

# Managing Disruptive Behavior in the Healthcare Workplace

## Guidance Document



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## Executive Summary

Disruptive behavior is a longstanding issue in Alberta's healthcare workplaces. This type of behavior includes objectionable language, uncontrolled anger and verbal and physical threats.

Disruptive behavior can also be passive in its approach. This might include repeated refusals to comply with known and accepted practice standards; chronic refusal to work collaboratively with colleagues, staff and patients; failure to respond to calls for assistance (when on-call or expected to be available) and persistent lateness.

It's been determined that only a small percentage of physicians act in this manner. However, just one disruptive individual can negatively impact colleagues and co-workers and the reputation of a workplace. Staff recruitment can be impacted, high staff turnover may become more common and requests for transfers and additional sick time from staff affected by the behavior may increase. If no action is taken, the workplace becomes known as dysfunctional, and ultimately, it is patient care and safety that suffers the most.

Disruptive behavior can also impact the physician who is causing it – his or her reputation may be damaged, trust with co-workers and patients may be diminished and careers might be impacted.

Without the guidance of specific policies, disruptive behavior in healthcare workplaces has been addressed in varying degrees - from being ignored completely, to being handled on an ad-hoc basis. These approaches have not been particularly successful in addressing specific situations or the underlying issue.

- In collaboration with a group of related stakeholders\*, the College has developed a draft guidance document to address this issue. The goals of the document are to:
- Emphasize that disruptive behavior in the healthcare workplace will no longer be tolerated,
- Help administrators manage issues of disruptive behavior in their organizations in a fair and consistent manner,
- Change the culture of healthcare workplaces that allow disruptive behavior to occur unchecked,
- Create a positive impact on the health of the disruptive individual and the team members he or she works with,

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- Ensure healthcare staff feel safe and empowered to report disruptive behavior without fear of retaliation,
- Ensure responses to disruptive behavior are proportional to the nature and circumstances of the behavior displayed,
- Ensure reports of disruptive behavior are not frivolous, vexatious or bad faith allegations,
- Ensure interventions for respondents are rehabilitative and therapeutic,
- Ensure sanctions, including loss of privileges, suspension and dismissal, are reserved for egregious offences or refusal to change,
- Reduce incidents of disruptive behavior in the healthcare workplace.

Implementation of the processes outlined in this document and toolkit, or variations of them, should help organizations, even those with limited resources, offer a more timely and effective approach to investigating and resolving incidents of disruptive behavior in the healthcare workplace.

\*A complete list of stakeholders is included, beginning on page 52.

# Introduction

This guidance document and toolkit was prepared to highlight the impact that a few disruptive individuals can have on workplace environments as well as patient care and safety. It also provides a framework to address such behavior when it occurs.

The information provided is the result of feedback from various healthcare organizations and a comprehensive consultation process with the medical profession and related groups. It is also adaptable for use when managing other disruptive healthcare providers in the workplace, such as technical and service personnel, researchers, teachers, nurses and administrators.

Processes for reporting, investigating and resolving disruptive behavior issues are included. The document also provides descriptions of acceptable and unacceptable behavior, outlines expectations of professional behavior and explains the implications disruptive behavior can have on staff, the organization as a whole and the disruptive individual. Accompanying this document is a toolkit with sample templates and checklists to guide the reporting, investigation and resolution process.

Using the information and tools alone may not successfully address the issue of disruptive behavior in your organization. A shift in culture may also need to occur. To make this kind of shift takes months, and sometimes years, but the improvement in morale, work performance, patient care and safety will be worth the effort.

**Notes:**

- This document does not outline how to deal with every possible form of wrong behavior.
- Offenses not covered in the document should be dealt with under the relevant legislation, Standard of Practice, policy, bylaw or code of conduct.
- This document is not intended as legal advice, or as advice regarding human rights or labor legislation. It is offered as a guide to help you manage disruptive behaviors by employees in the healthcare workplace.

## Defining Disruptive Behavior

To properly define disruptive behavior in the context of this document, several sources were consulted and words such as “unprofessional” and “unacceptable” were considered. The Oxford dictionary definition, “*disturbing to an activity or process*”, best reflects the effects of disruptive behavior in healthcare workplaces. For the purposes of this document, the following definition has been established: “*Disruptive behavior is an enduring pattern of conduct that disturbs the work environment*”.

Using the above definition in relation to healthcare workplaces, disruptive behavior can include objectionable language, uncontrolled anger and verbal and physical threats that cause a negative impact on colleagues, co-workers and patients, and potentially on the delivery of safe care.

Disruptive behavior can also be passive in its approach and more difficult to identify. This might include repeated refusals to comply with known and accepted practice standards; chronic refusal to work collaboratively with colleagues, staff and patients; failure to respond to calls for assistance (when on-call or expected to be available); and persistent lateness.

The term ‘enduring pattern’ is included to differentiate from what might be a single incident of disruptive behavior - which may require investigation but only as a single episode, or disruptive behavior that continues or escalates. Examples of an enduring pattern can include threatening or showing disrespect for others, or reflect misuse of a power imbalance between parties. Essentially, it is behavior that is uncooperative, contentious or litigious.

The seriousness with which disruptive behavior is judged depends on:

- its nature
- the context in which it arises
- the consequences which flow from it.

In addition to clarifying the definition of disruptive behavior, it is important to explain what disruptive behavior is not. For example, constructive efforts to change others, or the system, in order to improve patient care are not considered disruptive behavior.

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Likewise, giving a team member negative feedback is not considered disruptive, provided it is done in a professional and respectful manner.

The information provided in this document focuses primarily on disruptive behavior that is chronic, persistent and repetitive. When considering this information, it is important to recognize that occasional lapses can occur in even the most professional physician. It should also be noted that all disruptive behavior as defined would be considered unprofessional. However, not all unprofessional behavior is necessarily disruptive.

## Disruptive Behavior - Statistics

Although the occurrence of disruptive behavior is recognized as a longstanding problem, current, detailed and measurable information is not readily available.

Even if outdated, the available data demonstrates that only a small percentage of individuals act in a disruptive manner ( e.g. those who do not self-correct, apologize when wrong or make changes to their unprofessional behavior), yet a much larger percentage observe and report incidents of disruptive behavior. Examples for Canada and the United States are included below:

Percentage of reported disruptive individuals	Percentage of observed and/or reported cases of disruptive behavior
<p><b>In Canada:</b></p> <ul style="list-style-type: none"> <li>6.2 per cent of referrals to the Ontario Medical Association's Physician Health Program <sup>17</sup> are for disruptive behavior.</li> </ul>	<p><b>In Alberta:</b></p> <ul style="list-style-type: none"> <li>73 per cent of residents reported experiencing intimidation and harassment in the health care workplace <sup>8</sup>, through a 2003 survey.</li> <li>Up to 28 per cent of health professionals surveyed have observed disruptive behavior in their work settings, according to Breault<sup>3</sup>.</li> </ul>
<p><b>In the United States</b> (Leape and Fromson<sup>20</sup>):</p> <ul style="list-style-type: none"> <li>Surveyed nurses reported witnessing disruptive behavior from 4-5 per cent of physicians.</li> <li>Note: Due to the low response rate, this data is inconclusive.</li> <li>Physician executives reported that 1-5 per cent of physicians are disruptive.</li> <li>Leape's own best estimate is 3-5 per cent of physicians exhibit disruptive behavior.</li> </ul>	

# Expectations of Physician Behavior

The following examples of professional behavior are generally demonstrated in healthcare workplaces and should be supported and encouraged.

## 1. Communication skills with colleagues, co-workers, patients, etc:

- Realize everyone has a right to be heard. Listen to what others have to say.
- Address concerns regarding the clinical judgment of colleagues and co-workers in a private and constructive manner.
- Maintain composure at all times, even during difficult interactions with patients, colleagues and co-workers.
- Communicate clearly and directly with others while displaying consideration, sensitivity and respect for alternate points of view.
- Use proper etiquette when communicating by email.
- Consider all perspectives of an issue instead of reacting impulsively.
- Offer constructive advice to others when appropriate.
- Be open to constructive feedback from others and modify your behavior when appropriate.
- Confront and report egregious transgressions by colleagues and co-workers in a timely manner when necessary. Follow established procedures, including contacting the appropriate authorities if required.
- Be mindful to not impugn the reputation of others.

## 2. Health Care Delivery

### Dealing with patients:

- Incorporate patients' values, customs and beliefs into management plans, when appropriate.
- Advocate for individual patients and societal health issues.
- Adhere to institutional policies, procedures and practices for the benefit of patients.
- If a policy is believed to be incorrect or outdated, promote review and change in a positive and constructive manner.
- Participate in regular performance evaluations and committee activities intended to ensure good patient care.
- Answer questions honestly and tactfully.
- Engage in lifelong learning.

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**Dealing with colleagues, co-workers:**

- Treat colleagues and co-workers in a truthful, humane and non-demeaning manner. Focus on solutions rather than blame or punishment.
- Complete your assigned share of clinical and non-clinical team responsibilities in a timely manner.
- Take on extra work willingly, when appropriate to help the team, while also considering #54 of the Canadian Medical Association (CMA) Code of Ethics, which states:
  - *“Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practicing appropriate coping strategies.”*

**Dealing with patients, colleagues and co-workers:**

- Acknowledge and evaluate adverse events; work with others to prevent future recurrence.
- Maintain and complete clinical records in a timely fashion.
- Take responsibility and be accountable for one’s own errors. Apologize when appropriate.
- Respond promptly to requests for assistance from colleagues, interdisciplinary team members, patients and family members. This includes calls, pages and consultation requests.

**3. Collegiality**

- Improve team effectiveness through motivation and facilitation.
- Provide encouragement to work as a team.
- Respond appropriately to help a distressed or impaired colleague.
- Advocate for your colleagues.
- Resolve conflicts in a collegial manner, making compromises or respectfully disagreeing, as appropriate.
- Provide constructive and supportive feedback, using a positive framework that focuses on improvement.
- Arrive on time and prepared for scheduled activities and appointments.
- Make relevant contributions during classes, rounds or meetings.
- Refrain from dominating discussions and conferences.
- Validate the input of other team members.
- Respond receptively to diverse opinions and values, acknowledging others’ opinions as valuable.
- Listen to others respectfully and attentively, displaying appropriate body language to demonstrate attentiveness.

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- Solicit and value input from colleagues when appropriate.
- Acknowledge the limits of your knowledge and skills. Request help when needed.
- Provide mentoring to peers and other healthcare learners.
- Acknowledge ideas and performance of others in an honest (and constructive) manner.
- Refrain from setting unreasonable expectations for others.
- React appropriately when lapses in conduct and performance occur.

## CPSA Code of Conduct

The CPSA Code of Conduct clarifies the College's expectations for Alberta's physicians in all stages of their careers, in all facets of medicine, and in all methods of care delivery.

It is consistent with the Canadian Medical Association's *Code of Ethics* and complements the CPSA's *Standards of Practice*. Physicians are expected to know and abide by these rules; any breach of professional behavior will be judged against all three of these foundation documents.

While the Code outlines expectations regarding professional behavior, the College will consider the following when inappropriate behavior occurs:

- The well-being of the physician must be addressed
- Systemic issues within the health care system.

NOTE: Although these stressors must be identified and considered, they cannot be used as an excuse for inappropriate behavior.

Ideally, the CPSA Code of Conduct will serve as a template for healthcare organizations to use or modify as needed to deal with disruptive behavior. This should allow for more consistency in identification and management of disruptive behavior across the province.

### Notes:

- The CPSA Code of Conduct is referenced in the draft version of the Alberta Health Services (AHS) Medical Staff bylaws.
- A copy of the **CPSA Code of Conduct – *Expectations of Professionalism*** is included as **Appendix F**.

# Identifying Disruptive Behavior

**Note:** While disruptive behavior should not be tolerated, the context of this behavior must be considered before a formal investigation process is launched.

A single act of unprofessional behavior does not necessarily equate to disruptive behavior. It's understood that under certain circumstances, anyone can make an error in judgment or behave inappropriately. For clarification, the following lists provide specific examples of disruptive behavior.

## **Inappropriate communication with colleagues, co-workers, patients**

- Using inappropriate labels or comments when discussing patients and colleagues.
- Shaming others publicly for negative outcomes.
- Berating an individual in public or private settings.
- Exhibiting uncontrolled anger.
- Engaging in public displays of temper.
- Yelling or using foul, insulting or demeaning language.
- Threatening co-workers with retribution, litigation or violence.
- Using intimidation tactics to gain compliance or control of others.
- Employing inappropriate means of conflict resolution (such as gossiping or spreading rumors about colleagues instead of addressing the issue directly).

## **Unethical or questionable practices**

- Arbitrarily sidestepping reasonable clinical and administrative policies, such as refusing to complete forms, manage records, sign orders, etc.
- Targeting those with less power or status (e.g. students, residents and nurses) on a personal and/or professional level.
- Attempting to exploit patients, family members or staff, in order to pursue one's own interests. For example, placing patients or families in the middle of a conflict between healthcare providers or using care issues to meet one's own agenda.

## **Harassment**

Harassment can appear in a variety of forms in the workplace and outside. The following lists provide examples of workplace, sexual, personal, discriminatory and retaliatory harassment.

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**Workplace Harassment** is defined as offensive or unwelcome comments and actions that serve no purpose in the workplace. It can be a single event or a series of incidents that belittle, demean, humiliate or embarrass the recipient.

- Examples include:
  - written or verbal discrimination.
  - sexual and personal harassment.
  - retaliation against an individual.

**Sexual Harassment** is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature. It occurs when:

- Such conduct can be expected to embarrass, humiliate, offend, or cause insecurity or discomfort to another person or group.
- Such conduct interferes with a person's work performance or creates an intimidating, hostile or offensive work environment.
- Submission to such conduct is made a condition of employment, either directly or indirectly.
- Rejection of such conduct negatively affects an employee's job security, potential for promotion, performance evaluation, salary or benefits.
- Examples include:
  - telling sexist jokes that are clearly embarrassing or offensive, especially after the joke teller has been asked not to.
  - leering, staring, commenting or gesturing in an obscene or sexual manner.
  - displaying degrading or stereotypical images of a sexual nature.
  - using sexually degrading words to describe a person.
  - making derogatory or degrading remarks toward one's gender or one's sexual orientation.
  - making unwelcome inquiries or comments about a person's sexual life.
  - pursuing unwanted contact or attention in a persistent manner, after a consensual relationship has ended.
  - requesting sexual favors.
  - imposing unwanted touching.
  - making abusive or threatening verbal comments of a sexual nature.
  - committing sexual assault.

### **Personal Harassment**

Includes conduct in the workplace that:

- Is considered unwelcome by sensible and rational individuals.
- Results in the recipient feeling intimidated, humiliated, or embarrassed.
- Creates a hostile work environment.
- Serves no legitimate workplace purpose.

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- Examples include:
  - intimidating, threatening or coercive actions.
  - patronizing and insulting remarks (e.g. about an employee's intelligence).
  - berating an individual in public/the workplace.
  - humiliating conduct that demeans an individual.
  - bullying behavior such as name-calling, spreading rumors, or causing social isolation.
  - threatening unwarranted discipline or loss of job.
  - intimidating gestures such as slamming doors or throwing objects.
  - excessive and unreasonable monitoring of employee's work progress.
  - excluding an employee from the communication loop or withholding information needed to perform work.
    - this might include not sending or replying to memos or emails, or intentionally not giving notice of meetings.

### **Discrimination**

Discrimination is any unwelcome practice, comment or behavior (intentional or not) related to the following grounds protected in legislation: age, ancestry, place of origin, color, family or marital status, physical or mental disability, political belief, source of income, race, religious belief, gender and sexual orientation.

- Examples include:
  - making derogatory comments.
  - telling or posting of jokes, slurs, posters, cartoons, etc.
  - drawing attention to an individual's protected grounds to undermine his/her role in a professional or business environment.
  - innuendo, taunting, or ostracizing an employee based on the protected grounds.
  - making an employment decision on protected grounds that negatively affect the individual.

### **Retaliation for reporting disruptive behavior/acting as a witness**

All staff members must feel empowered to report disruptive behavior and not fear retaliation for doing so. Taking action against someone who reports disruptive behavior, or acts as a witness regarding disruptive behavior, is prohibited.

- Examples of these actions include:
  - unwarranted dismissal of the reporter or witness.
  - Demotion, transfer or denial of opportunities.

# Causes of Disruptive Behavior

Disruptive behavior have many etiologies (personal and systemic), and often results from a combination of circumstances. It can also reflect a behavior pattern that others have tolerated over a long period of time, and becomes ingrained in the individual. In many cases, it begins as early as medical school. The following lists describe factors that may contribute to disruptive behavior:

## 1. Systemic /Environmental factors (require correction/resolution if possible, when identified)

### Lack of resources in the workplace.

- Financial support for staffing, office equipment, etc
- Human resources – professional and others
- Meeting basic equipment needs
- New technology to provide better patient care
- Physical space limitations, including bed closures
- No fatigue management plan for the organization

### Heavy demands on the physician.

- Expending more time and energy
- Increased on-call responsibilities
- Increased work complexity
- Increasing clinical, research, academic and administrative workloads

### Tolerance of disruptive behavior by others.

- Colleagues and co-workers ignore and/or work around the behavior.

## 2. Personal Factors

### Stress.

- A physician's stress level can increase significantly due to overwork, fatigue and family and person situations, contributing to disruptive behavior.

### Illness.

- 78 per cent of physicians identified as displaying disruptive behavior may suffer from a major psychiatric disorder. Of this percentage, up to 40 per cent may suffer specifically from depression.

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- A physician may also suffer from a personality disorder.
- Lack of insight regarding the effects of disruptive behavior may be a prominent characteristic of individuals with these disorders.

#### **Dependency.**

- In approximately 20 per cent of cases, substance misuse exists. However, it is not necessarily the direct cause of the behavior.

#### **Character Traits.**

- The behavior in question may simply be an exaggeration of normal traits many physicians possess including rigidity, perfectionism, compulsiveness and independence. These feelings may be coupled with insecurity and feeling threatened or jealous of another's success.

#### **Personal issues.**

- Divorce, separation and/or financial issues can contribute to disruptive behavior.

#### **How the physician is viewed and views himself/herself**

- Beyond the personal factors already listed, there may be a significant discrepancy between how a physician views him/herself and the perception of the physician by others.
- Sotile<sup>29</sup> stated that disruptive physicians see themselves under the following characteristics:
  - autonomous
  - high performing
  - high achieving
  - perfectionist
  - objective
  - efficient
  - hard working
  - knowledgeable
  - competitive
  - successful
- These same physicians may be perceived by others as:
  - cold
  - lacking empathy
  - domineering
  - demeaning
  - uncaring
  - critical

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- intimidating
- self-centered
- questionably competent in their practice.

This kind of discrepancy can lead to presumptions that a physician is ill or just a challenging or difficult person, with no further explanation needed. However, the behavior may be at least partly attributed to other factors, such as those previously listed.

## Preventing Disruptive Behavior

Administrators and educators may be able to prevent disruptive behavior from occurring by adopting the following:

- Early and continuing education – from medical school, through residency and into practice.
- Identify disruptive behavior clearly so all healthcare staff understand what is considered unprofessional.
- Regularly evaluate students and faculty members to ensure their behavior are within the expectations of their profession.
- Create and follow a code of conduct, such as the CPSA version included as **Appendix F**.

# Effects on the Healthcare Workplace and Patient Safety

It's well understood that disruptive behavior negatively affect the morale and function of healthcare teams and can also compromise patient care and safety.

Staff and other physicians may resort to 'work-arounds' to avoid dealing with the disruptive individual. Patients may lose confidence in their physician and the institution he or she works in, and may not be willing to partner in their own care. Patients might even become too afraid of a disruptive physician to return for further care.

The care of patients can also be influenced by the following:

## **Medical Colleagues**

- Refuse to consult or assist with surgical procedures, potentially causing delays and risking patient safety.

## **Co-workers (e.g. nurses, technicians, support staff)**

- Choose to leave their job rather than endure an atmosphere of stress and tension.
- Become fearful and practice avoidance of the disruptive individual.
- Hesitate to call the physician for help, or to clarify orders.
- Defer patient care while waiting for another physician to come on duty.
- Take more sick time due to low morale and tension in the workplace.

## **Administrators**

- See an increase in staff sick time.
- Have difficulties attracting new staff or keeping existing staff.
- Spend additional time/energy to deal with the behavior – taking time away from more direct patient care issues.

## **Medical Students and Residents**

- Are provided with a negative role model at a critical time during their professional development that could affect their future dealings with patients.

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**Individual**

- The actions of a disruptive physician can also affect that individual and his or her family. He or she may:
  - suffer from stress and uncertainty if the physician's reputation is temporarily or permanently damaged.
  - incur costly legal fees.

With such a broad scope of potential consequences, early intervention and appropriate resolution of disruptive behavior is vital for healthcare workplaces and the safety of patients.

In light of this observation, Barnsteiner<sup>2</sup> proposed that authorities develop, disseminate and implement a disruptive behavior policy that incorporates an educational component or program for physicians, other healthcare workers and administrative personnel.

The goals of such a policy should be to:

- Protect everyone involved and affected.
- Publicize and acknowledge norms of behavior and consequences if good behavior is not followed.
- Establish channels with clear steps for individuals reporting disruptive behavior.

Upon receipt of a verbal or written report of disruptive behavior, the person in authority should determine:

- Whether the event reported has merit and, if so, whether action is needed.
- Initiate a full investigation including:
  - interviews with the respondent, reporter and any witnesses.
  - assessment of the respondent if necessary.

Note: Assessments should be conducted independently.

Once the investigation is complete, a plan of action should be developed, such as a Remediation Agreement or Continuing Care Contract or Agreement (see page 36). This plan might involve other policies and agencies.

## Potential Issues

Determining what qualifies as disruptive behavior and managing the situation can be a challenge to programs, organizations and medical associations. The following are issues that may arise while managing incidents of disruptive behavior:

### **Late recognition of long-standing disruptive behavior.**

- Colleagues and/or administration may ignore minor issues or handle them informally. This makes the situation increasingly difficult to manage.
- A pattern of disruptive behavior from under- or post-graduates is not always identified or acted on early in a respondent's career and will possibly continue into future practice.

### **The belief that disruptive conduct is acceptable and helpful.**

- Some physicians may believe that acting in a disruptive manner is normal or in the patient's best interest and therefore acceptable.
- If/when challenged, the physician may respond with threats of litigation.

### **Support for, and tolerance of, a highly competent physician with disruptive behavior.**

- If the physician in question is competent, performs at a high standard of technical performance and patient care and/or is the only option for care in smaller/rural medical centers, acts of disruptive behavior may go unresolved.

### **Deferring the issue for others to deal with.**

- Instead of local administrators and/or staff dealing directly with disruptive behavior incidents, the situation may be left for a new Chief of Staff or referred to the College of Physicians & Surgeons of Alberta (CPSA) or the Alberta Medical Association's Physician & Family Support Program (PFSP).

### **A physician reverts to disruptive behavior after treatment/resolution.**

- Some of the more difficult situations involve physicians who initially agree to mend their ways and accept treatment and counseling, only to later revert to their previous behavior.

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**Additional notes:**

- Be prepared for workplace stress to increase once a report regarding disruptive behavior has been made. Staff counseling and other supportive measures can help manage the situation.
- Special consideration should be given to rural areas where this type of support may not be readily available.
- When a physician is removed from the workplace due to disruptive behavior, there is often a lingering feeling of anger and frustration among other members of the healthcare team.
  - Carefully develop a re-integration plan that is both clear and accepted by all parties before the physician returns to work.
- Recognize that disruptive behavior may be symptomatic of system-level problems in the organization, staffing issues, unreasonable work demands or onerous call schedules.
  - Examining these elements is necessary to determine the causes of the behavior and to identify how to prevent future incidents.

## Reporting Disruptive Behavior - Introduction

All healthcare employees should be aware of how and when to report incidents of disruptive behavior. However, many will not take action, feeling the behavior won't be dealt with effectively and won't result in any real consequences to the disruptive individual.

Those who experience unacceptable conduct or harassment, either personally or as a witness, are entitled and encouraged to:

- Inform the disruptive individual that such behavior is unwelcome.
- Enlist the support of a friend or colleague to witness the reporter's discussion with the individual regarding the reported behavior.
- Seek confidential advice from, or report the behavior to, a person in authority with the applicable agency or institution: e.g. hospital, university, Registrar for the College of Physicians & Surgeons of Alberta (CPSA).
- Discuss the impact disruptive behavior have on the reporter through a verbal (if the matter is urgent) or written report.
- Receive assistance in formatting their submitted report, to ensure all relevant details are included.

**Note:**

- To support reporting of disruptive behavior without fear of retaliation may require a change in the culture of the workplace.

# Reporting Disruptive Behavior - Principles

The following principles are recommended for managing reports, investigations and resolutions for incidents of disruptive behavior:

## **Follow a consistent process.**

- Do not back down if a respondent threatens litigation, but recognize that a respondent may have legal counsel to assist him or her.
- Focus on rehabilitation measures when possible.
- Encourage mediation as part of the resolution process, if both parties agree and particularly if there is shared responsibility for the behavior. For example: disruption caused by a surgeon reacting to a repeated loss of operating time.

## **Ensure the timeliness of a response is appropriate to the severity of the behavior.**

- Consider the transitory availability of evidence.
  - transitory evidence includes a witness who may not be available at a later date, body fluids toxicology, abrasions or contusions, etc.
- Thoroughly document all encounters with the reporter and respondent.
  - a brief synopsis should be stored in each individual's personnel file.
  - a complete version of the report should be stored in a secure, central location for future reference.
  - provide copies of the complaint report and final findings to the respondent upon request, unless such disclosure is precluded by legislation.

## **Ensure the respondent is aware he/she is entitled to a fair process. This includes:**

- Notice of all allegations and charges
- The opportunity to face the reporter
- The opportunity to hear, and be heard, in a formal hearing before an impartial adjudicator or tribunal and,
- The opportunity to appeal the decision.

## **Additionally, one should:**

- Ensure the respondent is aware that attempts to intimidate or exercise retribution against a reporter will significantly elevate the status of the report.
- Advise a reporter that his/her report may be submitted anonymously. However, if action is taken against the respondent (e.g. disciplinary), the reporter's identity must be revealed.
- Provide regular updates to the reporter throughout the report and investigation process.
- Consider financial costs of investigations and who is responsible for these costs.

# Reporting Disruptive Behavior – Steps and Processes

Note: All documentation related to disruptive behavior incidents should be stored securely in a single location. This provides a single source of information regarding past events, simplifying searches for information and identification of behavior trends.

## 1. Report

When reporting disruptive behavior, a written version of the report is preferable in all instances to ensure proper documentation throughout the review, investigation and resolution process.

In the case of a severe incident, a verbal report may be submitted initially so action can be taken in a timely manner. However, a written version should be submitted before the review and investigation proceeds.

Recommended reporting structures are included in **Appendix I on page 51** of this document. A sample report and template are included in the **Toolkit, pages T6 and T7**.

## 2. Review

When a report of disruptive behavior is received, a review should begin as soon as possible. The review should be conducted by a local administrator or equivalent, as close as possible to the place and time where the incident occurred.

The purpose of this first review is to gather enough information to determine whether a formal investigation is justified.

### Notes:

- You must have the reporter's consent to share the report with the respondent and others, in part because the identity of the reporter will become known (in most cases).
- Documentation of the initial report and the review process is vitally important as missing information may cause subsequent intervention efforts to fail.

*Continued on page 28 ...*

Before proceeding with an investigation, the following review should be conducted:

**History of the event reported – new or chronic behavior as related by the:**

- Physician/Respondent
- Complainant/Reporter
- Co-workers
- Colleagues
- Patients and visitors
- Organization’s administration

**Explore the allegation:**

- **Where** did it occur?
- **When** did it occur?
- **Why** did it occur?
- **How** did it occur?

**Notes:**

- Consider past disputes that may influence the allegation.
- Determine what form of resolution the reporter is seeking – e.g. apology, discipline, etc.
- When interviewing witnesses and/or reviewing correspondence and meeting minutes (for cases of passive disruptive behavior), focus on information that supports facts versus opinion. For example, ask “Did you observe?” versus “What did you think about it?”

**TOOLKIT: Review Overview Checklist**

Page T9

### 3. Investigation

The individual or team chosen to investigate a report may vary but will generally be a member(s) of the respondent’s healthcare discipline, perhaps together with input from the reporter’s discipline if the two are different.

These investigators require the requisite training and experience to enable a fair and informed adjudication. Training is available through organizations such as the Association of Physician Executives, the Physician Manager Institute (PMI) through the Canadian Medical Association (CMA), and other local resources.

*Continued on page 29 ...*

### Elements of a successful investigation:

- A completed risk assessment (**Checklist Investigation Flow Page T8**) for patient, workplace and physician (respondent) safety.
  - Note: if a high risk level is determined, the physician (respondent) should (voluntarily or otherwise), be removed from practice during the investigation.
- Corroborating and correlating information from more than one person if possible.
- Recognition of what information should remain confidential.
- Accepting only objective accounts of witnessed behavior, not opinion or conjecture.
  - in cases of passive disruptive behavior you may use documented evidence such as minutes or correspondence in lieu of witnesses.
- Determining the degree of concurrence among the report(s) submitted.
- Insisting on confidentiality from all parties.
- Careful evaluation of the context for the behavior, particularly when systemic issues may have influenced the behavior by generating or contributing to it. (See pages 14-15 for details).
  - Note: systemic issues may explain disruptive behavior, but do not justify them.
- Consideration of possible mitigating factors such as cultural issues, single event frustration and chronic systemic provocation such as repeatedly lost surgical operating times.
- Reviewing documentation concerning prior incidents (if applicable) and past efforts to manage the prior incidents. Include information regarding any attempts at remediation.
- Determining if the report is based on false information, possibly submitted by an angry or jealous member of the health care team.
  - Note: in such a case, a false report would be considered disruptive behavior and the reporter would face consequences for this action.
- Considering the possibility of 'mobbing'. ("Mobbing" refers to the submission of several trivial or false reports regarding an unpopular or vulnerable individual).

Throughout the investigation, consider the potential for misunderstandings regarding cultural, ethnic and religious roots of a patient or member of a healthcare team. In cases like these, additional communication may be required to inform and change attitudes.

*Continued on page 30...*

**Notes:**

- Organizations that lack the administrative resources to launch an investigation locally (such as smaller clinics, rural settings, etc), may contact the following for assistance:
  - Zone Medical Directors
  - The College of Physicians & Surgeons of Alberta (CPSA)
  - The Physician and Family Support Program (PFSP), of the Alberta Medical Association
- Until an allegation is confirmed, the College's participation is limited to general advice that does not identify incidents or individuals.
- If the allegation of disruptive behavior by a physician is confirmed, the College need not be involved in all cases, but must be notified if there is any restriction or termination of privileges. Reports regarding other healthcare workers should be directed to the appropriate regulatory body or association.

**TOOLKIT: Investigation Summary Checklist**

Page T11

**4. Assessing the Respondent****Notes:**

- An assessment of the respondent is especially needed in cases involving Stage Four behavior, but may also be used for lower level issues.
- Overlooking any of these factors could lead to serious misinterpretation of the situation.

**Physical status**

- Independent external review of physical health.
  - pay particular attention to possible longstanding sleep deprivation.
  - consider aging and possible cognitive deterioration.

**Mental status**

- Independent external reviews of mental status.
- Burnout
  - stress can be a factor due to changes in healthcare delivery (e.g. heavy workload, frequent on call duty, lack of resources).
- Depression.
- Bipolar disorder.

*Continued on page 31 ...*

- Personality disorder.
- Addiction, including alcohol, chemicals and process.
- Boundary issues.
- Basic personality traits.

#### **Family history**

- Domestic discord with spouse, children and nuclear family members.
- Stress due to physical or mental illness in family members.

#### **Social history**

- General lifestyle.
- Modes of relaxation.
- Social or professional isolation.
- Religious or cultural differences.

#### **Work history and issues (if applicable)**

- General assessment of the quality of the physician's work.
- What is the physician's workload – days per week, on call duty, patient complexity and number, teaching, research and administration?
- What are the opinions of the physician from colleagues including peers, other staff and administration?
- How long has the respondent worked in the present position?
- Has there been a recent promotion or other change in status?
- What was the respondent's previous location and for how long? Why did it change?

### **TOOLKIT: Assessing the Respondent Checklist**

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## **5. Assessing the Severity of Disruptive Behavior – Stages 1 – 4**

Note: Acknowledgement, apology and commitment to acceptable behavior can resolve many incidents, except for those that are egregious in nature.

#### **Stage One (Low Severity)**

- First report of disruptive behavior, but may not be the first incident.

#### **Stage Two (Moderate Severity)**

- Repeated Stage One behavior, despite intervention.
- First report and repeated Stage One behavior that escalate to moderate severity.
- Lack of cooperation and inadequate or inappropriate response by the respondent.
- Escalation in frequency or severity (beyond Stage One).
- Sexualized behavior, even if this is the first incident.

*Continued on page 32 ...*

**Stage Three (Medium to High Severity)**

- Behavior beyond Stage Two, despite intervention.
- Persistent disruptive conduct beyond moderate severity.
- Egregious conduct that raises concerns of harm to the respondent and/or others.

**Stage Four (High Severity)**

- Behavior beyond Stage Three that includes threats or attempts to harm self or others, significant legal liability, immediate risk of patient injury.

Note: All incidents should be managed locally, where the event(s) occur, with the exception of egregious Stage Four behavior. These should be referred to the Registrar of the College of Physicians & Surgeons of Alberta (CPSA).

**6. Intervention (Informal/Formal)**

Upon receiving a report and gathering preliminary information (e.g. review old files, interview persons involved), meet with the respondent and determine next steps.

The level of intervention taken with a respondent depends on the severity of the disruptive behavior. It can be an informal conversation to discuss the incident – one-on-one with an administrator or colleague, or a more formal meeting.

If a more formal meeting is required, the following steps are recommended:

Note: A checklist outlining these steps can also be found on page T14 of the Toolkit.

**Create a written narrative of case facts to:**

- Clarify thinking.
- Ensure adequacy and quality of data.
- Be consistent (this is invaluable in the event of a physician's legal challenge).

**Determine the content of the intervention/meeting**

- Focus on behavior.
- Avoid references to motives. Never refer to diagnosis or the respondent's character.
- Use objective, non-judgmental, respectful language.
- Include the date, time and location of events.
- Include other relevant circumstances and context.
- Document witness statements.
- Include as many examples of the disruptive behavior as possible.
- Include the reasons the behavior were unacceptable.

*Continued on page 33 ...*

### **Intervention meeting plan**

- Choose a neutral peer to witness events at the intervention.
- Clearly set out the goals for the meeting. Ensure respondent is aware of these goals well in advance of the meeting.
- Choose a suitable site for the meeting (e.g. private but safe location, should there be any escalation in behavior. The meeting should not occur in a corridor or public space.)
- Negotiate a time with the respondent and keep the meeting to a maximum of one hour.
- Prepare a draft remediation contract before the meeting.
- Before the meeting, determine which items are negotiable and which are not.

### **Conduct the intervention**

- Always be respectful – thank the physician for participating.
- Lay out the rules of engagement. Speak first and allow the physician to respond. Get the physician’s agreement before proceeding.
- Clearly explain the purpose and goals of meeting.
- Acknowledge the physician’s worth and identify good attributes.
- Review the written narrative of case facts.
- Conclude with acknowledgement of your confidence in the physician’s good intentions, and expectations of cooperation for improved conduct in the future.
- Follow scripted information, and try not to deviate from what you have prepared.
- Speak slowly and carefully.
- Refocus the discussion whenever the physician tries to divert the issues; offer to discuss those matters at a separate meeting.
- Stop and repeat information regularly, to prevent misunderstandings. Paraphrase and ask physician to repeat what he or she understands from your statements.

## **TOOLKIT: Respondent Intervention Checklist**

Page T14

## **7. Recommended Responses to Disruptive Behavior (Stages 1 – 4)**

### **Introduction**

Unless the behavior issues are extremely serious and/or criminal in nature, a non-disciplinary dispute resolution process is preferred.

As a first step, interest-based conflict resolution can often be achieved through one-on-one discussions. In many cases, acknowledgement, an apology and commitment to discontinue the behavior is sufficient. In other cases, resolution may involve counseling, assessment, treatment and/or medication.

*Continued on page 34 ...*

Other options include:

- Discussion of possible recurrence/relapse of behavior and the consequences of such.
- Developing a plan for monitoring the individual that includes regular performance reviews and conditions if a relapse occurs.
- Documentation of the discussion and the agreed-upon plan.

**Stage One - formal discipline not necessary.**

<b>Required</b>	<ul style="list-style-type: none"> <li>· Document proposed process for follow-up.</li> </ul>
<b>Expected</b>	<ul style="list-style-type: none"> <li>· Discuss the situation with a senior colleague you are comfortable speaking with, possibly a confidante.</li> <li>· Seek the physician's understanding and commitment to change. Arrange for supportive but firm counseling. Note: Clarify who will provide the counseling.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>· Refer physician to the Alberta Medical Association's Physician &amp; Family Support Program (PFSP).</li> <li>· Refer physician for an external physical and/or mental status assessment.</li> </ul>

**Stage Two - formal discipline may be required.**

<b>Expected</b>	<ul style="list-style-type: none"> <li>· Conduct an immediate formal review at the next level of authority.</li> <li>· Developing a contract between the physician and administration concerning redress, monitoring, mentoring, etc.</li> <li>· Note: Monitoring should include behavioral expectations and conflict resolution strategies.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>· Refer the physician to the Alberta Medical Association's Physician &amp; Family Support Program (PFSP) or an external consultant.</li> <li>· Consider sharing costs between the physician (respondent) and intervening agency (e.g. hospital, clinic, university), such as assessment or mediation by appropriate professionals.</li> </ul>

**Stage Three**

<b>Required</b>	<ul style="list-style-type: none"> <li>· Notify the registration department of the College of Physicians &amp; Surgeons of Alberta (CPSA) regarding reduced privileges or anticipated resignation due to possible suspension.</li> <li>· Conduct a formal investigation.</li> <li>· Develop a formal, written report.</li> </ul>
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*Continued on page 35 ...*

<b>Expected</b>	<ul style="list-style-type: none"> <li>Involve the Medical Advisory Committee (MAC) and follow applicable bylaws.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>Refer the physician to the Alberta Medical Association's Physician &amp; Family Support Program (PFSP).</li> <li>Consider disciplinary actions such as: restriction of practice, direct supervision of practice, suspension of privileges.</li> </ul>

Note: Generally, the first three stages should be addressed locally. Stage Four often requires the involvement of the College of Physicians & Surgeons of Alberta (CPSA).

#### Stage Four

<b>Required</b>	<ul style="list-style-type: none"> <li>Conduct a formal intervention.</li> <li>Launch an immediate investigation: document the process, including appropriate external mental and/or physical assessments of the respondent and appoint an independent investigator. <b>Note:</b> Smaller jurisdictions may need to contact a larger centre or the College of Physicians &amp; Surgeons of Alberta (CPSA) for assistance.</li> <li>Ensure appropriate therapy is in place (if deemed necessary from the assessment.)</li> <li>Consider disciplinary action. This may be delayed until completion of criminal action in the courts.</li> <li>Notify the registration department of the College of Physicians &amp; Surgeons of Alberta (CPSA) regarding reduced privileges or anticipated resignation due to possible suspension.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>Impose an interim suspension of privileges.</li> </ul>

#### Notes:

- Formal discipline is determined according to relevant legislation, bylaws and policies.
- Be prepared for those involved taking adversarial positions.
- Every effort should be made to resolve disruptive behavior situations on a **local level**.
- The College should only be involved in serious cases, or where local resolution is not possible.
- The goal of assessment is to understand all factors contributing to the unacceptable behavior and which factors need to be addressed.
  - The request for assessment should specify that the report cover diagnosis, fitness to practise, need for restrictions, recommended treatment, monitoring, and risk of recurrence.

*Continued on page 36 ...*

## 8. Resolution

Depending on the severity of the incident, most incidents of disruptive behavior can be resolved informally and quickly. In the case of a single complaint regarding a minor incident, (as dictated by the Stages of Disruptive Behavior) a more informal approach is generally sufficient.

This may include an apology to the reporter from the respondent, or a formal acknowledgment (e.g. letter) stating recognition of the incident and a promise the behavior will not occur again.

When the behavior is more serious, such as Stage 3 and 4 scenarios, a more formal approach should be followed. This may include remediation, a contract or agreement for treatment and monitoring or, in cases that are more serious, disciplinary steps and/or legal actions.

## 9. Remediation

Remediation or Continuing Care Contracts or Agreements can be used to monitor behavior and progress. Successful remediation requires acceptance by the respondent of responsibility and willingness to make personal changes.

Expectations and the issue which resulted in the contract or agreement must be clearly defined by the investigator. The contract or agreement may also include the following elements:

- Steps to address any health-related issues
- Provisions to monitor professional behavior e.g. Practice Monitor, Medical Staff Head or Supervisor.
- Consequences for continued lapses in professional behavior including:
  - reassessment of personal/health factors
  - any limitations, restrictions or alterations to the physician's practice
  - behavioral benchmarks
  - specific time frames
- Further approaches and possible consequences for lack of compliance or progress, and recidivism.
- Contracts or agreements should also include:
  - the name of the monitor and/or mentor (if applicable)
  - a statement regarding how the information will be shared with the appropriate regulatory body.

Note: A statement is also included in the respondent's file regarding the remediation process and contract or agreement, if applicable.

## Managing Disruptive Behavior – Determining Success

Successful management of disruptive behavior will result in a decrease in such behavior, or a complete cessation of the behavior altogether.

According to the *Physicians Universal Leadership Skills Education Program*<sup>27</sup> or P.U.L.S.E. Program, the attitude and actions of individuals who had displayed disruptive behavior will show improvement by:

- Remaining approachable, even when under stress.
- Treating team members with respect.
- Handling difficult team members effectively.
- Remaining open to suggestions.
- Responding to conflict by working out solutions.
- Adapting to changing policies, procedures and priorities.

## Managing Disruptive Behavior – Organization’s Authority to Respond

The authority for administrators to respond to reports of disruptive behavior is guided by the following, as relevant to your organization:

### **Provincial legislation (alphabetical order)**

- *Freedom of Information Act*
- *Health Professions Act*
- *Hospitals Act*
- Human rights legislation
- Privacy legislation
- *Occupational Health and Safety Act*

### **Institutional policies and bylaws where applicable: (alphabetical order)**

- Alberta Health Services Code of Conduct
- Alberta Medical Association (AMA) & Alberta Health & Wellness (AHW) – Collective bargaining agreements
- Canadian Medical Association (CMA) – *Code of Ethics*
- College of Physicians & Surgeons of Alberta (CPSA) – Bylaws, Code of Conduct, Standards of Practice
- Hospital Medical Advisory Committee (HMAC)
- Medical Staff Associations (MSA’s) or equivalent
- Provincial Medical Staff Bylaws
- University of Alberta, University of Calgary – Faculty of Medicine
- Your institution’s internal policies on discrimination, equity and harassment

## **Appendix A - Acronyms**

ADR = Alternate Dispute Resolution

AHS = Alberta Health Services

AHW = Alberta Health & Wellness

AMA = Alberta Medical Association

CMA = Canadian Medical Association

CMPA = Canadian Medical Protective Association

CPSA = College of Physicians & Surgeons of Alberta

MAC = Medical Advisory Committee

NBME = National Board of Medical Examiners

PFSP = Physician and Family Support Program (of the Alberta Medical Association)

PMI = Physician Manager Institute

## **Appendix B – Physician and Family Support Program (PFSP)**

The Physician and Family Support Program (PFSP) of the Alberta Medical Association can be accessed toll free at 1.877.767.4637. This service is available 24 hours per day, seven days per week. The Assessment Physician responding to your call will be able to direct your concern appropriately.

The PFSP Case Coordination service has developed an algorithm to work together with physicians, their workplaces and medical administrations together regarding issues of alleged disruptive behavior.

Please contact the PFSP Clinical Director to discuss Case Coordination processes inclusive of the algorithm.

## Appendix C - Sample Bylaw

The following sample bylaw gives administrators the necessary power to intervene when physicians exhibit disruptive behavior.

The bylaw can be:

- added to your hospital's or organization's current bylaws
- used for performance evaluations
- used to specify expectations or requirements that are conditions of appointment.

*"Physicians are required to observe the spirit and content of an approved Code of Conduct and are subject to investigation of and response to breaches observed and reported, the possible consequences ranging from counseling to suspension or dismissal."*

NOTE: The *CPSA Code of Conduct* (see Appendix F) is referenced in the draft Medical Staff bylaws for Alberta Health Services (AHS).

## Appendix D- Continuing Care Contracts and Remediation Agreements

Continuing Care Contracts and Remediation Agreements can be used as part of the resolution process to monitor behavior and progress and are designed to minimize patient risk and support the physician's health needs, if applicable.

These contracts or agreements:

- Allow administrators to monitor physicians with health problems
- Place personal or practice restrictions on a physician, and/or comply with disciplinary decisions.
- Outline clear expectations of the physician and consequences for lack of compliance or progress, and recidivism.

**Note:**

- Before agreeing to the terms of a Continuing Care Contract or Remediation Agreement, physicians are encouraged to consult with a CMPA lawyer.

**Checklist – Continuing Care /Remediation Agreement**

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## Appendix E - Sample Case Study

This fictional case study is offered as an illustration of an individual acting in a disruptive manner.

### Background – Dr. Smith

- 46 year old physician,
- Infectious Diseases Specialist,
- Tertiary care hospital practice,
- Works with HIV infected patients,
- Seen as a devoted physician.

### During Dr. Smith's residency:

- Poor evaluations on several rotations,
- Overly critical of nursing staff,
- Overly demanding of junior colleagues,
- Knowledge base always excellent,
- Worked very hard on all rotations.

### As an attending physician:

- Tough taskmaster with trainees at all levels,
- High standards for himself,
- Expects same standards from all others,
- No-nonsense approach.

### Scenario #1: Evening Shift

---

- Nurse forgot to give antibiotic to patient.
- Dr. Smith demanded to see the nurse.
- At the nursing station, in front of several patients and other nurses, Dr. Smith:
  - yelled at the nurse that she was incompetent to practise.
  - said her lapse was evidence of her stupidity.
- Nurse tried to apologize for her error.
- Dr. Smith continued to yell and walked off.
- Nurse, in tears, complained to her supervisor about Dr. Smith's behavior.

**Question: What should be done about this incident?**

*Continued on page 44 ...*

**Scenario #2: One Month Later**

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**Dr. Smith:**

- Stormed into the clinical care unit.
- Spoke to residents and medical students.
- Said he had never worked with a group so lazy, incompetent and dangerous.
- Said he would sleep in-house when on call to ensure they didn't kill any patients.

**Question: *What should be done about this incident?***

**Scenario #3**

---

**Department Head received a call from the laboratory stating that Dr. Smith:**

- Was annoyed by a delay in lab results.
- Told the lab technicians they were lazy and incompetent.
- Said he would hold them responsible if their delays caused any patient harm.

**Case Study Questions:**

- How should this pattern of behavior be addressed?
- Is this an example of disruptive behavior?
- What drives Dr. Smith?
  - system factors
  - personal factors
- How would you resolve this?
- Can Dr. Smith (and the institution) be helped?

## Appendix F

### CPSA Code of Conduct

#### *Expectations of Professionalism for Alberta physicians*

##### Introduction

Integrity, trustworthiness, compassion and ethical conduct underpin the practise of medicine. Patients, co-workers, residents and students expect professional behavior from physicians, and this behavior has an enormous impact on how health care is delivered and received.

The vast majority of physicians act professionally, and research shows this translates to a healthier workplace and good patient outcomes. Alternatively, inappropriate physician behavior can contribute to a number of issues in the health care environment, including:

- a) Negative effect on patient safety and quality of care
- b) Erosion of relationships with staff, patients, learners, families
- c) Difficulty recruiting and retaining staff
- d) Reduced work attendance by co-workers, colleagues
- e) Direct impact on a physician's health and/or reputation

In order to address these issues, expectations of physicians must be clear.

The CPSA Code of Conduct was developed in response to requests from physicians for clarity and advice about professional behavior. It was written in consultation with physicians, other health care providers, health care organizations, regulatory bodies and post secondary institutions.

The Code of Conduct is intended to:

- Support a culture that values professionalism, integrity, honesty, fairness and collegiality, and that aids and encourages effective care of patients.
- Promote an optimally caring environment of quality and safety for the health and well-being of patients and families, physicians, nurses and other health care workers, learners and teachers, and others in the health care workplace.
- Help physicians meet the principles outlined in the *CMA Code of Ethics* and the *CPSA Standards of Practice*
- Help physicians model professional behavior and teach their younger colleagues.
- Encourage open and respectful discussion related to the delivery of health care.
- Support physicians and others to address physician behavior that does not meet their expectations.

*Continued on page 46 ...*

### **Use of the Code**

The Code of Conduct clarifies the College's expectations for Alberta's physicians in all stages of their careers, in all facets of medicine, and in all methods of care delivery.

It is consistent with the Canadian Medical Association's *Code of Ethics* and complements the CPSA's *Standards of Practice*. Physicians are expected to know and abide by these rules; any breach of professional behavior will be judged against all three of these foundation documents.

While the Code outlines expectations regarding professional behavior, the College will consider the following when inappropriate behavior occurs:

- The well-being of the physician must be addressed
- Systemic issues within the health care system. NOTE: Although these stressors must be identified and considered, they **cannot** be used as an excuse for inappropriate behavior.

### **General Principles**

The CPSA Code of Conduct is based on the following ethical and professional principles:

- Strive for high-quality patient care
- Focus on safety
- Treat others with respect
- Maintain confidentiality
- Do the right things for the right reasons
- Be aware of your professional and ethical responsibilities
- Be collaborative
- Take action when inappropriate behavior occurs
- Communicate clearly

### **Specific Expectations**

#### **Accountability**

*As a physician, I will:*

- a) Act, speak, and otherwise behave in the health care workplace in a way that promotes safety, high quality patient care and effective collaboration with others in the healthcare team.
- b) Maintain high standards of personal and professional honesty and integrity.
- c) Take responsibility for my own behavior and ethical conduct regardless of the circumstances.
- d) Be accountable for my personal decisions, actions or non-actions in the workplace.
- e) Record and report accurately and in a timely fashion clinical information (history, physical findings, and test results), research results, assessments and evaluations.
- f) Communicate with integrity and compassion.

*Continued on page 47 ...*

- g) Accurately attribute ideas developed with others and credit work done by others.
- h) Deal with conflicts of interest, real or perceived, openly and honestly.
- i) Engage in lifelong learning.

### **Confidentiality**

*As a physician, I will:*

- a) Regard the confidentiality and privacy of patients, research participants, and educational participants as well as their associated health records as a primary obligation.
- b) Ensure confidentiality by limiting discussion of patient health issues to settings appropriate for clinical or educational purposes, and to caregivers within the 'circle of care'. Discussion with others should occur only with explicit patient consent or as permitted by legal and ethical principles.
- c) Know and comply with applicable legislation regarding confidentiality and health information.

### **Respect for Others**

*As a physician, I will:*

- a) Interact with patients and families, visitors, employees, physicians, volunteers, health care providers and any others with courtesy, honesty, respect, and dignity.
- b) Refrain from conduct that may reasonably be considered offensive to others or disruptive to the workplace or patient care. Such conduct may be written, oral, or behavioral, including inappropriate words and/or inappropriate actions or inactions.
- c) Respect patient autonomy at all times by appropriate discussion of investigation and treatment options with the competent patient and, only with consent, identified other persons.
- d) Ensure appropriate consultation occurs when a patient lacks the capacity to make treatment decisions, save for emergency circumstances.
- e) Respect the personal boundaries of patients, including, but not limited to, refraining from physical contact outside the proper role of a physician, including sexual or romantic overtures.
- f) Respect the personal boundaries of co-workers and their rights to privacy and confidentiality in the same manner as I would patients. Avoid unwanted physical contact, including sexual or romantic overtures.
- g) Avoid discrimination based on, but not limited to, age, gender, medical condition, race, color, ancestry, national or ethnic origin, appearance, political belief, religion, marital or family status, physical or mental disability, sexual orientation, or socioeconomic status. (NOTE: In human rights legislation, this is known as protected grounds.)
- h) Allow colleagues to disagree respectfully without fear of punishment, reprisal, or retribution.
- i) Recognize the important contributions of colleagues, whether generalist or specialist.

*Continued on page 48 ...*

### **Responsible Behavior**

*As a physician, I will:*

- a) Ensure that patient care and safety assume the highest priority in the clinical setting. The duty of physicians to advocate for patients does not excuse or justify unacceptable behavior; it must be done constructively.
- b) Attend to my personal health and well-being to enable attendance to professional responsibilities.
- c) Recognize my own limitations and seek consultation or help when personal knowledge, skills, or physical/mental status is inadequate or compromised.
- d) Supervise and assist others appropriate to their need and level of expertise.
- e) Participate in quality improvement initiatives and strategies to deal with errors, adverse events, close calls, and disclosure.
- f) Express my opinions on health care matters in a manner respectful of others' views and the individuals expressing those views.
- g) Abstain, when conducting my professional activities, from exploitation of others for emotional, financial, research, educational, or sexual purposes.
- h) Teach and model the concepts of professional behavior in research, clinical practice, and educational encounters.
- i) Encourage and model language, appearance, and demeanor appropriate to the professional health care setting.
- j) Avoid misuse of alcohol or drugs that could impair my ability to care safely for a patient.
- k) Attend to other factors that could impair my ability to provide safe care to my patients.
- l) Address breaches of professional or scientific conduct or unskilled practice by a health care professional by discussion directly with that person or, if necessary, by reporting to the appropriate authorities or through established procedures. Respect the need to avoid unjustly discrediting the health care system or the reputation of other members of the health care, research, or academic team by trivial or vexatious reports.
- m) Know and adhere to the *CPSA Standards of Practice*
- n) Participate in professional development and assessment processes.
- o) Respect the authority of the law and understand my professional and ethical obligations.

### **Acknowledgement**

*This document was developed with input from various health professions and using codes of conduct from other institutions and organizations. Particularly helpful were statements from the College of Physicians and Surgeons of Ontario, the University of Calgary Faculty of Medicine, the University of Alberta Office of Equity and Faculty Development, and the Medical Council of Canada.*

April 2010

## **Appendix G - Reporter's Rights & Responsibilities**

### **Rights**

- To be heard and be understood.
- To choose a friend, relative or colleague for support.
- To have assistance in writing the report.
- To have no fear of retribution for reporting.
- To expect (and receive) confidentiality and respect for privacy, balanced with principles of natural justice for the respondent.
- To be informed of progress during investigation and resolution.
- To meet safely with respondent in person.

### **Responsibilities**

- To be fair and complete in reporting, avoiding any gossip about the respondent.
- To fairly weigh any apologies and commitments to change.
- To not commit frivolous or vexatious reporting.
- Be willing to reflect on one's own behavior that may have prompted or contributed to the disruptive behavior reported.

## **Appendix H - Respondent's Rights & Responsibilities**

### **Rights**

- To be informed of a report, its nature and the content of allegations.
- To choose a friend, relative or colleague for support.
- To engage legal counsel to ensure all relevant bylaws or other applicable legislations are followed
- To meet safely with the reporter in person.
- To respond to allegations.
- To be heard and be understood.
- To receive a fair and objective investigation.
- To expect (and receive) confidentiality and respect for privacy, balanced with principles of natural justice for the respondent.
- To be informed of progress during the investigation and resolution processes.
- To appeal an adverse outcome.
- To expect efforts to reduce or eliminate system stressors.

### **Responsibilities**

- To be fair and complete in responding.
- To understand that others' perspectives are important and to accept responsibility for one's own actions.
- To cooperate in the investigation, assessments and evaluations.
- To accept referral for treatment if needed.
- To change behavior if found to have been disruptive.

## Appendix I - Recommended Reporting Structures

### For Physicians

- Submit reports regarding nurses to:
  - Physician's superior
  - Nurse's superior
- Submit reports regarding administrators, physicians or non-physicians to:
  - Administrator's superior
  - Physician's superior (e.g. division head, department head or medical director)
  - Applicable governing authority (e.g. board, university, etc)
  - Zone Medical Administration (Note: should be in alignment with bylaws).

### For Nurses

- Submit reports regarding physicians to:
  - Unit supervisor
  - Physician's superior (e.g. division or department head)
  - Vice president of nursing (or equivalent)
  - Union representative
  - Hospital administration
  - Patient care manager

### For Medical Trainees

- Submit reports regarding faculty members or preceptors to:
  - Physician's superior
  - Undergraduate or Post-graduate office (Training Program Director)
  - Provincial Association of Residents of Alberta (PARA)
  - Post-graduate Dean

### For Faculty Members

- Submit reports regarding trainees (under-graduate or post-graduate) to:
  - Residency Training Program Director
  - Supervising Faculty (preceptor)
  - Under-graduate or Post-graduate Deans

### For Patients and Families

- Submit reports regarding physicians to:
  - Hospital ombudsperson
  - Division or department head
  - Hospital administrator
  - College of Physicians & Surgeons of Alberta (CPSA) – Complaints department

## Acknowledgments

- 1 Managing Disruptive Behavior Planning Group:
  - Ms Debra Allan, College and Association of Registered Nurses of Alberta
  - Dr. Ian Bennett, Physician and Family Support Program, Alberta Medical Association
  - Dr. Michelle Carle (from May 2008), Professional Association of Residents of Alberta
  - Dr. Sandra Corbett, Northern Lights Health Region
  - Dr. David Dawson (from January 2008), David Thompson Health Region
  - Dr. Ken Gardener, Capital Health Authority
  - Dr. Owen Heisler (until December 2007), David Thompson Health Region
  - Ms Amy Lister, Calgary Health Region
  - Dr. Dianne Maier, Physician and Family Support Program, Alberta Medical Association
  - Dr. Douglas Perry, Alberta Health and Wellness
  - Ms Deb Prowse, Calgary – Public representative
  - Mr. Graham Quest, Edmonton – undergraduate medical student representative
  - Dr. Edmond Ryan, Edmonton – University of Alberta, Faculty of Medicine and Dentistry
  
- 2 Managing Disruptive Behavior Working Group:
  - Dr. James Bell, College of Physicians and Surgeons of Alberta
  - Dr. David Dawson, David Thompson Health Region
  - Dr. Vince DiNinno, Palliser Health Region
  - Dr. Tom Feasby, Faculty of Medicine, University of Calgary
  - Dr. Ken Gardener, Capital Health Authority
  - Dr. Jeff Hankinson, Aspen Regional Health
  - Dr. Bill Hnydyk, Alberta Medical Association
  - Ms Linda Iwasiw, Palliser Health Region
  - Dr. Vern Jubber, Chinook Health Region
  - Dr. Dianne Maier, Physician and Family Support Program, Alberta Medical Association
  - Dr. Tom Marrie, Faculty of Medicine and Dentistry, University of Alberta
  - Dr. David Megran, Calgary Health Region
  - Dr. Cheri Nijssen-Jordan, Northern Lights Health Region
  - Dr. Odell Olson, East Central Health
  - Dr. Doug Perry, Alberta Health and Wellness
  - Dr. Brent Piepgrass, Peace Country Health
  - Dr. Robert Rivington, Canadian Medical Protective Association
  - Ms Mary-Anne Robinson, College and Association of Registered Nurses of Alberta
  - Dr. Brian Stewart, Calgary Health Authority
  - Mr. Brent Windwick, Field Law

*Continued on page 53 ...*

- 3 Dr. Lorraine Breault, Associate Dean, Faculty of Medicine and Dentistry, University of Alberta
- 4 College of Physicians & Surgeons of Alberta - Staff:
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  - Ms Rowena Doyle, Communications Advisor
  - Ms Charlene Hiemstra, Executive Secretary
  - Dr. Janet Wright, Assistant Registrar
- 5 College of Physicians & Surgeons of Alberta – Council Members
- 6 College of Physicians and Surgeons of Ontario (Ms Shenda Tanchak)
- 7 Stakeholder Consultations
  - Medical staff organizations in the former health regions
  - Professional Association of Residents of Alberta (PARA)
  - AMSCAR (at the Alberta Medical Students' Conference and Retreat 2009)
  - U of C Family Medicine residents
  - Patient/Family Safety Council, Calgary
- 8 Alberta Medical Association
  - Board of Directors
  - Representative Forum
  - Council of Presidents
- 9 National Board of Medical Examiners (NBME), Philadelphia, PA
- 10 Numerous other individuals in Alberta and across Canada

We are extremely indebted and grateful to everyone who contributed.

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## Conferences

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2. Ontario Hospital Association. Managing Physician Behaviour in the Professional Environment. Two- hour training seminar. July 3, 2008. Toronto, Ontario. Joint presentation by CPSO and OMA.





## User Survey

Please take a few moments to fill out the following questionnaire or you can take the survey online. Your answers will help the College measure the effectiveness of the guidance document and toolkit.

- 
1. Have you read the guidance document? Yes  No
2. Have you used the guidance document? Yes  No
3. Did you find the guidance document easy to understand? Yes  No

If no, please explain why: \_\_\_\_\_

- 
4. Have you used the toolkit? Yes  No
5. Did you find the toolkit easy to use? Yes  No
6. Was there anything missing from the document or toolkit that you would have found useful for managing incidents of disruptive behavior? Yes  No

If yes, please specify: \_\_\_\_\_

- 
7. Will you use the guidance document or toolkit in the future? Yes  No  Not sure
8. Do you think this document/toolkit will help address incidents of disruptive behavior? Yes  No  Not sure

Please explain \_\_\_\_\_

- 
9. Do you have any additional comments/suggestions? \_\_\_\_\_
- 
- 
- 

**Thank you for your feedback. Please fax your responses to 780-420-0651**

# Managing Disruptive Behavior in the Healthcare Workplace

## Toolkit



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## Toolkit - Introduction

With few exceptions, physicians, their colleagues and co-workers display exemplary professional behavior in the workplace. Only a small percentage of individuals are considered disruptive. However, just one disruptive individual in an organization can contribute to high staff turnover, requests for transfers and additional sick time if no action is taken.

This toolkit has been developed to help organizations deal with disruptive behavior in an effective and consistent manner. The templates can be used as is, or may be customized as needed to suit your organization's processes. The focus of this toolkit is to improve the management of physicians who behave in a disruptive manner in the healthcare workplace, however, the information and tools can also be applied to other healthcare providers.

## Reporting Disruptive Behavior – Steps and Processes

1. Report
2. Review
3. Investigation
4. Assessing the Respondent
5. Assess the Severity of the Behavior (Stages 1 – 4)
6. Intervention (based on severity of behavior)
7. Responses to Disruptive Behavior (Stages 1 – 4)
8. Resolution
9. Remediation

Note: All documentation related to disruptive behavior incidents should be stored securely in a single location. This provides a single source of truth regarding past events, simplifying searches for information and identification of behavior trends.

# 1. Report - Introduction

When reporting disruptive behavior, a written version of the report is preferable in all instances to ensure proper documentation throughout the review, investigation and resolution process.

In the case of a severe incident, a verbal report may be submitted initially so action can be taken in a timely manner. However, a written version should be submitted before the review and investigation proceeds.

Recommended reporting structures are included in **Appendix H** on page 50 of the guidance document. A sample report and template are included on the next two pages.

# Sample Completed Report

**Hospital:** Name  
**University:** Name      **Department:** Name  
**Clinic:** Name

**Reported:**      Date: April 8 2010  
To:                    Dr. U. Sleepwell, Chair of Anesthesia  
By:                    Mr. John Doe, Resp. Tech.  
About:                Dr. Jane Smith, Anesthetist  
Witness:             Mr. Bill Jones, Porter  
Witness:             \_\_\_\_\_

<b>Incident:</b> Date: <u>Saturday, April 3, 2010</u> Time: <u>3:20 a.m....</u> Place: <u>PARR, Getwell General Hosp.</u>
<b>Nature of Incident:</b> Yelling, profanity, throwing instruments and pans. Threatening gesture with fist.
<b>Circumstances/Context:</b> Three difficult cases during evening for Dr. Smith. I was delayed in coming to PARR when Dr. Smith paged me.
<b>System/Environment Issues:</b> Recent decrease in staffing with Respiratory Techs during overnight shifts.
<b>Effect/Impact of disruptive behavior:</b> I was truly fearful of being injured. Sweating and heart pounding. Could not sleep or eat after going home. Considering request for transfer of duties in Getwell Gen. Hosp., or may relocate to another hospital or city.
<b>Patient Care and Safety Issues:</b> My ability to cope adequately during the rest of my shift was impaired.

**Date:** \_\_\_\_\_  
**Signature:** \_\_\_\_\_      **Witness:** \_\_\_\_\_  
**Final Disposition** \_\_\_\_\_

**Note: Reporter can attach additional page(s) if more space is needed.**

# Template - Report

Hospital: Name

University: Name Department: Name

Clinic: Name

**Reported:**

Date: \_\_\_\_\_

To: \_\_\_\_\_

By: \_\_\_\_\_

About: \_\_\_\_\_

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

<b>Incident:</b>
Date: _____
Time: _____
Place: _____
<b>Nature of Incident:</b>
<b>Circumstances/Context:</b>
<b>System/Environment Issues:</b>
<b>Effect/Impact of disruptive behavior:</b>
<b>Patient Care and Safety Issues:</b>

Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Final Disposition \_\_\_\_\_

**Note: Reporter can attach additional page(s) if more space is needed.**

# Checklist - Investigation Flow

Ensures all steps in the investigation have been considered and what action was taken.

Date incident report received: \_\_\_\_\_

Report received by: \_\_\_\_\_

Position: \_\_\_\_\_

	YES	NO
<b>1. Evaluate the evidence: Is the reporter credible?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Assessing Severity : If allegations confirmed, is there a risk to:</b>		
· Patients?	<input type="checkbox"/>	<input type="checkbox"/>
· Reporter?	<input type="checkbox"/>	<input type="checkbox"/>
· Respondent?	<input type="checkbox"/>	<input type="checkbox"/>
· Workplace?	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Has the incident been assessed by:</b>		
· An external consultant?	<input type="checkbox"/>	<input type="checkbox"/>
· Alberta Medical Association’s Physician & Family Support Program?	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Have the reasons for the respondent’s behavior been identified?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. If a personal health issue has been diagnosed, has the respondent undergone treatment?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. What stage is the incident classified at? * See T 14 for details.</b>		
· Stage One	<input type="checkbox"/>	<input type="checkbox"/>
· Stage Two	<input type="checkbox"/>	<input type="checkbox"/>
· Stage Three	<input type="checkbox"/>	<input type="checkbox"/>
· Stage Four	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. How has the incident been resolved? (Check all that apply)</b>		
Alternate Dispute Resolution (ADR) <input type="checkbox"/>	Amend Privileges <input type="checkbox"/>	CMPA involved <input type="checkbox"/>
Counseling <input type="checkbox"/>	Disciplinary Hearing <input type="checkbox"/>	Informal <input type="checkbox"/>
Leave of Absence <input type="checkbox"/>	Refer to CPSA <input type="checkbox"/>	Refer to PFSP <input type="checkbox"/>
Suspension <input type="checkbox"/>		
<b>8. How is the incident being followed up?</b>		
Mentoring	<input type="checkbox"/>	<input type="checkbox"/>
Monitoring	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Is there a plan if relapse occurs?</b>	<input type="checkbox"/>	<input type="checkbox"/>

**Comments/Additional Notes/Actions/Follow up:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_

## 2. Review – Introduction

When a report of disruptive behavior is received, a review should begin as soon as possible. The review should be conducted by a local administrator or equivalent, as close as possible to the place and time where the incident occurred.

The purpose of this first review is to gather enough information to determine whether a formal investigation is justified.

**NOTE:**

- You must receive permission from the reporter before interviewing the respondent and any applicable witnesses.
- Documentation of the initial report and the review process is vitally important as missing information may cause subsequent intervention efforts to be less successful.

A **Review Checklist** is included on the next page.

# Checklist – Review Overview

Specific details of the allegation.

History of event as related by the:	New	Chronic
· Respondent (physician)		
· Reporter (complainant)		
· Co-workers		
· Colleagues		
· Patients and visitors		
· Organization’s administration		
<b>Details of the allegation:</b>		
a) Describe the allegation (as related by the reporter)?		
b) Where did the behavior occur?		
c) When did the behavior occur?		
d) What is the reason given for the behavior?		
e) What form or resolution is the reporter seeking? (e.g. apology, discipline, etc)		
<b>Additional comments:</b>		
<b>Notes:</b>		
<ul style="list-style-type: none"> <li>· Consider past disputes that may influence the allegation.</li> <li>· When interviewing witnesses and/or reviewing correspondence and meeting minutes (for cases of passive disruptive behavior), focus on information that supports facts versus opinion. For example, ask, “Did you observe?” versus “What did you think about it?”</li> </ul>		

# Checklist – Investigation Summary

To be completed before assessing the respondent.

Assess risk to safety of:	Low	Moderate	High
Reporter			
Respondent			
Patient(s)			
Co-workers			
Colleagues			
Workplace			
NOTE: If one or more are high risk, the respondent must voluntarily, or otherwise, leave practice during the investigation.			
<b>Confirmation of allegations:</b>		<b>Yes</b>	<b>No</b>
· Allegation confirmed			
· Witness statements confirmed			
· Reviewed meeting minutes/correspondence (particularly in cases of passive disruptive behavior)			
· Do witness statements and information correspond with original report?			
If no, explain the discrepancy:			
<b>Confidentiality</b>		<b>Yes</b>	<b>No</b>
Specify information that remains confidential.			
Signed declaration of confidentiality by all parties?			
<b>Context for disruptive behavior:</b>			
· System?			
· Personal?			
· Cultural issues?			
Details:			
<b>History:</b>			
Prior Incidents?	Yes	No	Not known
Resolution from prior incidents (including remediation)	Yes	No	Not known
Documentation from prior incidents?	Yes	No	Not known
Referred to College of Physicians & Surgeons of Alberta?	Yes	No	
Is report based on false information?	Yes	No	Not known
Is report due to ‘mobbing’? (see page 29 in guidance document for definition)	Yes	No	Not known
Note: If yes to either of the last two questions, the report itself could be considered an act of disruptive behavior and investigated/dealt with as such.			

# Checklist - Assessing the Respondent

To determine what factors that contributed to disruptive behavior by the respondent.

## Physical status -- Independent external review of physical health.

	Pay particular attention to possible long-standing sleep deprivation
	Consider possible aging and cognitive deterioration

## Mental status - Independent external review of mental status. Consider the following:

	Burnout – stress can be a factor due to changes in healthcare delivery (e.g. heavy workload, frequent on call duty, lack of resources)
	Depression
	Bipolar disorder
	Personality Disorder
	Addiction, including alcohol, chemicals, process
	Boundary issues
	Basic personality traits (if none of the above is contributing to the disruptive behavior)

## Family history - Is there ... (Note: Privacy issues must be respected)

	Domestic discord with spouse, children and nuclear family members
	Stress due to physical or mental illness in family members

## Social history - What is the respondent's general lifestyle?

	Does it include relaxation activities?
	Is there social or professional isolation?
	Are there religious or cultural differences that lead to misunderstanding or are unrecognized?

## Work history and issues (if applicable)

	General assessment of the physician's work quality. Consider the following: <ul style="list-style-type: none"> <li>· How many days per week, hours per day is the respondent working?</li> <li>· Are there on call responsibilities. If so, how much?</li> <li>· Are there issues with patient complexity and the number of patients?</li> <li>· Is the physician involved in teaching, research or administration?</li> </ul>
	How is the physician regarded by colleagues including peers, other staff and administration?
	How long has the physician worked in his/her present position?
	Has there been a recent promotion or other change in the physician's status?
	What was the physician's previous location and for how long? Why did it change?
	Are there documented concerns about patient care?

### Notes:

- Primarily used for Stage Four cases, but may also be necessary for Stages One through Three.
- This information should come from external assessments. It is not a list of areas to be assessed by a local administrator.
- Overlooking any of these factors may lead to misinterpretation of the situation and affect the outcome of the investigation.

# Checklist - Assessing the Severity of Disruptive Behavior

Following confirmation of the reported allegation, it is important to assess the severity of the respondent's behavior as part of the investigation process using the following categories:

## Healthy/Acceptable Categories:

	Challenging
	Learning
	Questioning

## Unhealthy/Unacceptable Categories:

	Bullying
	Disrespecting others
	Not adhering to appropriate code of conduct (e.g. CPSA Code of Conduct)

## Abusive Categories:

### Active:

	Harassing others
	Physical assault
	Threatening
	Using status to intimidate others

### Passive:

	Chronic refusal to work collaboratively with colleagues, staff and patients
	Failure to meet responsibilities
	Failure to respond to calls for assistance (when on-call or expected to be available)
	Persistent lateness
	Repeated refusals to comply with known and accepted practice standards

## Critical Category (Relates to Stage Four responses):

### Violence:

	To coworkers
	To patients
	To self

# Checklist - Respondent Intervention

Suggested steps for preparation.

## Create a written narrative of case facts to:

Clarify thinking
Ensure adequacy and quality of data
Be consistent (this is invaluable in the event of a physician’s legal challenge)

## Content of the intervention/meeting

Focus on behavior
Avoid references to motives. Never refer to diagnosis, or the respondent’s character
Use objective, non-judgmental, respectful language
Include the date, time, location of events
Include other relevant circumstances and context
Document witness statements
Include as many examples of the disruptive behavior as possible
Include the reasons the behavior were unacceptable

## Intervention meeting plan

Choose a neutral peer to witness events at the intervention
Clearly set out the goals for the meeting. Ensure respondent is aware of these goals well in advance of the meeting.
Choose a suitable site for the meeting (e.g. Private, but safe location, should there be any escalation in behavior, it should not occur in a corridor or public space.)
Negotiate a time with the respondent and keep the meeting to a maximum of one hour
Prepare a draft remediation contract before meeting
Before the meeting, determine which items are negotiable and which are not

## Conduct the intervention

Always be respectful - thank the physician for participating
Lay out the rules of engagement. Speak first and allow the physician to respond. Get the physician’s agreement before proceeding
Clearly explain the purpose and goals of meeting
Acknowledge the physician’s worth and identify good attributes
Review the written narrative of case facts
Conclude with acknowledgement of your confidence in the physician’s good intentions, and expectations of cooperation for improved conduct in the future
Follow scripted information, and try not to deviate from what you have prepared
Speak slowly and carefully
Refocus the discussion whenever the physician tries to divert the issues; offer to discuss those matters at a separate meeting
Stop and repeat information regularly, to prevent misunderstandings. Paraphrase and ask physician to repeat what he or she understands from your statements

## Recommended Responses to Stages of Disruptive Behavior

### Stage One - formal discipline not necessary.

<b>Required</b>	<ul style="list-style-type: none"> <li>Document proposed process for follow-up.</li> </ul>
<b>Expected</b>	<ul style="list-style-type: none"> <li>Discuss the situation with a senior colleague the respondent is comfortable speaking with, possibly a confidante.</li> <li>Seek the physician's understanding and commitment to change.</li> <li>Assess the need for counseling. <b>Note:</b> Clarify who will provide the counseling.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>Refer physician to the Alberta Medical Association's Physician &amp; Family Support Program (PFSP) and/or PFSP Case Coordination Service.</li> <li>Refer physician for an external physical and/or mental status assessment.</li> </ul>

### Stage Two - formal discipline may be required.

<b>Expected</b>	<ul style="list-style-type: none"> <li>Conduct an immediate formal review at the next level of authority.</li> <li>Develop a contract or agreement between the physician and administration concerning redress, monitoring, mentoring, etc.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>Refer the physician to the Alberta Medical Association's PFSP Case Coordination Service, or an external consultant.</li> <li>Consider sharing costs between the physician (respondent) and intervening agency (e.g. hospital, clinic, university), such as costs for assessment or mediation by appropriate professionals.</li> </ul>

### Stage Three

<b>Required</b>	<ul style="list-style-type: none"> <li>Notify the registration department of the College of Physicians &amp; Surgeons of Alberta (CPSA) regarding reduced privileges or anticipated resignation due to possible suspension.</li> <li>Conduct a formal investigation.</li> <li>Develop a formal, written report.</li> </ul>
<b>Expected</b>	<ul style="list-style-type: none"> <li>Involve the Medical Advisory Committee (MAC) and follow applicable bylaws.</li> </ul>
<b>Optional</b>	<ul style="list-style-type: none"> <li>Refer the physician to the Alberta Medical Association's Physician &amp; Family Support Program (PFSP) and/or PFSP Case Coordination Service.</li> <li>Consider disciplinary actions such as: restriction of practice, direct supervision of practice, suspension of privileges.</li> </ul>

#### Notes:

- Generally, the first three stages should be addressed *locally*.
- Stage Four often requires the involvement of the College of Physicians & Surgeons of Alberta

*Continued on page T16 ...*

## Stage Four

<b>Required</b>	<ul style="list-style-type: none"><li>· Conduct a formal intervention.</li><li>· Launch an immediate investigation: document the process, including appropriate external mental/physical assessments of the respondent and appoint an independent investigator.</li><li>· <b>Note:</b> Smaller jurisdictions may need to contact a larger centre or the College of Physicians &amp; Surgeons of Alberta (CPSA) for assistance.</li><li>· Ensure appropriate therapy is in place (if deemed necessary from the assessment.)</li><li>· Consider disciplinary action. This may be delayed until completion of criminal action in the courts.</li><li>· Notify the registration department of the College of Physicians &amp; Surgeons of Alberta (CPSA) regarding reduced privileges or anticipated resignation due to possible suspension.</li></ul>
<b>Optional</b>	<ul style="list-style-type: none"><li>· Impose an interim suspension of privileges.</li></ul>

### Notes:

- Formal discipline is determined according to relevant legislation, bylaws and policies.
- Be prepared for those involved taking adversarial positions.
- Every effort should be made to resolve disruptive behavior on a **local level**.
- The College should only be formally involved in serious cases, or where local resolution is not possible.
- The goal of assessment is to understand all factors contributing to the unacceptable behavior and to determine which factors need to be addressed.
  - The request for assessment should specify that the report cover diagnosis, fitness to practice, need for restrictions, recommended treatment, monitoring, and risk of recurrence.

# Checklist - Remediation Agreement

Use if resolution process requires a remediation agreement for the respondent.

**Check all that apply:**

	Description of disruptive behavior and circumstances
	Description of any assessment and/or agree-upon statement of facts
	Description of expected behavioral expectations
	Description of any monitoring arrangements including reports from: <ul style="list-style-type: none"><li>· Practice monitors</li><li>· Alberta Medical Association’s Physician &amp; Family Support Program (PFSP)</li><li>· Supervising physician, Division Head, Department Head or Chief of Staff.</li></ul>
	Description of any practice restrictions or limitations
	Description of consequences of recurrent disruptive behavior including: <ul style="list-style-type: none"><li>· Proposals to restrict or limit the physician’s practice</li><li>· Additional assessment of contributing factors (personal, system, etc)</li><li>· Additional notification to other organizations or regulatory bodies</li></ul>

# Checklist - Report Resolution (check/complete all that apply)

To record investigation resolution and remediation.

## Resolution

	Alternate Dispute Resolution (ADR)
	Amend privileges. Specify:
	Attention to personal health issues. (may include counseling). Specify:
	Disciplinary hearing
	Informal (e.g. apology, promise to not repeat behavior, etc)
	Refer to CPSA
	Suspend privileges

## Remediation

	Does respondent accept responsibility for the incident and agree to make personal changes?
	Are expectations clearly set out for the respondent?
	Is there an agreement for expectations of professional behavior?

## Contract

	What method of redress is recommended? (e.g. counseling, psychological testing, substance abuse, therapy, etc). Details:	
	What method of monitoring is recommended? (Monitoring should include behavioral expectations and conflict resolution strategies) Details:	
	Who is responsible for monitoring?	
	Name:	Position:
	Who is the mentor?	
	Name:	Position:
	Are there any behavioral benchmarks to track? If yes, specify:	
	What is the timeframe for the contract?	
	Proposed consequences for lack of compliance or recurrence of disruptive behavior. Specify:	
	Specify notification of other organizations, regulatory bodies or authorities such as: <ul style="list-style-type: none"> <li>Alberta Health Services (AHS), Zone Medical Director, University of Alberta/University of Calgary, Alberta Medical Association - Physician &amp; Family Support Program (PFSP), College of Physician &amp; Surgeons of Alberta (CPSA).</li> </ul>	

## Checklist- Response Following Investigation

Upon verifying a report of disruptive behavior and assessing its severity (Page T12 - Checklist Assessing the Severity of Disruptive Behavior), the investigator can develop an appropriate response to the respondent's behavior using the following checklist:

### Supportive (for unhealthy, mildly abusive behavior)

	Attend counseling
	Attend educational sessions on communication, teamwork, etc
	Develop learning plans
	Participate in a mentoring program
	Develop a performance management system that specifically outlines the terms of the contract and any practice limitations.

### Protective (for severely abusive behavior)

	Ensure policies, regulations and legislation are enforced
	Develop a performance management system that involves loss of privileges and/or appointment if the behavior continues.

### Imperative (for serious threats of harm to others or violence)

	Contact the College of Physicians & Surgeons regarding the need to consider suspension or removal of the physician's license
	Initiate legal action if necessary
	Determine whether police intervention is required

### Immediate intervention if:

	Immediate patient care is compromised, or is likely to be.
	A risk is identified to anyone in the healthcare setting including: the physician, colleagues, team members, administration, patients, family members, etc.
	The continued presence of the physician will diminish the ability of others to deliver safe patient care.
	Unacceptable legal liability seems apparent

## Template - Investigator Summary

<b>Report</b>	
<b>Reported incident</b>	
<b>Description of incident (if different from Reporter's account)</b>	
<b>Response</b>	
<b>Investigation</b>	Summary of fact-finding process and efforts at local resolution.
<b>Assessment</b>	Summary of evaluation, assessment and external consultation
<b>Diagnosis</b>	If identified (e.g. specific medical condition or substance abuse problem)
<b>Recommendations</b>	
<b>Description of specific areas addressed:</b>	
Education	
Counseling	
Mentoring	
Monitoring and treatment	
Outcome statement	
<b>If efforts were successful, please explain how/why?</b>	
<b>If efforts were not successful, please explain how/why?</b>	
<b>Summary of the final resolution</b>	

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