

**ONTARIO NURSES' ASSOCIATION**

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# Managing Disruptive Physician Behaviour

Approved: June 2010 Board of Directors Meeting



The Ontario Nurses' Association (ONA) is the union representing 55,000 registered nurses and allied health professionals and more than 12,000 nursing students providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

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## Introduction

### Purpose of the Guide

The Ontario Nurses' Association (ONA) has developed this guide to assist its membership and staff through the multiple processes for dealing with disruptive physician behaviour. This guide includes a synopsis of law and policies applicable to disruptive physicians, as well as guidance and flow charts to help develop appropriate responses when evidence points to a disruptive physician. For behaviour that:

- Is discriminatory or offensive, intimidating, humiliating, threatening, hostile or abusive: see the human rights/grievance and the professional responsibility advice sections.
- Affects the member's practice and/or patient/resident/client care: see the grievance and the professional responsibility advice sections.
- Poses an actual or potential health or safety hazard: see the occupational health and safety advice and flowchart.

### What is Disruptive Physician Behaviour?

Disruptive physician behaviour encompasses all sorts of communication and behaviour by a physician that affects nurses' and allied health members' practices and/or well being, patient/resident/client care and may interfere with the health facility's ability to operate in an orderly way.

Disruptive physician behaviour can include single or repeated episodes of:

- Persistent lateness in responding to calls.
- Forced changes to policy or processes without input from nursing staff.
- The imposition of idiosyncratic requirements on staff that have nothing to do with quality patient care.
- Public derogatory comments about the quality of care.
- Inappropriate medical record entries concerning staff and/or quality of care.
- The use of profanity or offensive language.
- Degrading and demeaning comments to staff or patients.
- Intimidation, threatening and/or abusive language.
- Sexual harassment.
- Racial or ethnic slurs.
- Threatening or intimidating physical contact up to and including actual or threatened assault.

Disruptive physician behaviour almost always affects nursing practice and a member's ability to provide quality patient/resident/client care, but it can also constitute discrimination, pose a hazard to a worker and/or patient/resident/client and violate the collective agreement and/or law in the areas of workload, human rights, health and safety and criminal acts.

**N.B.** Complete documentation of complaints and evidence of disruptive physician behaviour will greatly enhance ONA's ability in all forums to respond to and eradicate this serious problem.

## **How to Respond to Disruptive Physician Behaviour**

If a member should find themselves in immediate danger due to the behaviour of a physician/other staff member/visitor/patient/resident/client, then the first step is to ensure safety. Remove the worker from imminent danger and activate the employer's emergency response protocol, e.g. "CODE WHITE" (an emergency call broadcast over a public address system where a person demonstrates aggressive behaviour). The next step is to CALL THE POLICE.

On the following pages, we outline the additional responses that can be taken in order to address this problem from an occupational health and safety, professional practice and human rights perspective. Note that all of the recommended actions can be taken simultaneously.

## Occupational Health and Safety Response

A worker encounters disruptive physician behaviour that poses an actual or potential health and safety hazard:

### ***Ensure worker safety/treatment***

- If a worker is in imminent danger, ensure safety. Remove the worker from imminent danger, activate the employer's emergency response protocol e.g. "Code White," and considering calling police as appropriate (see ***work refusal/work stoppage***, below).
- If a worker is harmed or injured, ensure that s/he is treated as appropriate and that others are safe. Call police as appropriate (file a WSIB claim).

### ***Engage internal responsibility system (IRS) once the imminent danger removed***

- The employer should have conducted violence risk assessments and have separate policies and programs in place with respect to violence and harassment.
- Worker reports health and safety concern to supervisor/employer (section 28, OHSa).
- Unresolved concerns raised with Joint Health and Safety Committee (JHSC).
- Consider calling the Ministry of Labour (MOL) with a complaint (MOL to respond on a priority basis to complaints from workers with limited right to refuse unsafe work).
- If unresolved, consider writing officers and directors of hospital/facility corporation (for sample letter, see *Appendix C in Occupational Health and Safety, A Guide for ONA Members*).

### ***Consider work refusal/work stoppage***

- Consider exercising right to refuse unsafe work (section 43, OHSa, and ONA Guidance Document (*Appendix H in Occupational Health and Safety, A Guide for ONA Members*)).
- Certified member JHSC: consider initiating work stoppage process (section 45 OHSa.)
- If unresolved after stage 1 and worker continues work refusal, MOL must be called (section 43 (6) OHSa).
- MOL investigates and makes decision.

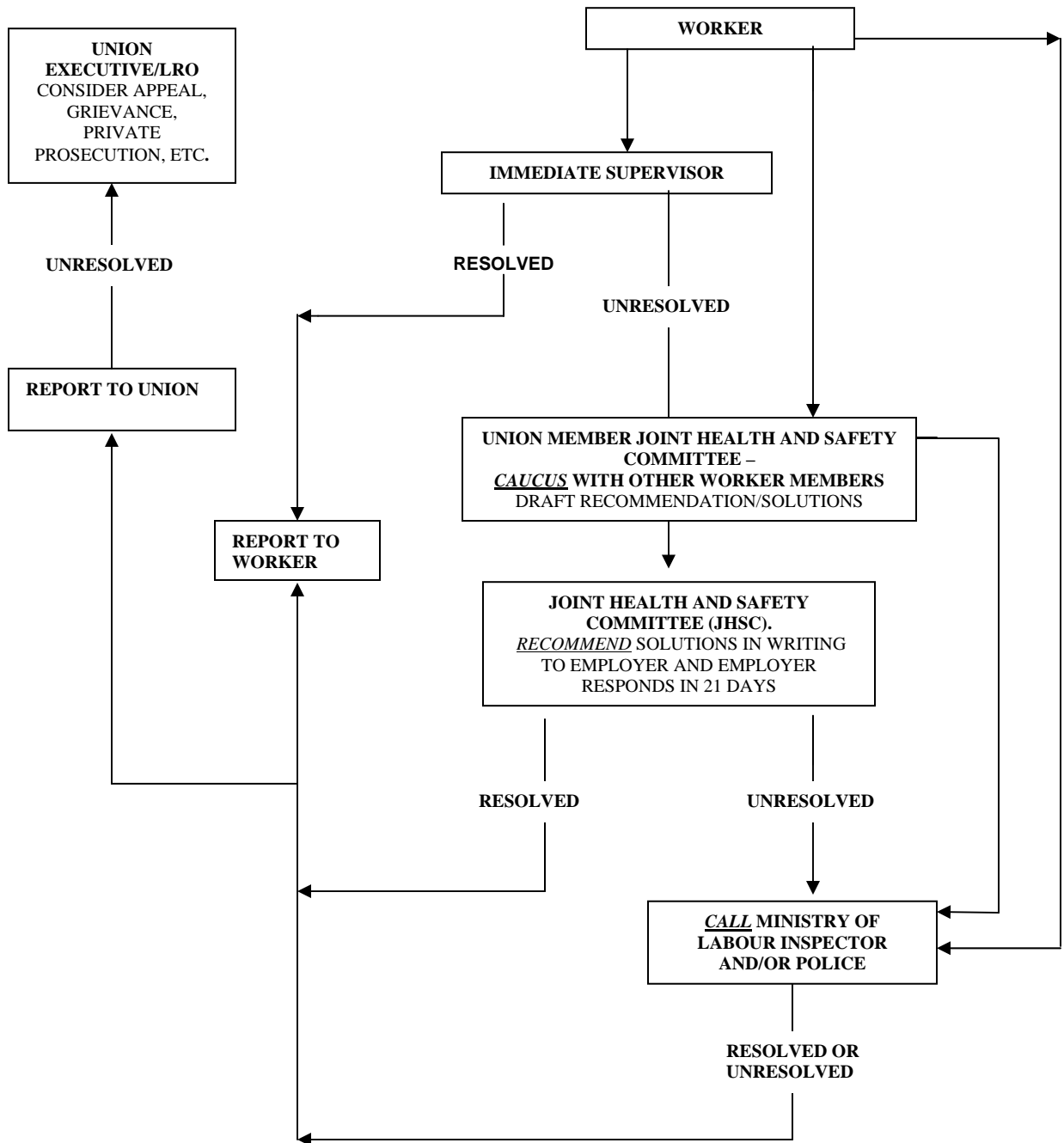
### ***Consider calling police to ensure safety and/or investigate with a view to prosecution for harm to worker***

- Everyone who has authority to direct work has a legal duty to take reasonable steps to prevent bodily harm to that person.

**At all stages, consider filing grievance(s).**

**At all stages, document concerns and evidence of hazard and response to hazard.  
(Completed Professional Responsibility Workload Report Form (PRWRF) may be copied  
and used to document health and safety concern when workload creates health and safety  
hazard)**

## Resolving Health and Safety Problems Arising from a Disruptive Physician



## **Professional Practice Response**

When nurses or allied health professionals encounter disruptive physician behaviour, it has a negative effect on their practice and patient/resident/client outcomes.

### ***Professional Responsibility Workload report form (PRW report form)***

- Complete a PRW report form for every incident of disruptive physician behaviour.

### ***Employer reporting policy***

- Follow the employer reporting policy and make sure risk management is made aware of the incident.
- If there is no employer reporting policy, ensure one is developed. This could be discussed at an Association-Agency meeting.
- Hospitals often have a Medical Advisory Committee that is accountable to deal with these complaints. The complaint is made to Chief of Staff who will then take it to the Committee.

### ***Association-Agency Committee***

- Discuss the PRW report forms related to disruptive physician behaviour and explain how the incident affected the member's practice and patient/resident/client care/outcomes.
- Develop clear processes for communicating disruptive physician behaviour to management and timelines for a response. See Appendix 1, a memo developed between the Union and the employer.
- Implementation of "Code Nurse" (referred to as Code Pink in other provinces, but can't be used here as we know code pink as a paediatric arrest). This can be agreed to at an Association-Agency Meeting or used by members as an informal method of dealing with disruptive physician behaviour. Members call a "Code Nurse" when there is an incident of disruptive physician behaviour and the member involved with the physician needs support. For example, if a doctor is shouting or being verbally abusive or throwing instruments, Code Nurse is called and all colleagues who can be released from patient care, come into the room and stand, silently, staring at the abuser. This has been shown to be very effective. See Appendix 2.
- If unresolved, involve a Labour Relations Officer (LRO) who may also involve a Professional Practice Specialist.

### ***College of Physicians & Surgeons of Ontario (CPSO)***

- Member(s) should consider reporting the physician to CPSO. See Appendix 3.

### ***Collective Agreement***

- Check the language of your collective agreement regarding professional responsibility and consider filing grievances if the language permits.

## **Human Rights/Grievance Response**

A worker encounters disruptive physician behaviour that is discriminatory or offensive, intimidating, humiliating, threatening, hostile or abusive.

### ***Identify any discrimination or harassment based on prohibited grounds***

- Determine if the worker has been targeted for discriminatory treatment or harassment because of his or her race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability.
- Determine if the worker has been subjected to persistent or repeated behaviour or a single incident that is serious in nature
- Determine if there is a poisoned workplace where discriminatory or harassing behaviours cause significant tension and disruption for the targeted individual and for others in the workplace. An example of a poisoned work environment is where a physician continually shouts at, belittles and humiliates a worker in front of other workers.

### ***Identify personal harassment or bullying***

- Determine if the worker has been subjected to persistent or repeated behaviour that is offensive, intimidating, humiliating, threatening, hostile or abusive.
- Personal harassment is harassment that is not based on any of the prohibited grounds in the *Human Rights Code*.
- Bullying is usually intentional in nature and an attempt to exert power or control over the target.

### ***Encourage the worker to follow the complaints process in the employer's workplace policies and procedures***

- Instruct the worker to report the behaviour to the employer.
- Encourage the worker to file a complaint under the employer's policies and procedures.
- The worker should be assisted and supported by an ONA representative throughout the process.
- Request the separation of the worker and the physician, where appropriate.
- Confirm with the employer that the respondent physician will be notified that the employer prohibits reprisals or threats or retaliation against a complainant for bringing forward a complaint.

### ***Consider filing grievance and proceeding to arbitration***

- Speak to a Labour Relations Officer about filing and processing a grievance in accordance with ONA policy.

***Instruct worker to keep records***

- The worker should keep detailed notes labelled, "Made for my lawyer." Notes should include each incident with the date, time, what happened, names of witnesses, and how the incident made the worker feel.
- Worker should keep copies of any letters, memos or e-mails from the physician and/or the employer.

## Law and Policy Applicable to Disruptive Physicians

### Human Rights

#### ***Human Rights Code sections***

- 5(1) - Equal treatment in employment without discrimination based on prohibited grounds.
- 5(2) - Freedom from harassment in the workplace based on prohibited grounds.
- 7(2) – Sexual harassment in the workplace.
- 7(3) – Sexual solicitation by a person in position to confer benefit, etc.
- 8 – Reprisals prohibited.

### ONA Collective Agreements

#### ***Central Hospital Agreement articles***

##### ***Discrimination and harassment/Personal harassment and bullying***

- 3 – Preamble – Commitment to a harassment-free environment.
- 3.01 – No discrimination for exercising rights under collective agreement.
- 3.03 – No discrimination because of prohibited grounds or any other factor not pertinent to employment relationship.
- 3.04(a) – Freedom from harassment based on prohibited grounds.
- 3.04(b)-(c) – Sexual harassment.
- 3.04(d) – Encouraging employees to follow the employer's complaints process.
- 3.04(f) – Union representation.
- 3.04(g) – Right to file grievance.
- 3.04(h) – Promoting measures to deal with discrimination and harassment.
- 3.07 – Ensuring fairness of complaint process.
- 3.08 – Incorporating recommendations from the Disruptive Physician Behaviour Initiative.
- 6.05 – Occupational health and safety.
- 8 – Professional Responsibility.
- Management rights clause in local issues.
- Any Local provisions on Violence.

##### ***Whistle-blowing protection***

- 3.06 – Whistle-Blowing Protection

#### ***Central Nursing Home Agreement articles***

##### ***Discrimination and harassment/Personal harassment and bullying***

- 4 – Preamble – Commitment to providing a positive environment for staff/right to be treated with respect and dignity/right to work in an atmosphere which promotes respectful interactions and is free from discrimination, harassment and aggression.
- 4.01 – No discrimination for exercising rights under collective agreement.
- 4.02 – No discrimination because of prohibited grounds or any other factor not pertinent to performance with respect to employment.

- 4.03 – Employer must abide by the Human Rights Code.
- 4.04(a) – Freedom from harassment based on prohibited grounds.
- 4.04(b) – Sexual harassment.
- 3.01 & 3.02 – Management rights.
- 6.06 – Occupational health and safety.
- 6.07 – Violence in the Workplace.
- 19 – Professional Responsibility.

## **Professional Responsibility**

### ***Collective agreement articles***

- See above: PRC clause, Hospital Article 8 and Homes Article 19.

### ***College of Nurses of Ontario***

- Professional Standards 2002, Professional Relationships, page 12.
- Practice Guideline, Disagreeing With The Plan of Care.
- Practice Guideline, Conflict Prevention and Management.

### ***Employer policy***

- Practice and procedure policies re harassment.
- Code of conduct.
- Vision/mission statement.
- Policies aimed at preventing conflict, abuse and violence (as required under the amended *OHSA*).

## **Occupational Health and Safety**

### ***Occupational Health and Safety Act sections***

- 25, 26 – Employer duties (take every precaution reasonable to protect workers).
- 27 – Supervisor duties (take every precaution reasonable to protect workers).
- 28 – Worker duties (report hazards).
- 32 – Directors' and officers' duties (all reasonable care).
- 32.0.1 – Violence and Harassment Policies.
- 32.0.2-32.0.5 – Violence program.
- 32.06-32.0.7 – Harassment program.
- 43-49 – Work refusal/stoppage.
- 50 – Reprisals prohibited.
- 9 – Joint Health and Safety Committee (JHSC) powers.

### ***Health Care and Residential Facilities Regulation***

- 8-9 – Duties to establish measures and procedures.

**Public Hospitals Act - Hospital Management Regulation**

- 4 (1) (d) – Health and safety program by-laws.
- 7 (6) – Medical advisory committee shall appoint one or more members of the medical staff to advise the JHSC.

**Criminal Code of Canada**

- 217.1, 219, 180 – The so-called “Westray sections” re: occupational health and safety duties established by Bill C-45.
- 425.1 – Reprisals prohibited.

**Ministry of Labour Operations Division Policy and Procedures Manual**

Contains policies about violence investigation and need to respond on a priority basis to complaints from workers with limited right to refuse unsafe work (available in members’ health and safety section of ONA website).

**College of Physicians and Surgeons**

- *Guidebook for Managing Disruptive Physician Behaviour* – See Appendix 4 (<http://www.cpsso.on.ca/policies/positions/default.aspx?id=1730>)
- *Complaints Process* (<http://www.cpsso.on.ca/policies/complaints/default.aspx?id=1772>)

## **Disruptive Physician Scenarios and Suggested Responses**

### **Scenario 1**

Nurse A is a circulating registered nurse in the operating room. After a surgery on March 23, 2010, she reported concerns about Dr. Disruptive to the Medical Director. Dr. Disruptive had undertaken a particular surgical procedure even though he was advised by the nursing staff that they may not have the proper equipment available. He raised his voice to nurses and called them incompetent throughout the procedure. He says women are too stupid for this work. The procedure took two and three quarter hours rather than one hour to complete. Nurse A reported this to the Medical Director because of her concerns regarding compromise to the patient in question.

### **Scenario 2**

In another incident with another nurse a month later, Dr. Disruptive started yelling at her and said that he needed an instrument NOW. His behaviour continued for several minutes. When he handed her a scalpel during surgery, he nicked her glove, tearing it open. Her skin was not cut. After the surgery, though still annoyed, he said his yelling wasn't personal and said the scalpel nick was an accident.

### **Scenario 3**

In yet another incident with another nurse, Dr. Disruptive was performing a needle aspiration on the elbow of a patient with a drug addiction. He approached the nurse with the exposed needle, stating that he needed a gram stain done immediately. The nurse asked him to discard or shield the needle and he responded by purging the contents of the syringe on the floor and followed her into the room with the needle still exposed. Despite repeated requests to shield it, he would not, and she felt increasingly uncomfortable with his behaviour. Dr. Disruptive at that point began to make stabbing motions towards her, laughing at her nervousness. The needle was finally properly discarded. Later, Nurse A expressed her concern to Dr. Disruptive who said he thought it was funny and would do it again. The nurse later learned the patient's elbow aspiration was positive for HIV.

### **Scenario 4**

That week, Dr. Disruptive's scheduled surgery was bumped by another surgeon with a higher-priority case. Dr. Disruptive became angry, loud and aggressive toward Nurse A because he didn't want to be bumped. The nurses continued to set up for the priority case and Dr. Disruptive yelled, "I do not have to put up with this bullshit from stupid bitches." He followed Nurse A, telling her not to continue prepping the suite for the other surgeon and yelled at the nursing staff in the area. She made calls to the chief of staff and nursing director but no one responded. He continued to badger her at the nursing station, waving his fists in the air, and standing over her yelling, to the point where she was concerned for her physical safety due to his hostile, angry, uncontrolled state.

## **Scenario 5**

One of Dr. Disruptive's patients is released from hospital and discharged to her home with community nursing care to tend to her surgical wound. The community nurse calls Dr. Disruptive to report her observation of possible infection, and to request an order for medication. Dr. Disruptive yells at the nurse on the phone, calls her stupid, and asks if she knows he is not properly paid for such interruptions in his day. He finally prescribes something, then in a raised voice again calls her stupid and slams down the phone. This is the third time in two weeks that Dr. Disruptive has treated this particular nurse this way when she has called him about his patients under her care.

### ***Occupational Health and Safety Responses***

The employer is required by law to take every precaution reasonable in the circumstances for the protection of a worker. And, as of June, 2010, harassment is covered under the *Occupational Health and Safety Act*. The employer is explicitly required to establish policies and programs with respect to harassment and violence. In addition, workers who believe they are threatened with violence in the workplace may exercise their right to refuse unsafe work (see ONA's *Guide to Occupational Health and Safety* for guidance on a health care worker's right to refuse unsafe work).

#### **Scenario 1 Response:**

Dr. Disruptive harassed nurse A and the others during the first surgery above, and as such, the worker can:

- Process their concern via the employer's harassment procedure.
- If there is none, raise the concerns (ie. That Dr Disruptive is harassing and that there is no procedure to address) with the supervisor.
- If concern(s) remain(s) unresolved, the worker can raise the unresolved concern with the Joint Health and Safety Committee (JHSC).
- The committee and/or the worker may complain to the Ministry of Labour if the employer does not prepare a harassment policy and develop and maintain a program for reporting, investigating and dealing with incidents and complaints.

#### **Scenario 2 Response:**

Here, Dr. Disruptive's behaviour escalates to workplace violence as defined under the *Occupational Health and Safety Act*. The worker can:

- Raise the health and safety concern with the supervisor.
- If unresolved, the worker(s) can raise the unresolved concern to the Joint Health and Safety Committee.
- If unresolved, the worker and/or the JHSC can call the Ministry of Labour.

### **Scenario 3 Response:**

Here, Dr. Disruptive's behaviour escalates to workplace violence as defined under the *Occupational Health and Safety Act*. The worker can:

- Raise the health and safety concern with the supervisor.
- If unresolved, the worker(s) can raise the unresolved concern to the Joint Health and Safety Committee.
- If unresolved, the worker and/or the JHSC can call the Ministry of Labour..
- In this case, this is arguably an assault and the police can be called as well.
- In this case, the worker may want to consider her right to refuse unsafe work, and the committee worker member may want to consider a work stoppage.

### **Scenario 4 Response:**

Here, Dr. Disruptive's behaviour escalates to workplace violence as defined under the *Occupational Health and Safety Act*. The worker can:

- Raise the health and safety concern with the supervisor.
- If unresolved, the worker(s) can raise the unresolved concern to the Joint Health and Safety Committee.
- If unresolved, the worker and/or the JHSC can call the MOL.
- In this case, this is arguably an assault and the police can be called as well.
- In this case, the worker may want to consider her right to refuse unsafe work, and the committee worker member may want to consider a work stoppage.

### **Scenario 5 Response:**

Dr. Disruptive's behaviour constitutes harassment and as such, the community nurse can:

- Process her concern via her employer's harassment procedure.
- If there is none, raise the concerns (ie., that Dr Disruptive is harassing and that there is no procedure to address) with the supervisor.
- If concern(s) remain(s) unresolved, the worker can raise the unresolved concern to the Joint Health and Safety Committee.
- The committee and/or the worker may complain to the Ministry of Labour if the employer does not prepare a harassment policy and develop and maintain a program for reporting, investigating and dealing with incidents and complaints.

### **NOTE:**

In all cases, the worker/Union may want to consider filing a grievance citing violations of any health and safety provisions of the collective agreement and breach of the *Occupational Health and Safety Act*. In addition, the grievance should cite human rights violations and professional practice violations as addressed below.

If the Ministry of Labour response to any call is not adequate, the Union may wish to appeal the Ministry's decision.

If the police response to any call is not adequate, the worker/Union may want to consider initiating their own prosecution.

### ***Human Rights Grievance Response***

There is evidence that Dr. Disruptive's behaviour:

- Appears directed at female workers.
- Makes derogatory comments toward women.
- Is repeated.
- Causes significant tension in the workplace.
- Constitutes bullying.

The worker can:

- Report the incidents of harassment and discrimination to their supervisor.
- File a complaint under the employer's workplace anti-discrimination and harassment policy.
- Request separation from Dr. Disruptive until the employer's investigation is complete under the workplace policy.
- Be represented by the Union, which will confirm with the employer that the respondent physician will be notified that the employer prohibits reprisals or threats or retaliation against a complainant for bringing forward a complaint.
- File a grievance citing violations of the sexual/gender discrimination and harassment provisions in the collective agreement and the protections in the Ontario *Human Rights Code*.

The worker and Union should:

- Keep detailed notes labelled "Made for my lawyer." Notes should include each incident with the date, time, what happened, names of witnesses, and how the incident made the worker feel.
- The worker should keep copies of any letters, memos or e-mails from the physician and/or the employer.

### ***Professional Practice Response***

This behaviour has an obvious negative effect on the member's practice and her/his ability to deliver patient/resident/client care. The worker should:

- Complete a PRW report form for each incident that occurs.
- Follow the employer's complaint procedure.
- Discuss the PRW report forms at the ONA/Agency committee.
- Implement "code nurse."
- Consider a CPSO report.



Niagara Health System | *Nursing*

March 11, 2009

To: All ONA Members  
Nursing Leadership

From: Pam Sheptenko, ONA President  
Ariel Poirier, Human Resources  
Donna Rothwell, Chief Nursing and Professional Practice Officer

**Re: Workplace Violence – Forms to be Completed**

At a recent Site Hospital Association Committee meeting, it was identified that staff were unclear as to what forms need to be completed should an incident of workplace violence occur for ONA Members. The RN must fill out the following forms:

- an Employee Incident Report (whether there has been physical injury or not),
- an ENCON form if the incident involves a Physician and/or patient/family member,
- an ONA Professional Responsibility Workload Report Form (PRWRF).

The RN is responsible to notify the Clinical Manager (or Manager on call) who will provide any necessary immediate supports and make every reasonable effort to rectify the abusive situation. The Manager (or Manager on call) notifies Human Resources and ONA within 24 hours of the incident and signs all of the incident reports identified above.

Thank you for your attention to this important issue.

*In Touch, Spring 2006  
Newfoundland & Labrador Nurses' Union*

Attachment 2

planned to be held in conjunction with the organization's  
40th anniversary celebration on May 15, 2006.

Office: (709) 753-9969 or toll-free at  
1-800-565-5100

For more information and details  
please contact us at (709) 753-9969

## CODE PINK

Bullying in the health care system has become so commonplace that the term "code pink" has been coined for a method of dealing with it. The term refers to the practice of supporting the victim by surrounding the victim as the perpetrator is carrying out the act. This has been shown to be very effective in stopping the bully

in his or her tracks. In a recent incident, a physician was dressing down a nurse in the hallway in front of visitors and other nurses. A "code pink" was called and all of the nurses on the floor came to the area and surrounded the nurse and the physician. This quickly ended the tirade and provided witnesses to the occurrence.

If everyone around the target is silent or withdraws, the target is victimized again. If you are neutral in situations of injustice, then you have chosen the side of the oppressor. It is critical that colleagues not look the other way when someone is being bullied.

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# Addressing the Phenomenon of Disruptive Physician Behavior

*Llewellyn E. Piper, PhD, ACHE*

This timely article provides current information on an age-old issue of disruptive physician behavior within the hospital setting. Documented in medical literature over 100 years ago, disruptive physician behavior has been an ongoing challenge to the hospital staff and the quality of patient care in the hospital. Covered in this article are the negative consequences of disruptive physician behavior and the call to respond. If allowed to go unchecked, a physician exhibiting disruptive behavior may threaten a hospital's image, staff morale, finance, and quality of care. Failure to respond undermines the leadership of the hospital and the trust of the community in the hospital's mission. Included in this article are suggestions obtained from the literature and from the author's experience in responding to disruptive physician behavior. Of emphasis is a methodology that includes supporting bylaws and policies to manage disruptive physician behavior. Key words: *disruptive physician behavior, healthcare management, medical staff, morale, staff morale*

**D**ISRUPTIVE PHYSICIAN BEHAVIOR has a long history with increasing prevalence in hospitals across our nation. A review of the current literature provides insight to the significance of this negative behavior on quality patient care from several perspectives. This article provides several suggestions to the chief executive officer (CEO) of hospitals in addressing the phenomenon of disruptive physician behavior.

Today, more than ever, CEOs must ensure that hospitals are as effective and efficient as possible in the competitive landscape of healthcare. A physician with disruptive behavior may threaten the hospital's image, morale, finances, and quality of care if allowed to go unchecked.

The CEO is by position a leader in the hospital setting. It is understood that for a hospital to be successful in its mission of the delivery of quality patient care within the community, it must have an effective leader. A

good leader in healthcare must have a clear vision and the ability to communicate that vision, and the leader must set the highest standards of performance for employees.<sup>1</sup> A factor that can negatively impact performance is the phenomenon of disruptive physician behavior.

CEOs of hospitals face and decide on many issues in the sublime duty of ensuring quality patient care in a safe and caring environment. Nothing can be more undermining to this duty and the quality performance of the hospital staff than the disruptive behavior of physicians. No issue so compels the complexity and dynamics of ensuring a safe environment with quality delivery of patient care than confronting a physician whose behavior is disruptive;<sup>2</sup> the behavior sends a negative ripple in the sense of harmony and safety in the one setting where these attributes are paramount for quality patient care.<sup>2</sup>

Today, more and more CEOs of hospitals are addressing the disruptive physician behavior syndrome.<sup>2,3</sup> CEOs who are confronting the physician exhibiting disruptive behavior are experiencing the complexity of the dynamics in dealing with the alleged disruptive physician. In a world of litigation and paranoia, the tenuous decision is whether to

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*From the Onslow Memorial Hospital, Jacksonville, NC*

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ignore the problem or risk being accused of attempting to destroy a physician who many may say is a great physician but may simply show too much passion at times.

These alleged disruptive physicians fall into 2 quintessential stereotypes: (1) *The old guard*: This is the physician who has many years on the staff including a history of holding the offices of Chief of Staff and being a prominent member of the medical society and the community. However, everyone who associates with the physician knows the thin threshold that triggers explosive and disruptive behavior. (2) *The trauma drama*: This is the very young physician who is so motivated and well liked because of energy, tempo, and passion yet has a very thin threshold for triggering explosive and disruptive behavior. Several factors are known about these 2 types, the old and the young: they are usually clinically excellent physicians, they are usually highly intelligent, and they have quick and sensitive triggers for exploding toward the staff. Nevertheless, they are well liked and admired by their patients and by the community. Wilkerson reports that they are usually obsessive-compulsive as well as narcissistic, and they have some degree of paranoia as well.<sup>4</sup>

The CEO faces an approach/avoidance conflict issue in addressing these physicians. In approaching this issue, one opens a stormy landscape of reaction not only from the physician but also from all of the physician supporters. These supporters will claim that the CEO is attempting to destroy the physician. Yet more disconcerting, if the CEO fails to act, the morale and the hospital quality culture and eventually its quality of care and image will be compromised in the long-term. The disruptive physician undermines morale, alienates staff, heightens turnover, drives down productivity, increases risk of substandard quality care and malpractice suits, and drives away patients.<sup>3,5</sup> For the singularity of the act of addressing the disruptive physician, many CEOs are reluctant to respond to disruptive physician behavior. For many years, physicians exhibiting disruptive behavior have been largely ignored or excused by those who project the attitude:

"That is just the way they are." Dewitt wrote that "it is a help to a doctor, especially to one who is full of crotchets, to have as an assistant, a nurse who 'knows his ways' and who is not disturbed by his explosions of impatience."<sup>6</sup>

#### DEFINITION AND CRITERIA OF DISRUPTIVE PHYSICIAN BEHAVIOR

Kisson et al state that there is no commonly agreed upon definition of disruptive behavior.<sup>3</sup> Disruptive behavior refers to any type of interpersonal interaction that can lead to substandard patient care and negatively impacts on the organization's ability to operate in an orderly way to accomplish its mission.

Barnsteiner et al describe disruptive physician behavior as any behavior that is offensive and may jeopardize patient care or disrupt the tone of the unit.<sup>2</sup>

Wilhelm and Lapsley<sup>7</sup> state that disruptive behaviors include repeated episodes of the following:

- Sexual harassment
- Racial or ethnic slurs
- Intimidation and abusive language
- Persistent lateness in responding to call.

According to Wilkerson,<sup>4</sup> the disruptive physician presents a consistent pattern of behavior manifesting one or more of the following:

- Uses threatening or abusive language
- Makes degrading and demeaning comments
- Uses profanity or other grossly offensive language
- Uses threatening or intimidating physical contact
- Makes public derogatory comments about quality of care
- Writes inappropriate medical record entries concerning quality of care
- Imposes idiosyncratic requirements on staff that have nothing to do with better patient care.

#### LITERATURE REVIEW

The literature supports the notion that disruptive behavior falls under the term

physician impairment. At the beginning of the physician's health movement in the late 1960s and early 1970s, substance dependency was the commonly addressed physician impairment. In the 1990s, disruptive physician behavior began to be discussed in the literature and was described as a form of physician impairment. Although substance dependency is considered the number 1 form of physician impairment, disruptive behavior is increasing in number of cases being reported to state health physician programs.<sup>4,8</sup>

In the August 2000 issue of *The New Yorker*, the article "When Good Doctors Go Bad" revealed how the medical profession and the healthcare system are poorly prepared and designed to deal with disruptive physician behavior. The article further indicated that it usually takes months and even years before any action is taken. The main reason given for this reluctance and delay in taking action is due to the extreme difficulty of obtaining objective evidence and support to respond.<sup>9</sup>

Kisson et al report that codes of conduct have been a part of the healthcare system for a long time.<sup>3</sup> These codes of conduct within the hospital, however, were historically viewed as standards of behavior for everyone except physicians. For many years, physicians were considered the exception to being required to adhere to civil and harmonious forms of behavior.<sup>6</sup>

Horty describes the nature of the disruptive physician as one who is usually very clinically competent to the point of believing he or she is more competent than other members of the medical staff.<sup>10</sup> The disruptive physician is by nature a formidable person to deal with and therefore contentious and potentially litigious.

A conclusion drawn from the literature is that a physician's behavior reflects the inability of the physician to work harmoniously with the staff in the hospital and this disruptive behavior can be a critical negative factor in the delivery of quality patient care. The literature also supports the contention that the disruptive behavior diverts a great deal of physician leadership and CEO time from the focus of patient care activities.<sup>10</sup>

Kisson et al,<sup>3</sup> Benzer and Miller,<sup>8</sup> Horty,<sup>10</sup> and Pfifferling,<sup>5</sup> provide the consequences of disruptive physician behavior on the hospital:

- Disharmony and poor morale among staff
- Poor quality patient care
- High staff turnover
- Incomplete and dysfunctional communication
- Heightened financial risk and litigation
- Reduced self-esteem among staff
- Reduced public image of hospital
- Financial costs
- Unhealthy and dysfunctional work environment

#### MANAGING AND CONFRONTING DISRUPTIVE PHYSICIAN BEHAVIOR

From the author's experience and from the literature, a well-defined methodology is required to appropriately address disruptive physician behavior. It is probably the exception rather than the rule that a hospital is not or will not be challenged by the contentious and time-consuming ordeal of effectively and efficiently managing and confronting disruptive physician behavior. A general theme prevails in the current literature and in experience that without a well-defined methodology and awareness of the potentiality of the issue among the leadership of the medical staff, management, and hospital governance, the probability of successful management of disruptive physician behavior is greatly reduced.

Barbara,<sup>11</sup> Barnsteiner et al,<sup>2</sup> Horty,<sup>10</sup> and Kisson et al<sup>3</sup> provide some suggestions for addressing the phenomenon of disruptive physician behavior:

- Create an organizational culture of non-tolerance of disruptive behavior
- Establish organizational definition of disruptive behavior
- Agree on a channel to report disruptive behavior
- Establish hospital policy on disruptive behavior to include expectation of behavior and consequences of disruptive behavior

- Incorporate the means to address disruptive behavior in medical staff bylaws
- Incorporate the means to address disruptive behavior in hospital bylaws parallel to medical staff bylaws
- Establish policy and bylaws to include fact-finding methodology and meeting with the disruptive physician
- Address disruptive behavior in the credentialing process for initial appointment and for recredentialing
- Describe corrective action in bylaws and policy (Corrective action must be commensurate with the behavior.)
- Include disruptive behavior awareness issues and policy/bylaws to address them in staff and governance orientation
- Ensure that all members of medical staff are oriented on an annual basis on the code of conduct and ethical behavior
- Refer to and consult with the State Health Physician Program as necessary.

#### **A METHODOLOGY IN DEALING WITH A DISRUPTIVE PHYSICIAN**

A suggested method of dealing with the disruptive physician involves first a commitment from the triad leadership: the chair of the board, the CEO, and the Chief of Staff to ensure an organizational culture of appropriate behavior. A progressive methodology should be used. On the first reported occurrence of disruptive behavior, an objective fact-finding committee consisting of several respected physicians should investigate the reported occurrence. Next, the department chair should meet with the physician to discuss the behavior. If the committee finds evidence of disruptive behavior, the department chair should discuss the expectations for appropriate behavior and provide suggestions about refraining from disruptive behavior.

On the second reported occurrence of disruptive behavior, the Chief of Staff along with the CEO should evaluate the occurrence and if necessary ask a fact-finding team to investigate the facts related to disruptive incidences

to include a meeting with the physician. Documentation of the disruptive episodes need to be forwarded to the physician's credentials file. If a pattern of disruptive behavior continues, the physician should be asked to seek help with the State Physician Health Program.

The referral to the State Physician Health Program should be made with prior coordination with the physician regarding the occurrence. If the physician refuses to accept help from the Physician Health Program, the physician should be given the option of resigning from the medical staff or the pattern of behavior will be reported to the Medical Board. In some cases, the medical staff may have to take corrective action to suspend or terminate the physician's privileges. On cases where this extreme action has been taken, the cases have been supported by the court system provided due process has been followed.<sup>10</sup>

It should be noted that the method of confronting disruptive behavior may vary depending on such factors as the severity of the behavior to safety of staff and patient care and the frequency of the behavior. The State Physician Health Program should be contacted at any time for assistance. The hospital attorney should be consulted as well to ensure proper due process and adherence to bylaws and policies. The overall theme of this methodology is based on confidentiality, objectivity in the due process, and professional respect for the physician and the staff.

#### **CONCLUSION**

In conclusion, the CEO needs to be aware of the perils of disruptive physician behavior and the consequences of this behavior including the negative influence on quality care, morale of staff, image, finances, and trust. An objective methodology must be in place to manage and resolve disruptive behavior.

Disruptive physician behavior is an age-old problem, which most who have observed are reluctant to confront. Today, however, this issue must be addressed in order for quality patient care to prevail.

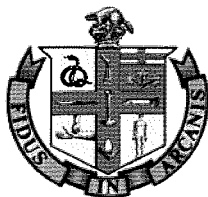
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APRIL 2008

# GUIDEBOOK FOR MANAGING DISRUPTIVE PHYSICIAN BEHAVIOUR



College of  
Physicians and Surgeons  
of Ontario



ONTARIO  
HOSPITAL  
ASSOCIATION

This guidebook is in effect as of April 2008 and periodically it may be updated.  
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## PURPOSE AND APPLICATION

This guidebook, which has been endorsed by the College of Physicians and Surgeons of Ontario (CPSO) and the Ontario Hospital Association (OHA), was developed in response to the growing body of literature that raised concerns about the behaviour of health care professionals, physicians in particular, and the impact of behaviour on patient outcomes. The publication offers some tools that the authors hope will be useful to those who work in a variety of educational and health care delivery settings. Most of the tools will need to be adapted to suit the setting in which they are to be applied. Some may not work in your setting at all.

While the guidebook primarily focuses on physicians, it could be adapted to apply equally to all members of the health care team. Likewise, while it specifically mentions conventions and regulations in Ontario, it could be used, with some amendments, in other jurisdictions.

The authors consider this work to be only a beginning. We will continue to collect information and examples of best practices and to make them available as widely as possible. Further to this aim, we welcome input and examples. Please e-mail us at [policyfeedback@cpsy.on.ca](mailto:policyfeedback@cpsy.on.ca).

## INITIATIVE OVERVIEW

This guidebook amalgamates the final work of the CPSO's Disruptive Physician Behaviour Initiative (DPBI). The goal of the DPBI was to bring together representatives from all aspects of a physician's career (from training through to independent practice) to recommend an infrastructure which would address the issue of disruptive physician behaviour and to develop resources and tools to identify, prevent and manage the harmful consequences of this behaviour.

The Initiative was comprised of five separate working groups. The Chair of each working group also sat on the Steering Committee. The Steering Committee met at regular intervals to ensure that the project stayed on track and that consensus could be reached on decisions that would have an impact on the whole group.

The task of the Policy working group was to develop a definition of disruptive behaviour and to articulate expectations of professionalism.

The Education working group was charged with developing a framework to provide guidance to Ontario faculties of medicine in the area of professionalism and disruptive behaviour of both physicians on faculty and physicians-in-training.

The task of the Institutional working group was to develop recommendations for approaches to managing physicians who demonstrate disruptive behaviour in work places.

The task of the Physician Assessment/Treatment working group was to identify approaches to assessing and treating physicians who are unable to maintain acceptable levels of professionalism.

The Regulatory Response working group was charged with developing recommendations to the profession as to how it might address this problem from the regulatory perspective: first identifying disruptive behaviour and then for clearly establishing expectations and a range of potential regulatory responses.

The working groups completed their initial mandates and issued draft reports in November 2006. This document is intended for practical application in a variety of settings.

**NOTE:** This guide does not offer legal advice. Readers will need to consider its processes in the context of its own legal requirements.

Note also that there are a number of applicable provincial laws relating to aspects of behaviour in the work environment, including, for example, human rights and occupational health and safety legislation, which prescribe specific expectations of behaviour within the workplace and the process of investigation when a complaint occurs. This guide does not offer advice about compliance with such legislation, although following the advice in this guide may assist an institution in compliance.

## 1. Introduction

Disruptive behaviour occurs 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 behaviour interferes with, or is likely to interfere with, quality health care delivery.

Institutions and organizations can take steps to prevent the occurrence of unprofessional behaviour, but despite the best training and modeling, disruptive behaviour will be exhibited from time to time. Each setting must promote a culture that normalizes the identification, including reporting, and management of such problems and recognizes that successful remediation is both possible and desirable.

The approach to managing inappropriate behaviour is specifically focused on remediation rather than punishment. The premise of the group that authored this work is that it will nearly always be beneficial to patients to keep skilled practitioners at work in the practice setting—each of the recommendations set out below has this as its objective. Unprofessional behaviour compromises the ability to provide the best quality care to patients, so changing the behaviour is imperative, but in almost all cases it will be possible for the physician and those around him or her to work together to achieve the common goal of continuing to provide the best quality patient care.

## 2. Expectations for Appropriate Behaviour

The standards and values of Ontario's medical profession are defined by the physicians of Ontario. As the voice of self-regulation for Ontario's physicians, the CPSO articulates expectations of physicians with respect to their relationships with patients and colleagues. Standards for behaviour may also be defined at the organizational level, whether in academia or in a health care delivery institution, through Codes of Conduct, policies or by-laws. Finally, whether behaviour is acceptable in a particular setting will also depend on the perception of those subject to the behaviour.

Each physician is expected to take responsibility for his or her own behaviour. Where the behaviour interferes with the delivery of quality care to patients, the physician is expected to change his or her conduct to meet the articulated standard.

There will be some instances in which the physician will be unable to make the necessary changes on his or her own. There are a variety of resources that may be of assistance in helping facilitate change and as much as it is the physician's responsibility to make the change, employers, colleagues, teachers and others can be instrumental in helping the person to identify the problem and get the necessary assistance. Appendix A of this guidebook (on p. 27) offers an overview of treatment opportunities and approaches for physicians who are unable to maintain professional behavioural standards. All readers are urged to consider the possible underlying causes of the problematic behaviour (especially if it is a recent change) and to read this section of the document.

### 3. Definition of Disruptive Behaviour

Disruptive behaviour is demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality health care delivery. Disruptive behaviour may, in rare circumstances, be demonstrated in a single egregious act (for example, a physical assault of a co-worker)<sup>1</sup> but is more often composed of a pattern of behaviour. The gravity of disruptive behaviour depends on the nature of the behaviour, the context in which it arises, and the consequences flowing from it.

#### What disruptive behaviour is not

Not all instances of behaviour which initially seems inappropriate will be disruptive. Whether behaviour truly disrupts the delivery of care depends not only on the nature of the behaviour, but also on the context in which it arises and the consequences flowing from it. Some examples of behaviour which are not likely to fit within the criteria for disruptive or unprofessional behaviour include healthy criticism offered in good faith with the intention of improving patient care or facilities; making a complaint to an outside agency; testifying against a colleague; or good faith patient advocacy.

On occasion, in the course of advocacy intended for the betterment of individual patients, the institution or the system, physicians may find themselves in conflict with colleagues or the administration of the institution in which they work. In such a circumstance, it may be difficult to evaluate whether the behaviour is disruptive. In such circumstances, the physician and the people with whom he or she works should carefully assess the impact of the conduct on the ability to deliver quality health care to the patient or patients. When the delivery of health care is impaired by the physician's advocacy efforts, the physician and institution may need to consider and discuss whether the advocacy effort is, in fact, in the patient's best interests.

#### Examples of behaviour that may be disruptive

The list below is not exhaustive. However, disruptive behaviour may sometimes include the following:

##### ***Inappropriate words:***

- profane, disrespectful, insulting, demeaning or abusive language;
- shaming others for negative outcomes;
- demeaning comments or intimidation;
- inappropriate arguments with patients, family members, staff or other care providers;<sup>2</sup>
- rudeness;
- boundary violations with patients, family members, staff or other care providers;
- gratuitous negative comments about another physician's care (orally or in chart notes);
- passing severe judgment or censuring colleagues or staff in front of patients, visitors or other staff;
- outbursts of anger;
- behaviour that others would describe as bullying;

<sup>1</sup> See further examples of behaviour in section 7.10 on p. 17.

<sup>2</sup> Respectful discussions in which disagreement is expressed are not arguments.

- insensitive comments about the patient’s medical condition, appearance, situation, etc.; and
- jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance or socioeconomic or educational status.

**NOTE:** Comments that are or may be perceived as being sexually harassing which are directed at patients may fall under the definition of sexual abuse at s. 1(3) in the *Regulated Health Professions Act, 1991 (RHPA)*. Such comments which are directed at non-patients may be professional misconduct.

***Inappropriate actions/inaction:***

- throwing or breaking things;
- refusal to comply with known and generally accepted practice standards such that the refusal inhibits staff or other care providers from delivering quality care;
- use or threat of unwarranted physical force with patients, family members, staff or other care providers;
- repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available;
- repeated and unjustified complaints about a colleague;
- not working collaboratively or cooperatively with others; and
- creating rigid or inflexible barriers to requests for assistance/cooperation.

## 4. Effects of Disruptive Behaviour

Unprofessional behaviour exists along a continuum of severity. At its most extreme, such behaviour can destabilize patient care in a variety of ways. It is this problem which makes such behaviour untenable in the professional environment.

Disruptive behaviour may contribute to adverse events, medical errors, compromises in patient safety, and can affect patient mortality.<sup>3</sup> It may undermine patient confidence, which makes patients less likely to ask questions or provide information that may be critical to their care; delay patient care as others seek to refer patients elsewhere or staff avoid dealing with disruptive practitioner; and deflect attention from the patient, thereby impairing clinical judgment and performance. It also can contribute to or create a hostile working environment for other health care professionals who may choose to leave rather than endure.<sup>4, 5</sup>

3 “VHA Research Finds Disruptive Behavior Common in Operating Rooms; Behavior Linked to Adverse Events, Medical Errors, and Mortality” (2007), <http://www.surgicenteronline.com/07/06/2006>.

4 Benzer DG and Miller MM (1995) The Disruptive-Abusive Physician: A New Look at an Old Problem. *Wisconsin Medical Journal*. 94(8):455–460; Pfifferling JH (1997) Managing the Unmanageable: the Disruptive Physician. *Family Practice Management*. November-December: 87–92.; Davies JM (2001) Painful Inquiries: Lessons from Winnipeg. *CMAJ*. 165(11):1503; Cassirer C et al (2000) Abusive Behaviour is barrier to High-reliability Health Care System, Culture of Patient Safety. *QRC Advis*. 17(1):1–6; Veltman L (1995) The Disruptive Physician: The Risk Manager’s Role. *Journal of Health Risk Management*. 15(2):11–16.

5 Cox, HC (1994) Excising Verbal Abuse. *Today’s OR Nurse*. 16(1):38–40.; Rosenstein AH (2002) Original Research: Nurse-Physician Relationships: Impact on Nurse Satisfaction and Retention. *American Journal of Nursing*. 102(6): 26–34.

Disruptive behaviour also has personal costs for the individual whose behaviour is the problem. These include decreased health, increased risk of self harm, social isolation, risk of disciplinary action or lawsuits.<sup>6</sup>

## 5. Identifying Unprofessional Behaviour

Colleagues and those charged with responsibility for fellow professionals tend to ignore early warning signs. Aside from being ill-equipped to recognize and manage the problem, some may consciously choose not to identify and respond to the behaviour. Below are just some of the reasons why warning signs are ignored:

- independence is so highly valued that physicians are loath to evaluate or confront a colleague with whom they must have an ongoing relationship;
- leaders or administrators experience such time-consuming (or expensive) administrative inconvenience when they confront disruptive colleagues that they avoid it whenever possible;
- institutional policies are vague on behavioural expectations and lack a clear protocol for dealing with lapses in professionalism;
- institutional culture may, *de facto*, collude with the individual demonstrating inappropriate behaviour if it is felt that the institution would be worse off if it had to do without the individual, even on a temporary basis;
- some people worry that increased organizational scrutiny will result in loss of personal or professional autonomy, social or professional status, reputation, income, and hospital privileges;
- colleagues do not wish to be responsible for causing additional stress or distress for the individual about whom they have concerns; and
- colleagues are afraid of the personal or professional repercussions of reporting someone whose behaviour has been inappropriate or threatening.

### Early markers

The following list of behaviours or activities should heighten your concern about an individual's professionalism or well-being. These are examples of behaviours or attitudes that may not clearly breach a Code of Conduct or meet the definition of disruptive behaviour, but which may warrant attention from colleagues or individuals in a position of authority.

#### ***The individual:***

- refers emotionally, often to whomever will listen, to personal upset over recent events originating in the workplace or in personal life;
- deviates from the workplace/professional norm in inappropriate dress or conduct;
- fails to show respect for others in the workplace and/or patients;
- blames others for problems (either at work or in personal life);
- suspects the actions and motivations of others and holds grudges;

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6 Kauffman M (2001) Recognition and Management of the Behaviourally Disruptive Physician. *Ontario Medical Review*, April: 53–55; Molea J (2001) Managing Disruptive Physicians. *Health Exec*, 16(3): 68–69. Pfifferling, JH (1999) The Disruptive Physician. A Quality of Professional Life Factor. *Family Practice Management*. November–December: 87–92.

- makes frequent reference to other incidents of violence in a way that implies he/she would/could replicate them in this workplace if provoked;
- threatens to harm self or property;
- fails to pay heed to the concerns and opinions of patients, families of patients, staff;
- violates or challenges work restrictions and policies such as failing to be on time for meetings and clinics and attend to duties;
- evades, intimidates, threatens, challenges those who confront over disruptive behaviours;
- makes unwelcome romantic overtures to people in the workplace;
- stalks/obsesses over fellow workers;
- expresses a fascination with weapons;
- describes a specific proposal to act in a disruptive and/or violent manner;
- takes risks that threaten safety of patients and co-workers; and
- monitors the behaviour and activities of others, often maintaining records.

If you see this behaviour, you should consider speaking with the individual to determine whether the behaviour is indicative of a larger problem. No formal action is recommended unless the behaviour is markedly inappropriate or violates the Code of Conduct, but attending to these early warning signs (by having an informal conversation, ensuring that the person has support and assistance, etc.) may help to avoid future problems.

## 6. Articulating Expectations: Policies or Codes of Conduct

Codes of Conduct define expectations for behaviour in the course of the day-to-day life in an institution, school or other group setting. Codes of Conduct may incorporate the particular organization's vision, mission, purpose, and value statements. Codes of Conduct may also be referred to as policies, standards or by other names. For the purposes of this document we will refer to all such documents as Codes of Conduct (Codes).

While the principles of an organization should apply equally to all members of the community, some institutions have Codes of Conduct which apply to all while others have Codes specific to particular populations, for example physicians or students. There are arguments in favour of both approaches. What is appropriate for your organization should be determined based upon its particular culture and/or other circumstances.

Successful development and implementation of a Code of Conduct will depend on developing it in conjunction with those to whom it will apply and those in positions of leadership. Specific strategies to ensure success in developing a Code of Conduct include:

- ensure opportunities for discussion, input and agreement. Criticism should be tabled openly and discussed so that a durable consensus can be achieved;
- offer drafts or prototypes for discussions about the Code, rather than beginning with a blank slate;
- ensure leaders champion the process throughout the organization; and
- manage the development of the Code in as transparent a fashion as is possible.

The key to an effective Code is ensuring that each element is clearly articulated, well publicized and clarified so that as little as possible is open to personal interpretation.

The Code will be the measuring stick against which behaviour will be judged: its markings should be as clear as possible.

The generic Code of Conduct in Appendix B (p. 30) has been created based on examples currently in use. It may be adapted for use in your organization or institution. Note that it is distinct from a Code of Ethics and addresses professional behaviour only in relation to colleagues and others. It is not intended to replace or substitute for more comprehensive ethical or practical guidelines, such as the CPSO *Practice Guide* or the Canadian Medical Association's *Code of Ethics*.

## 7. Dealing with the Concern

For the purposes of this document, all reports about incidents of disruptive behaviour will be referred to as complaints. Likewise, the generic document refers to a Complaints Procedure. There is no legal meaning to this terminology and it could be changed for your institution. The person who makes the complaint is referred to throughout the document as the reporter. The recipient of the complaint is referred to as the reviewer. The person about whom the complaint has been made is referred to as the physician.

### 7.1 The staged response to a complaint

The response to the complaint must be titrated to the nature of the incident and the physician's history with the institution. Intolerance of unprofessional behaviour does not mean that punitive action is required. It does mean that some action is required. It is critical to note, however, that for a single complaint about a relatively minor breach of behavioural standards, a very informal approach would likely be the best. Where the behaviour is particularly offensive or representative of a problematic pattern a more formal approach will be required and more serious consequences are likely to flow.

The Behaviour Management Flow Chart, setting out the staged response, is located in Appendix G (p. 43). A case study, demonstrating application of the staged response, is in Appendix E (p. 37).

### 7.2 Fair process

As with the Code of Conduct, successful development and implementation of a process for dealing with complaints about conduct will depend on the engagement of those to whom it will apply. It will be important to ensure that the proposed process is thought to be fair by all parties.

Once a process has been developed, it will be critical to ensure that all of those to whom it will apply receive notice that it has been adopted. In conjunction with publicizing the Code of Conduct, the repercussions for failure to adhere to it should be made clear.

A sample complaints procedure is attached in Appendix C (p. 32). This document captures each of the elements described in section 7 and may be adapted to meet the needs of your environment.

### 7.3 Reporting complaints

If an institution is to take conduct concerns seriously, it must make it as easy as possible to report them. To the utmost of its ability, it must also make a commitment to protecting the complainant from repercussions, whether personal or professional. It will not usually be possible to offer anonymity to the reporter (because the person being reported is entitled to know the full contents of any report if any action is taken) but the institution should ensure that the procedure for making a complaint is widely known. It should be made clear that maintaining confidentiality of all information gathered during the process will be of the highest priority.

The institution should also make it clear that it values good faith reporting of complaints and will ensure that the reporter does not suffer professional repercussions for stepping forward. Identify a specific office or individual to whom the report should be made. At minimum, the complaint should include the name of the reporter, the name of the person about whom the complaint is being made, the date and time of the concerning incident, a description of the incident and the names of anyone else who saw the incident. The complaint could be made orally or in written form. (If the complaint is not made in writing, it is imperative that it be recorded and kept for the record).

It should be made clear that it is unlikely that any action would be taken about a complaint if the name of the reporter was not indicated at the time of the complaint.

### 7.4 Commencing the investigation

Each report of disruptive behaviour should be checked for validity as soon as it is received.

The reviewer should first consider whether a reasonable person would find the physician's behaviour inappropriate. If the answer is yes and if the behaviour does not meet the standard set out in the Code of Conduct then further steps will be warranted. If the behaviour does not seem to the reviewer to meet the definition of disruptive or breach the Code of Conduct, then the reviewer should speak to the reporter to discuss the matter further and attempt to resolve his or her concerns without taking any further action. If further action is warranted, the reviewer should speak to the reporter to confirm the details of the reported incident.

The reviewer should then advise the physician of the complaint. The physician must be provided with the opportunity to ask questions and to provide a response to the complaint.

If the behaviour identified is minor in nature, then the matter may be resolved at this stage (see further discussion of how it could be resolved under stage one in section 7.7, p. 12).

If an informal resolution is not advisable or possible then part of the review must be substantiating the objective facts with corroborating information. The reviewer should interview any witnesses to the incident and review the patient's chart, where relevant. Individuals providing information should be aware that in the event that a formal review proceeds, their comments will be disclosed to the physician.

In some cases, depending on the nature and severity of the reported behaviour, it will also be helpful and relevant to collect data from other sources such as academic records and the physician's files. The information in these records may contribute to establishing, or ruling out, the presence of a pattern of problematic conduct. Information in the files which has not been substantiated with witness interviews or other evidence will not be particularly helpful as it will not be fair to use it for the basis of any decision-making. If this is the sort of information that is in the file then it should be subject to the same processes as the report being reviewed in order to ensure that the information is substantiated and the physician provided with an opportunity to respond to the previously reported concerns. (This is one place where the importance of good record keeping about physician reports is critical).

If the review of the witness statements and other information concludes that the complaint cannot be substantiated, no further action should be taken. Again, however, the reviewer should discuss the matter with the reporter to ensure that reporters acting in good faith are not made to feel ignored by the process. A discussion with the physician is also critical if the physician was notified of the complaint. The physician should understand that the complaint will not have further consequences. A note of the failure to substantiate the complaint should be retained in the physician's file. (This may save further review and administrative work if the complaint is raised again at a later date). A copy of any documentation retained in the physician's file should also be provided to the physician.

If the information obtained during the review substantiates the complaint, then some further steps will be required. The process need not, however, be formal and it should not be punitive. The response should be appropriate to the behaviour. We have called this the staged approach. The nature of the action that will be taken, as well as who will determine what action is appropriate, will depend on the nature and severity of the disruptive behaviour.

The documentation of the complaints process should include an indication of the institutional policy regarding the sharing of information with others. For example, when behaviour will result in a report to the CPSO or appear on any documentation that is provided as a reference for the physician, this information should be clearly articulated in the process description.

## 7.5 Assessing the information collected

In many cases, it will be difficult to assess the malignity of the behaviour and to gauge the appropriate response. The following questions will help to collect enough data to evaluate the level of concern the behaviour should spark.

The reviewer(s) should ask the following questions to understand the incident about which the complaint was made in context:

- Did this incident represent a change in the physician's previous behaviour pattern?
- Does the potentially problematic behaviour appear to be increasing in frequency?

- Did the behaviour come accompanied with an inappropriate degree of emotion?
- Does the aberrant behaviour appear to be broadening in scope over time to include more than one of the “index” behaviours?

Is there any evidence or suspicion that the physician is:

- Withdrawing from customary activities and associations with friends, fellow students, colleagues?
- Neglecting his or her own personal, intellectual, physical, emotional, and spiritual needs?
- Launching or defending himself or herself in repeated workplace or class grievances?
- Abusing alcohol or substances?
- Embarking on frequent one-man crusades?
- Arriving late or unprepared for work with concerning frequency?
- Demonstrating a pattern of degradation in academic performance?
- Guilty of violent acts in the past?

Rule out circumstances that might *mitigate* the seriousness of the behaviour, such as:

- eccentric behaviour or behaviour which is culturally different as long as it is not directed in a threatening or abusive way towards others;
- occasional altercations;
- one-time situational frustrations;
- occasional demands for special, attention/consideration coming from those having legitimate special needs, for example, the disabled health care worker.

## 7.6 Staged approach

Behaviour occurs along a continuum which ranges from exemplary to unacceptable. A staged approach is a progressive approach to managing behaviour in which the response is dictated by the behavioural trigger. The objective is to ensure that action is always taken when inappropriate behaviour occurs but that the response is useful and appropriate and facilitates improvement in health care delivery. The intention of this approach is remediation but it is critical to note that remediation will not work unless the individual in question accepts the responsibility for his or her actions and acknowledges that he or she must make personal changes.

### 7.7 Stage one

The kinds of behaviour which might require a stage one intervention include a single or limited number of instances of relatively mild disruptive behaviour, such as:

- use of inappropriate language;
- an outburst of anger;
- inappropriately criticizing colleagues or staff in front of patients, visitors or other staff;
- demeaning comments or intimidation;
- inappropriate arguments with patients, family physicians, staff or other care providers;

- insensitive comments about the patient's medical condition, appearance, situation, etc.;
- a single instance of throwing or breaking objects;
- sudden difficulty working collaboratively or cooperatively with others;
- refusal to follow hospital policies that are not immediately critical to patient well-being (breach of critical policies would warrant a higher level of concern);
- a sudden behavioural change; and
- non-compliance with institutional processes or waste of resources.

It is important to note that the appropriate response to this sort of behaviour will depend on how egregious it is in its first presentation as well as the answers to the questions in section 7.5 (p. 11). Each situation will have to be carefully considered within its own context. For example, a single outburst of anger in response to a colleague's late arrival for surgery may warrant nothing more than a reminder that behaviour should be professional at all times. However, should that outburst be coupled with a sudden failure to dress appropriately and a marked level of emotional withdrawal from colleagues, the conscientious medical leader, colleague or teacher will consider the possibility that the behaviour is the first sign of a bigger problem and consider an approach that goes beyond an informal conversation.

If the preliminary review substantiates the complaint, the reviewer must notify the physician of the complaint and the physician must be provided with an opportunity to respond.

This notification may take place in writing, but it is preferable that it should take place in a face-to-face meeting. During the meeting, the reviewer should explain to the physician how the behaviour was perceived by those who were subject to it, the impact it had on them and how the behaviour deviated from the Code of Conduct or other statement of behavioural expectations.

In the absence of any mitigating factors, if the physician acknowledges that the event took place and makes a commitment to avoid a recurrence of the behaviour or to undertake steps to learn to manage his or her behaviour, and the reviewer is satisfied that the physician understands that it is unacceptable, this may be the end of the process.

There may be occasions where the medical leader or teacher will feel that it could be helpful to suggest that the physician seek some form of advice, personal support or counselling on a generic basis. This is a reasonable early course of action. There are instances when it is also reasonable to ask for confirmation that this action took place, without seeking any details. It is not reasonable, however, for the reviewer to presume a diagnosis or to prescribe any specific form of counselling or therapy. For example, it may make sense to make a recommendation that the doctor contact the Ontario Medical Association's Physician Health Program (PHP), or to provide a list of potentially helpful resources, but referral to an anger management course or a psychiatrist may be overly presumptive or prescriptive.

Even if no further action is anticipated, a note should be made about the discussion and the complaint and the note should be retained in the physician's file.

Before finalizing completion of the review, the reviewer should discuss the outcome with the reporter to ensure that the reporter is satisfied. If the reporter feels that such an informal process is not satisfactory, then the reviewer must weigh the advantages and disadvantages of taking the matter further. Determining that no further action is warranted in defiance of the reporter's wishes poses the risk of discouraging people from making complaints in the future. Proceeding in order to satisfy the reporter, however, undermines the value of the complaints process (by making it over-reactive) and causes undue stress to the physician. Unfortunately, it is not possible to establish a generic process which will fit every circumstance. The reviewer (and his or her colleagues) must weigh the relative interests and make the determination of how to proceed on a case by case basis.

In many cases, it will be advisable to follow up with the physician to ensure that no further problems arise or to ensure that any commitments to undertake action to address the problem have been fulfilled. A meeting three months from the date of resolution is recommended for this discussion. Even in the absence of any further problems, the fact of the meeting and the absence of problems should be noted in the physician's file. Such documentation may be useful to both parties in future. A record of successful resolution of a problem may be useful to the physician should questions arise about the process at future discussions about privileges, for example.

## 7.8 Stage two

Behavioural problems occur along a continuum of intensity and frequency. So do management strategies. The transition to stage two is not always clear cut. The description below is intended to provide examples and guidelines but medical leaders and teachers will need to use their own judgment to determine when a higher level and more formal intervention is required to address behaviour problems.

A stage two approach is most often required after stage one interventions have been attempted but have not resulted in the necessary, sustained behavioural changes. Even where a behaviour is of moderate concern, or part of a pattern, it may be worthwhile to attempt a stage one form of intervention if that has never been tried. However, when stage one efforts have failed, and/or when there is an observed escalation of disruptive behaviours, in frequency, intensity or severity, a more formal response will be required.

The reviewer may not be the appropriate decision-maker as we move up the ladder in terms of severity of the problem and appropriate responses to it. For example, if the reviewer at stage one was the Service Chief, the appropriate response as the behaviour escalates might be considered by both the Service Chief and the individual who occupies the next higher position in the hierarchy.

Some organizations might find it helpful to establish a Physician Health Committee so that the physician who demonstrates stage two disruptive behaviours will have the benefit of a broader peer review-based discussion. Depending on the size and structure of the organization, the Committee might also include a high-ranking physician of the senior management. In some cases, the physician's behaviour will be a consequence of institutional policies or actions which may come under scrutiny.

For this reason, it can be very helpful to have a senior administrator involved in the discussions from an early point.

Reviewers should never impugn motives or guess at underlying diagnoses. However, in order to determine how best to change the behaviour, the recommendations must be based on an understanding of what is causing or contributing to it. In many cases, it will be wise for the institution to outsource an investigation into the cause of the behaviour, and limit its own review to confirming that the behaviour took place. When considering an assessment to determine what course of action to recommend, some questions that might be asked are:

- Will the assessment include a review of the physician's personal/professional skills which may be contributing to the inappropriate behaviour? For example, clinical skills, communications and interpersonal skills, and the ability to manage stress?
- Will the assessment include physical, psychological, psychiatric or substance abuse components?
- Will the assessment include a review of family, social and economic factors?
- Will the assessment include a review of occupational and workplace factors?

The PHP is the best Ontario resource for physicians to obtain assessments. In order to demonstrate the complexity of the assessment process, a copy of an assessment report is available at [www.cpso.on.ca](http://www.cpso.on.ca) in the Publications section under Additional DPBI Resources.

Once the underlying cause of the problematic behaviour has been identified, the reviewer (or the PHP or other arm's length provider) and the physician should agree on the next steps. In some cases, a more therapeutic approach will be required, for example, to address stress management or addictions issues. In other situations, a more educational approach will be most effective, for example, teaching the physician about the impact of his or her actions and establishing a monitoring arrangement that notifies him or her quickly when there is a deviation from appropriate behaviour, to teach the physician to identify the behaviour independently.

It is recommended that the content of the program intended to lead to change in the behaviour be captured in the form of a contract. The following elements should be included:

- the method of redress for the cause of the problem (personal counselling, leadership training, substance abuse therapy, tutorial sessions, etc.);
- the method of monitoring for change/progress;
- the name of a mentor who will follow the physician's progress through the process — this person must be satisfactory both to the physician and the institution;
- a means of measuring satisfactory progress (behavioural benchmarks);
- a timeframe within which progress must be demonstrable;
- consequences if no progress is observed or if non-compliance with the methods and terms of remediation is noted, including impact on academic standing, or privileges, where applicable; and
- an indication of the institutional policy regarding the sharing of the record with licensing and credentialing bodies.

Documentation of all elements of the agreement must be kept in the physician's file.

There will be costs associated with many of the interventions at this stage. In many institutions, the responsibility for meeting these expenses is an item open to negotiation between the parties.

Intervention at this level will not have instant results. Depending on the agreement, failure to maintain an acceptable standard of behaviour may have repercussions such as course or module failure, suspension and/or a report to the CPSO. In instances where a physician's hospital privileges are altered there will be an obligation on the part of the administration to report the alteration to the CPSO.<sup>7</sup> See further discussion of this obligation in section 8 (p. 19).

## 7.9 Stage three

Stage three describes inappropriate behaviour that has persisted or escalated despite intervention.

The kinds of behaviours which fall into this category include:

- physical assault or physical sexual advances towards non-patients (sexualized behaviour directed at patients is likely to meet the definition of sexual abuse in the *Regulated Health Professions Act, 1991*, and should be dealt with accordingly);<sup>8</sup>
- behaviours attributable to impairment caused by mental illness or substance use; and
- behaviour that contravenes established laws (municipal, provincial, federal, criminal, etc.) or that gives rise to the obligation to make a mandatory report to police, the CPSO or hospital administration.

The process for the review and discussions with the physician, which are outlined in sections 7.7 and 7.8, apply equally at this level of behavioural problem. In addition, however, there is no discretion with respect to directing this behaviour to the attention of the uppermost authorities in the setting in which the behaviour is taking place (whether in a hospital, clinic, academic institution or other). It may be that the Medical Advisory Committee (MAC), a Professional Review Board or other authority will review the behavioural history of the physician and work to develop a more assertive rehabilitative strategy. In the alternative, the administration may determine that disciplinary action is appropriate. Disciplinary action may include:

- restriction/modification of practice within the organization;
- direct supervision of the physician's practice;
- suspension of privileges on a time-limited basis; and
- failure of a course or a year in the academic setting.

As the threat to the physician's ability to practice medicine in an unrestricted way increases, so does the formality of the process. At this level, the existing by-laws or other governing structure of the institution will play a significant role. It is likely

<sup>7</sup> See Mandatory Reporting policy at [www.cpso.on.ca](http://www.cpso.on.ca) under Policies.

<sup>8</sup> *Health Professions Procedural Code*, s.1(3).

that legal counsel will be involved. At this stage, the record of reported incidents and the reviews that took place to verify them, as well as the efforts that have been made to educate, accommodate or remediate the physician will all be an important part of the formal proceedings.

### 7.10 Crisis intervention

There will be times when patient safety is directly threatened by a physician's behaviour. In such circumstances, the physician should be immediately removed from the situation. The physician should be informed that this action is not definitive and that the incident and its repercussions will be subject to a more formal review once the crisis has passed. Addressing immediate danger almost always compromises due process to some extent.

Examples where crisis intervention is required might include instances when:

- the physician is so distressed or out of control that he or she poses a safety risk to other workers in the environment;
- the physician threatens to physically harm him or herself or others;
- the behaviour appears to create unacceptable legal liability; and
- the behaviour poses an immediate threat to patient care.

### 7.11 Disagreement by the physician

There will be occasions where the physician and the reviewer cannot reach agreement as to the appropriate disposition of the complaint or remediative steps to be taken by the physician. For these occasions, a basic appeal process could be established. We recommend that a Committee be struck to review the recommendations made at the first level. The Committee composition will vary with the setting, but in the hospital setting could include the Chief of Staff, President of the Medical Staff, and an uninvolved Department Head, for example. In the academic setting, it would be appropriate to have a student representative on the Committee, as well as the appropriate authority. This Committee should review the report of the investigation as well as the recommendations made and determine whether they are appropriate, make alternative recommendations or require further investigation.

This process would not apply in the event that the matter had already escalated to the point where it was the highest authority, such as the MAC, that is making the determination as to outcome of the complaint, or where the organization's by-laws or regulations stipulate an appeals process.

### 7.12 Meeting with the physician

We have recommended face-to-face meetings to discuss problematic behaviour. These conversations can be difficult and making them effective is critical. Of course, every conversation will vary with the circumstances, but the following suggestions may be of assistance. See Appendix D (p. 35) for a sample script for a meeting with a physician whose behaviour fails to abide by the Code of Conduct.

### 7.13 Preparing for the meeting

Prepare notes prior to the meeting. This will clarify your thinking and provide a double-check to ensure that you have adequate data to proceed. The notes should include:

- the goals of the meeting (for example, providing information, making an action plan);
- the dates, time, location and other circumstances relevant to the reported incidents;
- objective, non-judgmental, and respectful language. Never impugn motives or guess at underlying diagnoses;
- as many examples of the problem as possible; and
- reasons why the behaviour was unacceptable – with reference to the appropriate Code of Conduct and the impact on others.

It may be advisable to have a third party at the meeting; this person may assist later if an objective recollection of what was discussed is required. The right person may also help to ensure that the tone of the conversation remains neutral and may provide support to the physician. It should be someone both parties agree upon or someone who is officially appointed to take such a role.

The meeting should take place in a formal setting: the office of the person charged with providing the information or a meeting room.

Plan on no more than one hour.

If one of the intended goals of the meeting is to develop a contract outlining the agreement about what steps will be taken to address the problem, prepare a draft before the meeting. Consider which items might be subject to negotiation and which are not.

### 7.14 Conducting the meeting

The discussion should follow the format of a performance appraisal or assessment. Always act in a respectful manner. Thank the physician for attending the meeting. Lay out the rules of engagement – the person conducting the meeting will review all of the information first and then the physician will be offered a chance to respond.

Begin the discussion with a statement of recognition of worth of the physician, the things that he/she does well. Discuss the concerning incidents, with full details, the next steps (whether they are to be investigative, educational or grounded in a monitoring program) and review the draft agreement, if that is the course of action being followed. Close with a discussion of the steps that will be taken to measure success and plan the next meeting.

A few more tips on delivery: Speak slowly and don't deviate from the planned content. Be prepared for the physician to attempt to divert the conversation and especially to find an external explanation for, or source of, the problem. If this occurs, it would be appropriate to schedule another time to discuss these concerns, but be prepared to re-focus the intervention with something along the lines of, "I know you are concerned with the quality of the nursing on the unit. I will certainly look into that but right

now we are here to talk about your behaviour.” Also, be aware of your own emotional reactions to the situation and strive to remain objective throughout the meeting.

Assume that because of the emotionality of the content, miscommunications will occur. Stop and repeat items frequently. Paraphrase and ask the physician what he or she has understood from what you have been saying.

## 8. The Role of the College of Physicians and Surgeons of Ontario

The College has developed a policy entitled Physician Behaviour in the Professional Environment, which articulates expectations for professional behaviour in the workplace, and is available at [www.cpso.on.ca](http://www.cpso.on.ca) under Policies. This policy is intended to capture the expectations of Ontario physicians and to serve as support for development of Codes of Conduct and educational programs teaching professionalism. The College also has a relationship with the PHP which encourages a therapeutic approach to behavioural issues whose root cause is health-related. This arm’s-length partnership permits physicians to obtain confidential assistance from the PHP while dealing with difficulties.

Employers or others who are responsible for terminating the employment or revoking, suspending or imposing restrictions on privileges (or who intended to do so but did not because the physician resigned or voluntarily relinquished their privileges) must report these changes to the College.<sup>9</sup> If a physician resigns from medical staff during the course of an investigation, this too must be reported.<sup>10</sup> Applications for appointment or reappointment to a medical staff which are denied must also be reported to the College.<sup>11</sup>

The College believes that remediation will always be the most desirable outcome when behavioural problems arise and in many cases, after the College receives notice of a suspension, if the problem is being appropriately dealt with at the local level and if patients are not in jeopardy, such notification will not necessarily result in College intervention.

Ultimately, however, there will be cases where, despite best efforts at the local level, the physician whose behaviour is disruptive cannot or will not change. In these cases, the College will be required to investigate the conduct and disciplinary proceedings may result.

## 9. Information Pertaining to Specific Settings

### 9.1 Professionalism in medical schools

In addition to the universally applicable suggestions above, which included establishing a Code of Conduct, a fair and thorough review process and a procedural policy for dealing with reports of problematic behaviour, the medical school setting has some distinct features. The first, of course, is that the curriculum itself must contain content that teaches appropriate behaviour. This will be the single most important mechanism by which meaningful change will occur in the future.

<sup>9</sup> *Health Professions Procedural Code*, s.85.5(1) and 85.5(2).

<sup>10</sup> *Public Hospitals Act*, s.33.

<sup>11</sup> *Public Hospitals Act*, s.33.

## Curriculum

Revisions to the Liaison Committee on Medication Education (LCME) accreditation standards were adopted in June 2007 and specifically reflect the new expectations concerning the standard of professionalism in the learning environment.<sup>12</sup>

The LCME Accreditation Standard states:

MS-31-A: Medical schools must ensure that the learning environment for medical students promotes the development of explicit and appropriate professional attributes (attitudes, behaviors, and identity) in their medical students.

The medical school, including faculty, staff, students, and residents, and its affiliated clinical teaching sites, share responsibility for creating an appropriate learning environment. The learning environment includes formal learning activities as well as attitudes, values, and informal “lessons” conveyed by individuals with whom the student comes into contact. These mutual obligations should be reflected in agreements (for example, affiliation agreements) at the institutional or departmental levels.

It is expected that each medical school should define the professional attributes it wishes students to develop in the context of the school’s mission and the community in which it operates. Examples of professional attributes could come from such resources as the American Board of Internal Medicine Project Professionalism, or the AAMC Medical School Objectives Project. Such attributes should also be promulgated among the faculty and staff associated with the school, with suitable mechanisms available to identify and promptly correct recurring violations of professional standards. As part of their formal training, students should learn the importance of demonstrating the attributes (attitudes, behavior, professional identity) of a professional and understand the balance of privileges and obligations that the public and the profession expect of a medical doctor.

In addition to defining the attributes of professionalism expected of the academic community, the school and its faculty, staff, students, and residents should regularly assess the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct, and develop appropriate strategies to enhance the positive and mitigate the negative influences.

It is a commonly held pedagogical tenet that evaluation drives the curriculum. Learning objectives for professionalism, and their importance, should be articulated clearly at the beginning of each educative cycle and criteria (benchmarks) for meeting those objectives should be determined. The Code of Conduct and the examples of unprofessional (or disruptive) behaviour will be instructive in helping to clarify what professional behaviour looks like.

In this setting, professionalism (and its counterpart, disruptive behaviour) is just one aspect of the skill set being formally evaluated. So, in addition to the formal professionalism course work, it is recommended that medical schools ensure that demonstrating a consistently

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<sup>12</sup> Approved by the LCME in February 2007; effective July 1, 2008.

high standard of professional behaviour is a learning objective for all courses and/or defined learning modules and that meeting these professionalism objectives is the *sine qua non* for successful completion of all courses. Undergraduate and postgraduate programs recognize disruptive behaviour in trainees as a particularly serious breach of professionalism by equating such activity, once identified, to a failure in the professionalism component of the relevant course or module.

The review procedure explained in section 7 should be used before establishing that the student has failed that component of the course or module. The steps recommended for establishing an appropriate response should also be followed. The student, whether undergraduate or in postgraduate residency, should have the opportunity to get the assistance he or she needs to modify his or her behaviour (in accordance with the suggestions in section 7). Further consequences should occur according to the standard institutional policies regarding passed or failed remediation.

Evaluation of students for professional behaviour should be standardized, validated and appropriate. Different schools can be expected to develop differing solutions for this difficult challenge.

The result of such a set of policies is that disruptive behaviour that has not been successfully remediated will preclude the granting of a degree to the individual in question. It follows that the CPSO can then be assured that all Ontario-educated students/trainees bearing degrees and applying for supervised practice or independent practice certificates are “in good standing” with their training institutions and that further verification regarding disruptive behaviour is unnecessary.

### Faculty conduct

It is recommended that the professionalism curriculum be supplemented with student, resident and faculty professionalism workshops and faculty orientation about both the curriculum and the process for setting expectations and addressing concerns.

Role-modelling by the professoriate is recognized as integral to teaching professionalism and teachers must be held to the same high expectations for professional behaviour as are students and residents. In all institutional settings, largely because of their inherent hierarchy, it can be difficult to establish an environment that encourages reporting of professionalism breaches. It can be threatening and intimidating to a student to report a teacher (as much as for a hospital volunteer to report to a prominent surgeon). As discussed in section 7, it is not possible to guarantee confidentiality for reporters because, if it is to be acted on, the information they provide will have to be shared with the physician. However, it is appropriate and necessary to make the reporting process as easy as possible, to offer support for the reporter and to ensure that no professional repercussions occur as a result of the report.

Case examples developed by the DPBI’s Education working group are available at [www.cpsso.on.ca](http://www.cpsso.on.ca) in the Publications section under Additional DPBI Resources.

## 9.2 Professionalism in health care institutions

Health care institutions are not unique in the challenge they face in promulgating an environment that encourages frank discussion or reporting of problems in the workplace. Establishing a Code of Conduct and a reporting process that is fair and agreed upon by those it will effect can help. It will also be helpful to establish strategies to support resolution of conflict at the earliest stage possible; offer a clear indication that the organization will support those who report problematic behaviour as well as those who request assistance with respect to modifying their own behaviours; encourage and support teamwork and to communicate the message that all incidents should be reported; and protect the reporter from repercussions and maintain the confidentiality of the reporter wherever possible. (It must be made clear that should any formal action take place as a result of the report, it will not be possible to keep the identity of the reporter a secret).

### Administrative background

In hospitals, the authority to manage physicians arises from the *Public Hospitals Act (PHA)*,<sup>13</sup> via the organization's MAC and by-laws. The by-laws, in turn, outline the process and the requirements for ensuring quality care in the organization, the appointment and re-credentialing processes as well as the process for restricting or removing of physician privileges.

The *PHA* provides that each hospital shall be governed and managed by a Board. The Board has two fundamental responsibilities – decision-making and oversight. The decision-making function is carried out together with the assistance of management while the oversight function concerns the review of management decisions as well as the systems and controls in place. The Board is able to delegate some responsibilities while other responsibility must remain with the Board. For example, the *PHA* provides that only the Board can appoint physicians.

The *PHA* also provides that each hospital shall create a MAC. The MAC has two main functions – an advisory role to the Board and oversight responsibility for the review and evaluation of the clinical work in the hospital, and the conduct of members of the medical, dental and midwifery staff. The *PHA* provides that medical staff will be organized in a manner that will support this accountability. The MAC is charged with initiating such corrective measures as may be required to achieve this goal.

Hospital by-laws vary in complexity, sophistication and legal detail. Inherent in all by-laws lies the power to suspend or terminate physician privileges.<sup>14</sup>

### Recruiting, credentialing and privilege renewal

Hospitals recruiting new physicians should ensure that they obtain references and ask the references specific questions with respect to behaviour. All hospitals providing references should be honest in their responses.

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<sup>13</sup> R.S.O. 1990, c.P.40.

<sup>14</sup> Prototype hospital by-laws developed in 2003 by the OHA and OMA can be purchased directly from the OHA website at [www.oha.com](http://www.oha.com).

All physicians who are being recruited to an organization should be fully apprised of the organization's expectations with respect to behaviour. Copies of the Code of Conduct should be provided to the physician and a forthright discussion should take place regarding behavioural expectations. If the potential new recruit cannot provide a satisfactory response to questions about past conduct, or does not agree to act in a manner consistent with the expectations of the organization, the organization should not offer the physician a position.

The physician's agreement to act in a manner that is consistent with the hospital's Code of Conduct should be part of the contract between the organization and the physician. This agreement should be maintained in the physician's file.

The annual credentialing process gives the hospital and the physician the opportunity to reconsider whether the continuation of the relationship is in each party's best interest. If the hospital wishes to continue the relationship with the physician, an offer is made to the physician to reapply for appointment through the credentialing process. Should the physician's behaviour not meet the standards established by the institution and accepted and understood by the physician, despite the appropriate corrective efforts, then the institution must make a decision about whether to offer reappointment. (Note that there will be occasions when the physician's behaviour is sufficiently disruptive that it would not be appropriate for the hospital to wait until the end of a credentialing period to take action).

If a physician seeks reappointment and the hospital has determined not to make the offer, the physician may challenge the hospital's decision.<sup>15</sup> To support its decision, the hospital should ensure that the physician's file contains documentation that includes the information:

- the physician had notice of the behavioural expectations within the health care organization and agreed to those expectations (ideally evidenced by a contract);
- the physician had notice about the potential ramifications of failing to abide by the organization's behavioural expectations;
- the physician has been given formal notice that his or her behaviour is unacceptable;
- all reports of disruptive behaviour were appropriately substantiated;
- efforts were made to assist the physician in changing his or her behaviour;
- the behaviour has not been successfully eliminated; and
- a review of the ongoing problems has been conducted in keeping with hospital policy and by-laws and this has led to a decision that further interventions appear to be futile.

Some hospitals find that an annual performance appraisal, at the time of re-credentialing, assists in the identification of strengths and weaknesses in the physician's clinical and professional skills. This can be helpful in many ways, and may contribute to addressing behavioural aberrations before they become problematic.

A list of information to be collected in the credentialing process can be found at section 7 of the OHA, OMA prototype hospitals by-laws. The list, but not the entire by-law, can be found in Appendix F (p. 42).

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<sup>15</sup> Note discussion in section 8 (p. 19) about reporting such decisions to the College.

## 10. The Obligations of the Organization

The obligation of the physician and the student to demonstrate a high level of professionalism has been discussed in detail in this guidebook. It should be understood that each health care organization has a reciprocal obligation to the people who work within its confines, rules and policies. This means that the leadership, culture, processes, policies and resources must enable and support physicians to do their work to the best of their abilities.

For example, it is a reasonable expectation of professional behaviour that a surgeon starts surgery on time, is fully prepared and treats operating room staff appropriately. It is the organization's responsibility to ensure that it, too, is on time; that the operating rooms are fully staffed with appropriately trained and professional staff; and equipped with functioning equipment that has been properly maintained. Likewise, it may be the reasonable organizational expectation that the physician will provide all necessary requisitions for diagnostic tests in a complete and timely manner. The physician may have a reciprocal expectation that diagnostic tests occur in a timely manner consistent with the standard of care.

As in a variety of workplaces, the culture and administrative practices of the workplace may encourage those who work there to act to the best of their abilities or the workplace itself may perpetuate an environment where frustration and anger inhibit productivity. If disruptive behaviour is erupting in more than one practitioner in the workplace or if the workplace is otherwise a particularly unhappy, dysfunctional or even toxic place, then the environment itself should be reviewed to determine what changes need to take place to foster the best performance from all who work there.

Some of the questions that might be asked are:

- To what extent are the administrative arrangements of the work environment conducive to and supportive of the work that must be done (call schedules, records management, etc.)?
- Is the physical environment appropriate, comfortable, efficient, etc.?
- Are the material resources to support the work appropriate and available in appropriate supply?
- Are the human resources sufficient for the work that needs to be completed?
- Are the staff and physicians well trained, effective, collaborative, and appropriate team physicians?
- Are there unresolved personal conflicts which undermine team efficacy?
- To what extent are inappropriate behaviours tolerated (and thereby perhaps tacitly endorsed)?
- Are there supports available to the physician to help him or her when such stressors as workload and fatigue become unmanageable?
- Does the organization's leadership have the required education and skill set to appropriately manage the team?
- Has the organization's leadership made a commitment, in a real and substantive manner, to create a work environment that demonstrates respect, integrity and collaboration?
- Does the organization's leadership demonstrate appropriate behaviours in their own interactions?

- Does the organization's leadership take immediate and appropriate action to address disruptive behaviour?
- Is the organization's leadership prepared, willing and able to conduct a comprehensive assessment of the working environment?

There are a variety of management consultants who specialize in this sort of work, including some that specialize in health care environments. If the problems in the workplace are acute, this may be an avenue to consider exploring.



## APPENDIX A

### Treatment Opportunities and Therapeutic Approaches to Disruptive Behaviour<sup>16</sup>

#### Background

Local organizations, such as the Physician Health Program (PHP) of the Ontario Medical Association, and private consultants, such as Workplace.calm, address aspects of various issues relating to disruptive behaviour. However, there are no programs in Ontario which are specifically designed to provide a comprehensive one-stop approach to assessment and treatment for disruptive physicians or other health professionals.

The assessment and treatment of physicians whose behaviour is disruptive is much better developed in the U.S. A summary of services is available at [www.cpso.on.ca](http://www.cpso.on.ca) in the Publications section under Additional DPBI Resources.

#### Existing resources

For a breakdown of existing resources and a select bibliography, see Additional DPBI Resources, available at [www.cpso.on.ca](http://www.cpso.on.ca) under Publications.

#### Existing tools and services to assess the individual physician

A number of assessment services are currently available in Canada and Ontario. Common assessments of the individual physician might include addictions; psychiatric; psychological; and neurological. Ideally, the clinician conducting the assessment should have access to relevant background information and records.

There is no single service available to conduct a thorough assessment; for example, a hospital which has been dealing with behaviour via its internal mechanisms may also want to refer the physician to the PHP for assessment. The Medical Director will then need to collect background information (such as the physician's medical and employment records), and arrange the appropriate assessments. Largely, these will be done on an individual basis, fragmented and in isolation of one another. The PHP will act as coordinator to facilitate and collect all of the resulting information.

The workplace may also wish to engage the consulting services of private consultants to help deal with a workplace conflict situation.

#### Existing tools and services to treat the individual physician

Typical treatment strategies might include regular psychotherapy; addictions treatment; group therapy; psychiatric care; and education (for example, anger management and assertiveness training). Hospitals or regulatory agencies may require the physician to attend certain educational programs or clinical skills retraining, and individual clinicians will implement treatment modalities and perhaps recommend educational programs such as

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<sup>16</sup> Note: This information is current at the time of writing (2007).

anger management. Some physicians in Ontario attend professionals with Masters in Social Work (MSWs) or doctorates (PhDs) for assessment and treatment, in addition to being followed by MDs; however, the likelihood of the physician accessing multidisciplinary services is lessened in the more fragmented service model in Ontario.

If the physician has been involved with the legal system, the courts may also mandate treatment and education.

### Existing tools and services for management/follow-up of the individual physician

Follow-up in Ontario is generally conducted by and at the discretion of individual clinicians (particularly family physicians and psychiatrists) and, where appropriate, by supervisors in the clinical setting.

Follow-up may include reinstating treatment interventions as appropriate, and may include 360-degree re-evaluations.

Formal contractual monitoring with the physician is a key feature of follow-up. Behavioural monitoring contracts have been used by many American jurisdictions for some time. In Ontario, the PHP has recently instituted a behavioural monitoring contract as part of its process of managing disruptive behaviour.

***Caveat:*** A large scale evaluation of the effectiveness of treatments has not been implemented even in the U.S. While the management of individual physicians no doubt is being evaluated, there is a lack of literature available examining these findings. It is therefore premature to draw conclusions about the effectiveness of any existing program.

### Existing tools and services to assess, treat and follow up the physician's family/social group

Significantly fewer tools are available to manage care of the physician's family and social grouping. This situation is perhaps to be expected, given the historical emphasis of problematic behaviour on the individual, and the practical issues associated with assessing and implementing care for a larger grouping.

Typical evaluations might include a systems assessment of the marital dyad/family unit, and a work-life balance assessment. Treatments may consist of couples/family therapy, educational programs and workshops. Psychiatrists, psychologists, MSWs, family physicians and perhaps clergy will be involved. As well, where the PHP is involved, if asked, it can provide support to the physician's family throughout the process.

### Existing tools and services to assess, treat and follow up the physician's hospital or institution

A wide variety of tools exist to assess and "treat" the physician's hospital or institution.

A sizeable body of knowledge had been built by management consultants and auditors working with hospitals and other health care organizations well before the identification of disruptive behaviour as a problem. Typical components of a review might include human resources policies; lines of communication; decision-making; organizational charts; policy

and procedure manuals; credentialing and privileges; employment standards; occupational health and safety; etc. Such reviews ideally result in interventions targeted at problems or gaps identified during the review. Interventions (or “treatment”) might include educational programs, leadership training, on-site presentations, retreats, team building initiatives, etc.

In the disruptive behaviour context, a review would also include 360-degree evaluations of the individual physician, groups, departments and entire facilities, as appropriate. Larger-scale 360-degree evaluations may be desirable, first, to determine if the problematic behaviour is more of a systemic than individual issue, and second, in particularly sensitive matters, to diffuse focus on the individual physician, at least in the early stages of evaluation.

The physician, his or her colleagues and other staff may benefit from counselling and support at the work re-entry stage through facilitated educational sessions.

Finally, follow-up would include 360-degree re-evaluations, ongoing facilitation and counselling and, where appropriate, repeat interventions.

For a summary of resources that the working group recommends be developed, see Additional DPBI Resources, available at [www.cpsso.on.ca](http://www.cpsso.on.ca) under Publications.

## APPENDIX B<sup>17</sup>

### Sample of Code of Conduct

#### Introduction

*(The Medical Staff/the Hospital Community/the Faculty and Students)* at *(Name of Institution)* is committed to supporting a culture that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, physicians, nurses, other health care workers and employees.

*(The Medical Staff/the Hospital Community/the Faculty and Students)* endeavours to create and promote an environment that is professional, collegial, and exemplifies outstanding teaching, research and patient care.

Towards these goals, the *(The Medical Staff/the Hospital Community/the Faculty and Students)* strives to maintain a workplace that is free from harassment. This includes behaviour that could be perceived as inappropriate, harassing or that does not endeavour to meet the highest standards of professionalism.

#### Purpose

The purposes of this Code of Conduct are to:

- clarify the expectations of all *(physicians/staff/faculty/students)* during interactions with any individual at the *(Institution)*;
- encourage the prompt identification and resolution of alleged inappropriate conduct; and
- encourage identification of concerns about the well-being of a physician whose conduct is in question.

Disruptive conduct and inappropriate workplace behaviour may be grounds for suspension or termination of a contract, or cancellation, suspension, restriction or non-renewal of privileges.

*(Name of Institution)* will follow due process for matters which have an impact upon a physician's privileges (or staff physician's employment/student's academic standings) and will abide by the *(Hospital's by-laws/Public Hospitals Act/Institutional policies)*.

#### General expectations

1. Consider first the well-being of the patient.
2. Interactions with patients, visitors, employees, physicians, volunteers, health care providers or any other individual shall be conducted with courtesy, honesty, respect and dignity.
3. All physicians of the *(Name of Institution)* community are expected to refrain from conduct that may reasonably be considered offensive to others or disruptive to the workplace or patient care. Offensive conduct may be written, oral or behavioural. Examples of inappropriate conduct would include, but are not limited to:

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<sup>17</sup> This Code was developed as a consolidation of documents currently in use in some hospitals as well as practices recommended by the College of Physicians and Surgeons of Ontario's Disruptive Physician Behaviour Initiative.

***Inappropriate words:***

- profane, disrespectful, insulting, demeaning or abusive language;
- shaming others for negative outcomes;
- demeaning comments or intimidation;
- inappropriate arguments with patients, family members, staff or other care providers;<sup>18</sup>
- rudeness;
- boundary violations with patients, family members, staff or other care providers;
- gratuitous negative comments about another physician's care (orally or in chart notes);
- passing severe judgment or censuring colleagues or staff in front of patients, visitors or other staff;
- outbursts of anger;
- behaviour that others would describe as bullying;
- insensitive comments about the patient's medical condition, appearance, situation, etc.; and
- jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance or socioeconomic or educational status.

**NOTE:** Comments that are or may be perceived as being sexually harassing which are directed at patients may fall under the definition of sexual abuse at s. 1(3) in the *Regulated Health Professionals Act, 1991*. Such comments which are directed at non-patients may be professional misconduct.

***Inappropriate actions/inaction:***

- throwing or breaking things;
- refusal to comply with known and generally accepted practice standards such that the refusal inhibits staff or other care providers from delivering quality care;
- use or threat of unwarranted physical force with patients, family members, staff or other care providers;
- repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available;
- not working collaboratively or cooperatively with others; and
- creating rigid or inflexible barriers to requests for assistance/cooperation.

Approval:

Distribution:

Review:

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<sup>18</sup> Respectful discussions in which disagreement is expressed are not arguments.

## APPENDIX C

### Sample Complaints Procedure

#### Receipt of complaint

1. Every individual (the reporter) should feel free to file a complaint in good faith about abusive or unprofessional behaviour without fear of reprisal or retaliation.
2. Anonymous complaints will be considered to the extent possible but may not result in any formal action.
3. Complaints may be made to (*Department Chief/Designate*) in writing or orally. Where a complaint is received by someone else, it shall be referred to (*Department Chief/Designate*) for review.

#### Notification to physician

4. At the earliest opportunity (*Department Chief/Designate*) shall inform the subject physician (the physician) about the nature of the complaint and that the matter is being investigated.

#### Review of complaint

5. Upon receipt of a complaint, the following measures will be taken within 14 days:
  - 5.1 (*Department Chief/Designate*) will meet with the reporter to review the complaint and all available details, including names of others who may have knowledge of the incident.
  - 5.2 (*Department Chief/Designate*) will meet with all those who have knowledge of the event within 14 days of receipt of the complaint.
  - 5.3 (*Department Chief/Designate*) will review medical records or other documentation where relevant.

#### Disposition of unfounded complaints

6. If the information obtained in the investigation fails to demonstrate that the incident complained of took place, or if the reported behaviour did not, in fact, deviate from expectations of professionalism, (*Department Chief/Designate*) will find that there is no basis for the concern. In this event, the complaint will be retained in the physician's file in accordance with this policy, with a clear indication that it was unfounded together with the information that substantiates this.

#### Substantiated complaints

7. If it is determined that inappropriate conduct took place, a staged approach to behaviour management shall be considered in light of the prevalence, severity, persistence and consequences of the incident or behaviour.
8. (*Department Chief/Designate*) will meet with the physician. Either the physician or (*Department Chief/Designate*) may request the presence of a third party for this meeting.

- 8.1 At the meeting the following information will be provided to the physician:
- the details of the incident about which the report was received; and
  - an explanation of how this behaviour deviated from expectations.
- 8.2 The physician will be provided with the opportunity to respond to the information, either orally, during the meeting, or within 14 days in writing.
- 8.3 In discussion with the physician, (*Department Chief/Designate*) will determine whether further investigation as to the cause of the behaviour is warranted. Such an investigation will certainly be warranted where the physician feels that the behaviour is outside of his or her own control. The physician will be offered a referral to the Physician Health Program of the Ontario Medical Association, or (*any other appropriate resource for personal support, assessment or other interventions as indicated*).

### Behaviour management

9. Unless the behaviour complained of poses an immediate threat to patient care or the safety of others, or unless the outcome of a prior complaint has indicated otherwise, (*Department Chief/Designate*) will consider the findings of the review and make the following recommendations:
- expectations in relation to behaviour in the future;
  - remediative measures, if any. (An effort will be made to reach agreement with the physician about the steps required towards changing his or her behaviour; in keeping with a staged approach to management, the course of action could include such components as stress management training, psychotherapy, monitoring, teamwork training, an apology, monitoring etc.) The agreement as to what measures will be undertaken may take the form of a written contract between the physician and the institution;
  - disciplinary action, as may be appropriate;
  - the consequences of any repeated inappropriate behaviour; and
  - further follow up, as required.
10. (*Department Chief/Designate*) will provide the physician with a written summary of the meeting and a copy of the written summary will be retained in the physician's file.

### Egregious/repeated unprofessional behaviour

11. If the behaviour complained of poses an immediate threat to patient care or the safety of others, or if the outcome of a prior complaint has indicated as much, the matter will not be dealt with by the (*Department Chief/Designate*). Rather, (the appropriate higher level of authority: Medical Advisory Committee, Physician Wellness Committee, etc.) will consider the findings of the review and make the determination as to outcome, which could include (suspension of privileges; academic suspension; course or module failure; etc.).
12. If the physician feels that the process or determination is flawed, then the physician is entitled to request a review by a committee (the Committee composition will vary with the setting, but in the hospital setting could include the Chief of Staff, President of the Medical Staff, and an uninvolved Department Head). After review, the Chair of the Committee will communicate, to all involved, the final determination.

13. A physician who fails to act in accordance with this policy may be subject to disciplinary action, up to and including suspension/termination of privileges (failure of a course or learning module).

### Confidentiality

14. The complaints investigation procedure is intended to be a confidential procedure. All parties to the process are expected to respect and maintain the confidentiality of the process and not to divulge the details of the investigation to anyone. Where there is any risk to other physicians, employees and patients, disclosure will be made to the extent necessary to offer adequate protection.

### Documentation

15. The record of the investigation and its disposition will be retained in the physician's file for five years from the date that the most recent complaint was received.

## APPENDIX D<sup>19</sup>

### Sample Script for Discussion with Physician Whose Behaviour Does Not Meet Expectations<sup>20</sup>

1. Review the facts of the reported incident:

Dr. Smith, I understand that on Tuesday you became so angry at the late OR start that you swore at the nurses, banged the side table and threw the instruments to the floor. Can you tell me what happened?

2. Review the organization's Code of Conduct and expectations of physicians.

I know that you are familiar with the Hospital's Code of Conduct. It requires all health care professionals to refrain from offensive or disruptive conduct. Do you agree that your behaviour on Tuesday could be considered to have been offensive or disruptive?

3. Seek to develop a mutual understanding of how these behaviours might be interpreted and perceived by staff and other physicians of the health care team.

I gather that your angry behaviour frightened staff or made them uncomfortable. This might make it difficult for people to feel comfortable working with you. Can you see how they might have been feeling that way?

4. Seek to develop an understanding of what were other contributing factors the physician feels exist and to what extent these factors are amenable to change.

Can you help me understand what happened in the OR that may have prompted your anger?

5. Discuss what might be done to circumvent such behaviour in future. Be specific.

Your concern about the delay in receiving sterilized tools is a legitimate one. This delay has an impact on our ability to schedule surgeries and, ultimately, to meet our wait time targets. I will speak with CPD and see what can be done to address the delays. I will get back to you about this on Wednesday. Your response, however, was unprofessional.

5(a) You may wish to speak to the PHP about getting some help with coping with stress or anger management.<sup>21</sup> I can call the PHP on your behalf and they will contact you to set up a meeting. Your discussions with them will be wholly confidential.

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<sup>19</sup> The fictitious event upon which this script is based is described in more detail in the case studies in Appendix E (p. 37).

<sup>20</sup> This script is intended for use once confirmation of the concerning behaviour/incident has been obtained.

<sup>21</sup> The Physician Health Program is a good resource, but not the only one. A student whose behaviour has been problematic may be referred to an appropriate mentor or student health services. A physician may be referred to a person or service known to the organization. Be cautious, however, not to diagnose the source of the problem that led to the disruptive behaviour, this would be inappropriate and, ultimately, likely to be incorrect and lead to an inappropriate referral.

Or, if the instance was a first time occurrence of disruptive behaviour and the physician is resistant to seeking external assistance,

5(b) If you are confident that you understand what behaviour is expected of you and you can assure me that you will abide by the Code of Conduct in future, then we can leave it at this. But if you find that you are experiencing the same kind of anger again, or having trouble managing your anger, please come back and talk to me and we will see what we can do that might help.

6. Discuss the need to provide feedback to those who reported the problem or expressed concern.

I will let the staff who have expressed concern know that we have discussed the matter. You may wish to apologize to those who were present. I will let them know that you have assured me that this won't happen again.

7. If the incident was not a first time occurrence, or if the behaviour was more than mildly disruptive, identify remediative steps to be taken and, if necessary, set a date to discuss a concrete plan for remediation.

This behaviour is unacceptable and you need to take concrete steps to ensure that it is not repeated. I will make a referral to the PHP for (specify the reason for the referral or its goal). You need to speak with them within the next month. Together you can assess whether you might benefit from some assistance. Why don't you and I meet again on November 8 (choose a date about three months from this meeting) to discuss your progress and whether there is anything else that I can do to assist you.

8. Discuss what will happen in the event that the behaviour(s) of concern do not resolve, or if there is non-compliance with required interventions. Refer to Codes of Conduct, by-laws or other policies if possible.

Presuming incidents like this do not recur and there are no further valid concerns raised, then we will be able to bring this matter to a close at our next meeting. However, as you know, our Code of Conduct indicates that if these problems continue, we will be required to take a more comprehensive approach, including asking you to undergo a detailed assessment to understand the cause of your behaviour and to determine an appropriate course of action. Ultimately, if this behaviour cannot be resolved, there will be no option other than to refer the matter to the MAC which could have an impact upon your privileges. And it is important that you know that if changes are made to your privileges, then we will be required to make a report to the College.

9. Discuss the need to document the meeting and the physician's commitment to meet his or her behavioural obligations.

I will make a note of our conversation for your file, including your commitment to change. I will provide you with a copy of the note for your own files. Thank you for meeting with me.

## APPENDIX E

### Case Study<sup>22</sup>

Jane Smith

#### *Background*

Dr. Smith was recruited to the hospital because of her exceptional vascular surgical skills, particularly in the new area of radiologically-guided surgery. She is a recent graduate and excelled during her residency and fellowship training. She is generally pleasant and is very attentive to her surgical patients who are devoted to her.

Dr. Smith prides herself on her attention to detail. She doesn't mind being seen as a perfectionist and she expects a high level of performance from those with whom she works.

One morning, soon after she came to work at the hospital, there was an incident in the operating room. Upset that the case was not ready to proceed at the scheduled 8:00 a.m. start time, she shouted at the nursing staff, banged her fist on a side table and overturned a tray of instruments. The patient did not witness the incident, but the operating room nurses and the anesthetist were taken aback.

The surgery was delayed but proceeded the same morning.

After the case, the nurses reported the incident to the Operating Room Manager. The manager briefed the Chief of Surgery who scheduled a meeting with Dr. Smith. At the meeting, the Chief discussed the incident with Dr. Smith, reviewing the hospital Code of Conduct and how her behaviour contravened that Code.

#### **Scenario 1: Stage one behaviour with appropriate local response**

Dr. Smith did not deny that her behaviour was inappropriate and acknowledged that she has a short temper, but said that it was a brief moment of frustration that passed quickly. She felt the nurses were as much to blame as they were slow to set up the room.

The Chief of Surgery indicated that a full investigation would begin into the start times of the operating rooms. The Chief of Surgery also indicated that regardless of her frustration, Dr. Smith's behaviour was not appropriate. The Chief of Surgery asked Dr. Smith to manage her frustration and anger in a more constructive manner and suggested the name of a community-based psychologist if she wanted help in that regard.

Following the meeting, the Chief of Surgery sent Dr. Smith a letter outlining their discussion and a plan for follow-up with the Chief of Surgery in two month's time.

A review of OR start times indicated that 20 per cent of all vascular cases started late. This pattern of late starts was attributed to a delay in receiving the instruments from the central processing department (CPD). A review of the CPD as to the cause of this delay indicated that there were only two special endo-vascular instruments and if both had been used the previous day, then full sterilization did not occur until 30 minutes before the start of the next day's cases.

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<sup>22</sup> This case study is fictional.

This occurred about 20 per cent of the time. A decision was made to purchase a third endo-vascular instrument, thereby allowing a fully sterilized instrument to be available at the start of each day.

Dr. Smith contacted the psychologist and, with his help, learned a number of strategies that helped her avoid future angry outbursts.

**COMMENT:**

*In this example of an incident surfacing early in the career of a surgeon, there was an immediate and appropriate response. As a result, the surgeon learned that the behaviour which came naturally to her would not be tolerated. A perfectionist, after all, she was able to make use of help offered and modify her behaviour.*

**Scenario 2: Stage two behaviour, mismatched response**

During a surgery subsequent to the one described above, a nurse inadvertently handed Dr. Smith the wrong instrument. Dr. Smith threw the instrument over the patient, hitting the wall behind the anesthetist and barely missing the anesthetist's head. Dr. Smith berated the nurse and used profane language to characterize the nurse's skills. After a few moments Dr. Smith composed herself and continued with the surgery.

After the surgery, Dr. Smith met with the Operating Room Manager. In the course of their discussion, Dr. Smith became so outraged that she banged on the table with her fists, injuring her hand. This self-injury stunned her into silence and she was escorted to the ER where it was determined that she had sustained a fracture and was unable to do surgery for three months. The patients on her long waiting list had to be contacted and rescheduled causing a number of patients great discomfort and/or frank danger. The Operating Room Manager reported the incident to the new Surgeon-in-Chief.

The Surgeon-in-Chief met with Dr. Smith to discuss her behaviour and Dr. Smith indicated that she sometimes gets so angry she cannot control herself and that the staff is so unhelpful that it makes her even angrier. Dr. Smith did not deny the incident and indicated that there had been other outbursts.

The Surgeon-in-Chief indicated that she wanted to investigate the other incidents to understand the background issues better before any action would be taken. Upon investigation, the Surgeon-in-Chief discovered that there had been three other incidents. The first is described in Scenario 1; Dr. Smith met with the former Chief Surgeon about this incident, but there was no follow-up.

In a second outburst with her secretary, Dr. Smith refused to allow her secretary to leave her office until a specific project had been completed and had barred the door to the office with a small filing cabinet. The secretary had submitted her resignation the following day after making a complaint to the HR department. The HR department did not proceed with any investigation because the secretary was no longer at the hospital and because the HR department was unclear as to its authority over an independent practitioner.

Finally, at a clinic when a test result was not available, Dr. Smith became so angry that she threw a stapler at the clinic computer.

In reviewing the matter, the Surgeon-in-Chief felt that Dr. Smith was not capable of modifying her behaviour and, supported by the hospital Chief of Staff and legal counsel, recommended to the Medical Advisory Committee (MAC) that her privileges not be renewed.

Dr. Smith decided to take legal action to maintain her privileges. No remedial course of action regarding Dr. Smith's behaviour was undertaken.

In the end, the hospital did not succeed in removing Dr. Smith's privileges since it could not prove that it had attempted to offer Dr. Smith notice that her behaviour was unacceptable. Dr. Smith returned to work, although relationships with colleagues and nursing staff were strained.

#### **COMMENT:**

*This is an example in which stage one behaviour was not well-managed. Even if the intervention described in the example above did not result in satisfactory behaviour, the documentation would have helped to provide a background for the later incident. In this case, however, the absence of remedial effort was complicated by the absence of a record of the incident.*

*Furthermore, two subsequent incidents, which each would have reflected an escalation in the problematic behaviour, were not reported. As a result, stage two interventions were not initiated.*

*When it finally took action, the hospital used an intervention that would have been more in line with interventions for stage three: that is, where there is demonstrated evidence of failed earlier interventions.*

*There is high likelihood of a future behavioural incident because there are no positive steps in place to support different behaviour.*

**Scenario 3: Stage two behaviour, matched response**

The scenario described above has taken place.

In this instance, upon review of the three prior events, the Surgeon-in-Chief determined that a stage two response to the behaviour was required. Dr. Smith was asked to take a voluntary break from her hospital duties and was referred to the Physician Health Program for a complete assessment and management plan.

The Surgeon-in-Chief also undertook a review of the circumstances to determine:

- why the behaviours had not been reported earlier;
- what organizational structures could be improved, if any, to lessen environment contributors to Dr. Smith's behaviour; and
- strategies to support the entire health care team to work collaboratively in anticipation of Dr. Smith's return to the OR.

Dr. Smith discontinued working in the OR temporarily. She obtained legal counsel who supported a PHP organized assessment. She agreed to an educational and counselling program that was recommended. She also agreed to a behavioural monitoring program designed to give her feedback about her behaviour once back at work in the OR.

**COMMENT:**

*This is an example of a thorough response designed to identify problems both the doctor and the hospital might be experiencing. The stage two assessment and rehabilitation strategies that result offer the best chance of retaining a valuable resource and improving the working conditions at the hospital for all.*

**Scenario 4: Stage three behaviour, matched response**

After Dr. Smith returned to work at the hospital, there were no further problems with her behaviour in the OR. Then, after nearly a year, there was an incident in the Emergency Room.

On the day in question, after a full day in the OR, Dr. Smith was paged to the ER to see a patient who had sustained a serious vascular injury. Dr. Smith was not on-call and it was not clear to her why she was being paged to the ER. Frustrated, angry and tired, she stormed into the ER and swore at the nurses for paging her inappropriately.

The Nurse Manager in the ER, who was a witness to this outburst, asked Dr. Smith to stop swearing and to apologize to the nursing staff. Dr. Smith became so enraged that she pushed the Nurse Manager, causing her to fall to the floor and hurt her back. Dr. Smith left the ER without seeing the patient.

The incident was reported to the Chief of Surgery immediately. An urgent meeting was held with the hospital's legal counsel, MAC chair, Service Chief and CEO and it was determined that despite all interventions attempted in the past, immediate suspension of privileges was warranted. Immediate suspension of privileges also required formal notification to the CPSO.

**COMMENT:**

*This is an unfortunate example of a serious recurrence of disruptive behaviour that caused physical harm to a co-worker. Because of that fact, and also because earlier stage two interventions have not been successful in preventing the incident, the appropriate reaction is the stage three response of removing the doctor's privileges and notifying the College of Physicians and Surgeons of Ontario.*

## APPENDIX F

### Credentialing

#### 7.4.2 Criteria for Appointment to the Medical Staff<sup>23</sup>

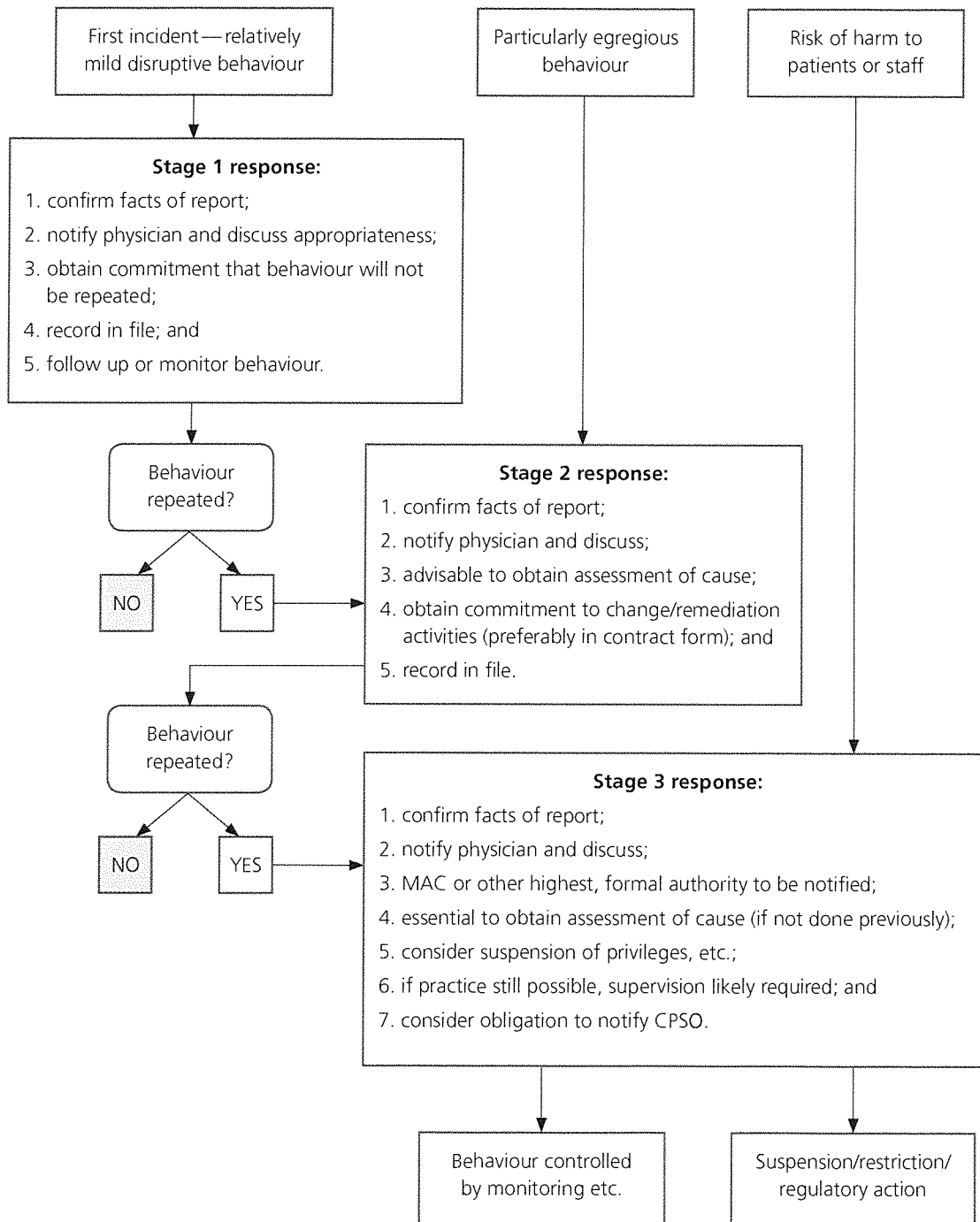
1. Only an applicant qualified to practice medicine and who holds a current, valid certificate of registration with the College of Physicians and Surgeons of Ontario is eligible to be a member of and appointed to the medical staff of the Hospital except as otherwise provided for in this By-law.
2. The applicant will have,
  - (a) a certificate of registration with the College of Physicians and Surgeons of Ontario;
  - (b) a current Certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario;
  - (c) a demonstrated ability to provide patient care at an appropriate level of quality and efficiency;
  - (d) a demonstrated ability to communicate, work with and relate to all members of the medical, dental, midwifery, extended class nursing staff and Hospital staff in a cooperative and professional manner;
  - (e) a demonstrated ability to communicate and relate appropriately with patients and patients' relatives;
  - (f) a willingness to participate in the discharge of staff obligations appropriate to membership group;
  - (g) adequate training and experience for the privileges requested;
  - (h) evidence of medical practice protection coverage satisfactory to the Board;
  - (i) a report on, among other things, the experience, competence and reputation of the applicant from the Chief of Staff, Chief of Department, or other such persons as is appropriate to contact, in the hospitals in which the applicant trained or held an appointment; and
  - (j) in the case of a certified specialist, a report from the Chief of Department in which training was completed, and/or a report from the Chief of the Department in which he or she last practiced.
3. The applicant must agree to govern himself or herself in accordance with the requirements set out in this By-law, the Rules of the Hospital and the Hospital policies.
4. The applicant must indicate to the Credentials Committee adequate control of any significant physical or behavioural impairment that affects skill, attitude or judgment.
5. There is a need for the services in the community.

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<sup>23</sup> Prototype hospital by-laws developed in 2003 by the OHA and OMA can be purchased directly from the OHA website at [www.oha.com](http://www.oha.com).

# APPENDIX G

## Behaviour Management Flow Chart



## ACKNOWLEDGMENTS

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Council of Ontario Faculties of Medicine	Dr. William McCready
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Dr. Vijay Anand	Mr. Michael McKelvey
Mr. Louis Balogh	Ms. Sharon McNickle
Dr. Dody Bienenstock	Dr. Alan Neville
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Dr. Karen Cross	Dr. Robert Rivington
Dr. Graeme Cunningham	Ms. Anitta Robertson
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Ms. Marg Harrington	Ms. Sheila Tymstra
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	Ms. Mary-Kay Whittaker



