occurrence of disruptive behaviors and improve effective communication among the healthcare team. These efforts may eventually lead to improvements in patient care and safety, as well as improvements in organizational performance.

INTRODUCTION

"Where are my instruments? I want my instruments!" To this request, the staff member replies to the physician that the instruments are being sterilized. Then, the physician takes an instrument and throws it at the wall.

The supervisor schedules a colleague to work 5 early shifts in a row unlike other staff members.

A healthcare worker continues coming to work late and smelling of alcohol.

These are some examples of disruptive behaviors. The American Medical Association (AMA) defines disruptive behaviors as "Conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care …".[1] Anger outbursts, comments or opinions by other members of a healthcare team that are suppressed by intimidating behavior, retaliation against a healthcare team member who has reported a violation of a code of conduct, and comments that weaken a caregiver's self-confidence in patient care are other examples of disruptive behaviors. The American College of Physician Executives (ACPE) 2004 survey of 1600 physician executives revealed that disruptive behaviors among attending physicians, nurses, resident physicians, and other healthcare members are a nationally

recognized problem.[2] More than 95% of 1600 physician executives surveyed by the ACPE stated that disruptive behaviors are encountered on a regular basis.[2] This frequent display of disruptive behaviors has been shown to have a negative effect on concentration, communication, collaboration, and workplace relationships.[3] Of these, communication has been one of the most frequently identified root causes of reported sentinel events from 2008-2010, as reported by The Joint Commission's Sentinel Event Data.[4] Thus, sentinel events can result from poor communication stemming from disruptive behaviors. Moreover, the Institute for Safe Medication Practices' (ISMP) survey revealed that seven percent of more than 2,000 healthcare professionals were involved in a medication error in which intimidation played a role.[5] In addition, Rosenstein and O'Daniel have shown in 2006 that the occurrence of adverse events, medical errors, compromised patient safety, impaired quality, and patient mortality are linked to disruptive behavior.[6]

To minimize the occurrence of these events, strategies or policies have been mandated by some healthcare organizations. The Institute of Medicine in 1999 emphasized that: "the health system has not had effective ways of dealing with dangerous, reckless, or incompetent individuals and ensuring that they do not harm patients".[7] In 2000, the

AMA recommended that: "Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive".[1] Finally, in 2001 the Joint Commission mandated hospitals to develop specific policies addressing disruptive behaviors [8] and in 2009, the Jointthe Joint Commission Leadership Standard required healthcare institutions to have a code of conduct that defines disruptive behaviors and to implement a process managing these disruptive behaviors.[9] However, the ACPE 2009 survey of physician and nurse executives reported that only 56% of the healthcare organizations held staff training programs to attempt to decrease disruptive behaviors between physicians and nurses.[10]

Despite these mandates, disruptive behaviors continue to be an escalating national problem. In 2004, more than 95% of 1600 physician executives surveyed by the ACPE stated that disruptive behaviors are encountered on a regular basis[2] and five years later, in 2009, another survey by the ACPE similarly reported that 98% of 2100 physician and nursing executives (67% nurses and 33% physicians) reported witnessing disruptive behaviors between doctors and nurses.[10] Furthermore, the ACPE 2009 survey reported that over 50% of the respondents felt that the number of disruptive behaviors between physicians and nurses had stayed the same over the past three years and 12% felt this behavior increased.[10] Therefore, in this review we aim to: 1) describe the most common types of disruptive behaviors-their prevalence, frequency, and distribution in various sectors of healthcare; 2) to recognize the factors that drive disruptive behaviors and their consequences on patient safety; and 3) to illustrate the organizational processes used to address the general issue of disruptive practitioners. We believe that increasing the awareness of disruptive behaviors and understanding the organizational processes that healthcare institutions can have to minimize these behaviors has the potential to reduce the occurrence of disruptive behaviors and improve effective communication among the healthcare team. These efforts may eventually lead to improvements in patient care and safety and organizational performance.

TYPES OF DISRUPTIVE BEHAVIORS

The types of disruptive behaviors encountered in healthcare range from disrespect, yelling, and abusive language to physical assault. The 2004 ACPE survey revealed that the three most common types of physician disruptive behaviors were disrespect (83%), refusal to complete tasks or carry out duties (52%), and yelling (41%); substance abuse accounted for less than 10% of problems with physician behavior.[2] However, in 2009, the ACPE survey revealed that the three most common types of disruptive behaviors were degrading comments and insults (85%), yelling (73%), and cursing (49%).[10] , Additionally, 4% of more than 2,000 healthcare professionals responding to the ISMP survey reported that they were subjected to physical abuse in their work environment.[5] Specifically, in the perioperative arena, staff identified yelling or raising the voice (79%), disrespectful interaction (72%), abusive language (62%), berating in front of peers (61%), condescension (55%), and insults (52%) as the most common types of disruptive behaviors.[6]

PREVALENCE OF DISRUPTIVE BEHAVIORS

In a survey distributed to physicians, nurses, and administrators conducted by Voluntary Hospital Association (VHA) West Coast, Rosenstein and O'Daniel reported that more than 50% of respondents thought that 1-3% of physicians exhibited disruptive behavior and about 60% thought that 1%-3% of nurses exhibited disruptive behavior.[3] Veltman surveyed nurse managers in labor and delivery units and revealed about 61% of labor and delivery units noted disruptive behavior in their units.[11] However, despite the low prevalence, the severity of the problem is such to affect the quality of work in the healthcare system and have detrimental effects on the care delivered.[3,6]

DISTRIBUTION OF DISRUPTIVE BEHAVIORS

The distribution of disruptive behaviors varies among healthcare providers, specialties, and clinical environments. In the VHA West Coast survey, 75% of all respondents witnessed disruptive behaviors in a physician; specifically, 86% of nurses and about 50% of physicians. Moreover, 68% of all respondents witnessed disruptive behaviors in a nurse; specifically, 72% of nurses and 47% of physicians.[3] In the 2009 ACPE survey, the authors reported that 48% of the respondents stated that disruptive behaviors were most often displayed equally by physicians and nurses; 45% responded that physicians most often exhibited disruptive behaviors; and 7% responded that nurses were likely to manifest disruptive behaviors.[9] Furthermore, the ACPE 2004 survey revealed that 70% of disruptive behaviors nearly always involve the same physician repeatedly.[2]

Some surgical specialties are more inclined to exhibit physician disruptive behaviors. Rosenstein and O'Daniel reported that general surgery was the surgical specialty in which disruptive behaviors were more prevalent (31%),

followed by cardiovascular surgery (21%), neurosurgery (15%), orthopedic surgery (7%), and obstetrics/gynecology (6%).[12] The nonsurgical specialties more prone to display disruptive behaviors were cardiology (7%), gastroenterology (4%), and neurology (4%).[12]

The distribution of disruptive behaviors also varies among clinical environments. For example, in labor and delivery units, Veltman reported that physicians accounted for the largest incidence of disruptive professionals (56 of 81 cases) with obstetricians having the highest incidence of reported disruptive behaviors followed by anesthesiologists.[11] Nurses accounted for the remainder of the reported disruptive behaviors in the labor and delivery units.[11] Furthermore, Rosenstein and O'Daniel reported that clinical units more apt to display disruptive behaviors were the medical units (35%), intensive care units (26%), operating room (23%), surgical units (20%), and the emergency department (7%).[13] When Rosenstein and O'Daniel evaluated the impact and implications of disruptive behavior in the perioperative arena, they found that disruptive behaviors were most prevalent among attending surgeons, anesthesiologists, nurses, and surgical residents.[6]

GENDER PREVALENCE OF DISRUPTIVE BEHAVIORS

Gender influences on the propensity to display disruptive behaviors differ among healthcare providers. In the VHA West Coast survey, the authors revealed that half of the respondents thought gender influenced the tendency to exhibit disruptive behaviors.[3] With regard to gender among physicians, 57% of respondents reported a greater tendency in male physicians, and 2% reported a greater tendency in female physicians, while 41% of respondents stated that gender makes no difference[3]. In regard to gender among nurses exhibiting disruptive behavior, 40% of respondents reported a greater tendency in female nurses; 7% reported a greater tendency in male nurses; and 53% stated that gender made no difference.[3]

FREQUENCY OF DISRUPTIVE BEHAVIORS

Overall, the surveyed frequency of disruptive behaviors has not significantly decreased from 2004 to 2009 and seems to occur most commonly several times per year.[2,10] The 2004 ACPE survey revealed that physician disruptive behaviors occurred most commonly 3-5 times per year (24%), monthly (18%), and once or twice a year (17%). Likewise, in 2009, the ACPE survey reported disruptive behaviors between physicians and nurses most commonly occurred several

times a year (31%), weekly (30%), and monthly (26%). However, in specific clinical units, such as the labor and delivery units, Veltman reported that 76% of disruptive behaviors occurred monthly.[11] Furthermore, in the perioperative arena, disruptive behaviors by attending surgeons were witnessed by perioperative staff 15% of the time on a daily basis and 22% of the time on a weekly basis; disruptive behaviors by attending anesthesiologists were witnessed 7% of the time on a daily basis, and 12% of the time on a weekly basis; and disruptive behaviors by nurses were witnessed 7% of the time on a daily basis and 21% of the time on a weekly basis.[6]

WHAT ARE THE CAUSES FOR DISPLAYS OF DISRUPTIVE BEHAVIORS?

Although the causes of what drives disruptive behaviors are largely unknown, the 2004 ACPE survey reported possible causes of these behaviors might be frustration, stress due to declining reimbursements and increasing regulatory requirements, a sense of vulnerability "due to changes within an organization", as well as a refusal to "embrace teamwork".[2] These issues are well illustrated by the comments provided by survey respondents. For example, a survey respondent wrote: "The problem seems to be worsening as many docs are asked to do more with fewer resources…".[2] Another respondent wrote: "perhaps they should be on the floor when the patient rings for an hour for a bedpan, or when the dietary aide removes the untouched tray from the sick patient before he has had any assistance in eating it. The hospital is full of cruelties that should be corrected and monitored…Do you think these omissions affect the spirit, if not the behavior, of the physician caring for the patient?"[2]

Other factors to consider may include the stress of the clinical environment, production pressure, lack of support of colleagues and leadership, unsafe scheduling of staff coverage, workforce pressures, increased governmental oversight, intrusive managed care regulations, home life, cultural biases, and underlying psychological disturbances/personality disorders of the individual. These workplace stresses and pressures can lead to physician changes in attitude and burnout with resultant displays of disruptive behavior.[14] Finally, the shift to a team-based approach may also contribute to an individual's perceived loss of autonomy and increased frustration.[15]

WHAT IS THE IMPACT OF DISRUPTIVE

BEHAVIORS?

The impact of disruptive behaviors in healthcare can be deleterious. In addition to their effect on workplace relationships and the retention of staff, disruptive behaviors can facilitate medication errors and wrong-site surgery, and have been linked to the occurrence of adverse events, medical errors, compromised patient safety, impaired quality, and patient mortality.[5,6,16,17]

The influence of intimidating disruptive behaviors has been shown to facilitate errors in the dispensing or in the administration of medications.[5] Seven percent of the more than 2,000 healthcare professionals responding to the ISMP survey revealed that intimidation contributed to a medication error they were involved with.[5] Almost 50% of clinicians felt pressured by a practitioner exhibiting disruptive behavior to dispense or administer a medication despite unresolved safety concerns and almost 50% changed the method of order clarifications or questions about medication orders based on previous experiences with intimidating healthcare members.[5] Moreover, many respondents (about 40%) felt compelled by the intimidating behavior to comply with the request for a medication despite having concerns about the safety of the order, or asked another colleague to interact with the disruptive provider rather than interact directly with the individual.[5]

In the article, 'Wrong site' Surgeries On The Rise" which appeared in USA Today, Dennis O'Leary, then president of The Joint Commission, stated that wrong site surgery is increasing.[17] Disruptive behaviors may lead to this increasing incidence in wrong site surgeries, as disruptive providers who deliberately ignore a system process ("time-out" before a procedure) may increase the chance of preventable mistakes.

Disruptive behaviors may also affect behavioral variables, which have been linked to preventable adverse events.[3] For example, surveyed nurses, physicians, and administrators reported that disruptive behaviors have a significant effect on psychological and behavior variables such as stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, impaired nurse-physician relationships (83-94% of respondents); have a strong association with negative clinical outcomes (adverse events, errors, patient safety, quality of care, and patient satisfaction (53%-75%); have a link with patient mortality (25%); and could potentially have a negative impact on patient outcome

(94%).[3] Furthermore, 60% of these respondents were aware of any potential adverse events that could have occurred from disruptive behavior and most (75%) thought that these events could have serious, very serious, or extremely serious impact on patient outcomes.[3] Specifically, 17% of these respondents were aware of specific adverse events that did occur as a result of disruptive behaviors and 78% felt this event could have been prevented.[3] Moreover, in labor and delivery units, surveyed nurse managers reported that there were near misses in which disruptive or intimidating behaviors were a contributing factor (53% of responders) and felt there were specific adverse outcomes in which disruptive or intimidating behavior was a contributing factor (42%).[11]

Finally, subtle as well as covert abuse in the workplace can potentially contribute to concerns of patient safety.[18] For example, a provider may work unrecognized, unsupported in endeavors, scheduled to work later than others, and scheduled to work in potentially patient compromising conditions. This provider's self-esteem goes on being beaten, while this behavior is allowed to continue until the day of when a patient safety event occurs. This scenario has been shown to be a realistic consequence of disruptive behavior in the healthcare environment, as Cassirer et al. linked workplace abusive behavior to stress and "human system failure" and thus to errors and injuries with risks to patients.[18]

ORGANIZATIONAL PROCESSES ADDRESSING DISRUPTIVE BEHAVIORS

Although some organizations may have a written code of behavior and established formal disciplinary processes to be followed when doctors are accused of violating behavior norms, there still does not seem to be uniform implementation and enforcement of these processes addressing disruptive behaviors. For example, 60% of 2,000 healthcare professionals responding to the ISMP survey felt their organization had a clear process for effectively addressing disagreement in the safety of a medication order; 70% felt their organization would support them in reporting intimidating disruptive behavior; yet, less than 40% felt intimidating behavior was dealt with effectively in their organization.[5] In addition, more than 70% of the respondents of the 2004 ACPE survey reported that their organization has a written code of behavior and 80% stated there was an established formal disciplinary process to be followed when doctors are accused of violating behavior norms.[2] However, less than half of these respondents said that these rules were

enforced uniformly. Reasons for this inconsistency may be found in respondents' answers. Many respondents felt that physicians with disruptive behaviors who generated higher income within the institution were treated more leniently than physicians who generated less income and that disruptive physician behaviors were only reported when a physician was "completely out of line and a serious violation occurs".[2] In addition, 30% of responders failed to report the disruptive behaviors for fear of reprisals and 63% felt that physicians were "treated more leniently than other employees because of their professional stature", whereas only 9% of respondents felt that physicians were "treated more harshly and held to a higher standard of behavior than other employees".[2] One of these responders gave a different explanation, as he stated that "[Hospital] physicians are often treated differently (including more leniently) not because of their professional status but because they are private volunteers (medical staff members) and not employees. Medical staff bylaws are not the same as employee HR [Human Resources] policies."[2]

ORGANIZATIONAL PROCESSES ADDRESSING SPECIFIC TYPES OF DISRUPTIVE BEHAVIORS

The organizational processes developed to address a specific type of disruptive behavior may vary among the institutions, but they largely consist of corrective actions including discussion of the disruptive behavior event with the individual, written warnings, provision of counseling, and, in some cases, termination of employment. For instance, almost all of the 2004 ACPE survey respondents reported that representatives of their organizations met with physicians with specific disruptive behaviors to discuss their behavior problems; two-thirds issued them a written warning; over half asked the physician to seek counseling; and about a third terminated a physician or didn't take any action.[2] Moreover, in 2009, ACPE surveyed physician and nurse executives reported that less physicians were terminated (22%) compared to the survey of 2004 and that 61% of nurses were terminated due to behavior problems.[10]

SUCCESS OF ORGANIZATIONS RESPONDING TO DISRUPTIVE BEHAVIORS

Many of the respondents of several surveys did not feel their organizations successfully and effectively responded to disruptive behaviors. For example, only 14% of 2004 ACPE survey respondents felt that the actions of their organizations were successful 75%-100% of the time and about 25% of respondents felt that the actions to correct these behaviors were successful either 26%-50% of the time or 51%-75% of

the time.[2] Furthermore, only 39% of more than 2,000 healthcare professionals responding to the ISMP survey felt that intimidating behavior was dealt with effectively in their organization and only 33% felt that the organizational process allowed them to bypass their own supervisor or an intimidating prescriber to avoid a medication error.[5] One of the reasons for the general lack of success of healthcare organizations in responding to disruptive behaviors has been illustrated, in an article reported in The New Yorker, "When Good Doctors Go Bad". In this article, the extreme difficulty of obtaining evidence and support to respond was considered a reason for the reluctance and delay in action in addressing disruptive behaviors.[19]

RECOMMENDED STRATEGIES TO IMPLEMENT AND ENFORCE PROCESS IMPROVEMENTS FOR DISRUPTIVE BEHAVIORS

1. Awareness. It consists of highlighting the importance and the gravity of disruptive behaviors and gathering data through internal processes to identify the incidence, circumstance, and impact of disruptive behaviors to direct attention to problem areas and potential opportunities for improvement. Furthermore, at this stage, efforts should be made at emphasizing behavior standards and their relationship to patient safety.[12,14]

2. Education. It consists of instructing employees about the characteristics of disruptive behaviors; the relationship between disruptive behaviors, behavioral factors, and patient safety; and the policies and procedures available to address disruptive behaviors. In addition, healthcare organizations can provide support to prevent these events from occurring with educational workshops aimed at addressing conflict and stress management, communication skills, sensitivity, diversity, and assertiveness training.[11,13] In order to combat the deleterious consequences of lack of effective communication exhibited by providers with disruptive behaviors, it has been proposed that healthcare organizations should provide training and support in the education of staff regarding different styles of communication, factors that may influence communication styles, and how to respond appropriately.[12,15] Tools such as the Situation, Background, Assessment, Recommendation (SBAR), the Situation, Task, Intent, Concern, Collaborator (STICC), and The Joint Commission Guide to Improving Staff Communication may provide a more specific structure to communication interchanges.[21, 22, 23]

3. Policies and Procedures. A policy of universal code of

conduct that describes and sets criteria for acceptable behavior should be set by healthcare organizations.[12,15] This policy should be endorsed and accepted by all staff members across disciplines, with the acknowledgement that continued failure despite education and counseling will lead to disciplinary actions.[12,15] In order to be effective, this code of conduct policy must be endorsed by a strong commitment from administration and clinical leadership. Organizations should also develop a confidential reporting system to alleviate fear of retaliation with the assurance of appropriate enforcement, follow-up, and feedback.[24] Moreover, organizations should formulate a multidisciplinary committee to review complaints, hold disruptive individuals accountable for actions, and make recommendations for follow-up.[12,15] These policies and procedures need to be upheld consistently and universally regardless of the individuals involved, the revenue generated by the disruptive employee, and other factors that may result in favoritism toward the disruptive individuals. Finally, provision of support, or "service recovery", for those staff members, patients, and colleagues who have been disrupted is essential for the credibility of the process.[25]

4. Structure and Process. To coordinate and provide consistency, organizations need to develop a multidisciplinary committee to coordinate education and training processes and provide supportive resources for individuals with disruptive behaviors. Concurrently, these organizations should create task forces to discuss problem areas and to recommend a solution to resolve conflicts.[12,15] Of interest, as of 2006, only five programs nationwide have physician assessment programs to evaluate disruptive behaviors.[20]

The model adopted by Vanderbilt University School of Medicine (VUSM), which focuses on four graduated interventions, is an example of a strategy for addressing disruptive behaviors.[25] For single unprofessional occurrences, an informal intervention, such as a "cup of coffee conversation", takes place except in situations where the law mandates reporting of the event.[25] The model implies that most "coffee cup conversations" do not need to be documented; however, this may depend on the gravity of the event.[25] For recurring unprofessional or disruptive behaviors, an awareness intervention is conducted by an authoritative figure or a peer with the goal of directly confronting the offender with the pattern of disruptive behaviors.[25] For those practitioners in which the pattern of behavior persists, leaders develop improvement and continuing evaluation

plans with ongoing accountability.[25] For those practitioners failing to respond to all prior interventions, disciplinary intervention is implemented. This may include restriction or termination of privileges with appropriate reporting to governmental agencies.[25]

Another example of an interventional process that addresses specific disruptive behaviors reported by patient/family complaints at VUSM is the Patient Advocacy Reporting System (PARS[SM]). This process analyzes and profiles patient/family complaints and then may involve subsequent interventions with the disruptive provider.[25] The core of PARS[SM] involves confidentiality, respectful attitudes, and supportive behaviors. The VUMC database of patient complaints is then utilized to create a profile for physicians with a high number of complaints and compares the number of complaints to other group members. This process is enforced by the Patient Complaint Monitoring Committee (PCMC), a multidisciplinary assembly of physician peers or authority figures created under peer review and quality assurance statutes to protect any information from legal discovery. In the PARS process, the PCMC implements three levels of intervention: level one is a confidential, nonpunitive peer awareness intervention; level two is intervention by authority and requires development of an action plan; and level three is disciplinary action.[25] After level one intervention, Moore et al. reported that about 60% of physicians showed less patient/family complaints, less than 2% recurred, yet 20% required additional level two intervention to improve, and 20% retired or relocated.[26] Hickson et al. suggested that PARS may also be applied to resident physicians whose patient-relations representatives identify and record residents involved with patient complaints.[27]

COST-SAVING BENEFITS OF IMPLEMENTING A PROGRAM TO ADDRESS DISRUPTIVE BEHAVIORS

The benefits of implementing a program to address disruptive behaviors can far outweigh the costs of such programs.[25] These benefits include enhancing the satisfaction and retention of staff; improving the reputation of the institution; developing a culture of professionalism (an ACGME core competency), which serves as a model for medical students, resident physicians, staff, and colleagues; improving patient safety by decreasing reluctance of staff to identify patient care issues and empowering staff to identify disruptive behaviors and improve communication; and decreasing liability exposure and risk-management activity.

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DISRUPTIVE BEHAVIORS: REPORTING AND SUPERVISING RESPONSIBILITIES

The Medical Staff Executive Committee of a hospital, the Physician Health Service, some state statutes, as well as many health management organizations (HMO) have varying responsibilities in the supervision and reporting of disruptive behaviors.[27] For example, the Medical Staff Executive Committee often has procedures in place for investigating and responding to allegations of disruptive physician conduct. In addition, some state medical societies sponsor a Physician Health Service to oversee a confidential and comprehensive evaluation and treatment of impaired physicians. Also, some state statutes require the reporting of certain physician conduct to the state medical board and to the National Practitioner Data Bank.[28] Many health management organizations have clauses in their contracts that require the physician to notify the HMO in the event of a finding of misconduct. Finally, unknown to some practitioners, hospitals must access the National Practitioner Data Bank biennially to check on the status of health care practitioners.

DISRUPTIVE BEHAVIORS: LEGAL ISSUES

Administrative bodies that deal with the conduct of practitioners include state medical boards, ethics committees, as well as credentialing committees of hospitals, third-party payers, and independent practice associations.[27] A practitioner who is found guilty of misconduct by an administrative board may no longer be eligible for insurance reimbursement such as Medicare and Medicaid or have access to the hospital in which he or she practiced. Patient harm or proximate causes are not necessary for a physician to be found guilty of disruptive behaviors. Furthermore, a physician's license to practice medicine may be revoked based on results of an administrative inquiry. Physicians facing charges of disruptive behavior before an administrative agency do not have the same protections they would have if they were charged with civil and criminal acts. In contrast to malpractice litigation that is typically covered by malpractice insurance, the disruptive practitioner has limited coverage for legal fees.[27]

CONCLUSIONS

The findings of significant numbers of healthcare providers witnessing disruptive behaviors challenge the healthcare system and may result in a negative impact on patient care and safety. These behaviors undermine employee self-esteem, increase stress and frustration, do not facilitate retention of staff, and lead to adverse patient event outcomes. Hospitals can no longer afford to accept disruptive behaviors due to concerns about patient safety, reputation, retention of staff, liability, and pay for performance issues. What is needed is to develop cultures where healthcare members work collaboratively and respectfully and all members contribute to work and decisions regardless of rank and personal friendships. Organizations need to take an active approach in developing this culture and addressing disruptive behaviors in the workplace. Many strategies for improvement are currently available. Nevertheless, by increasing the awareness of disruptive behaviors, encouraging the elimination these behaviors, and improving effective communication among the healthcare team, patient care and safety may improve along with growth in individual and organizational performance.

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