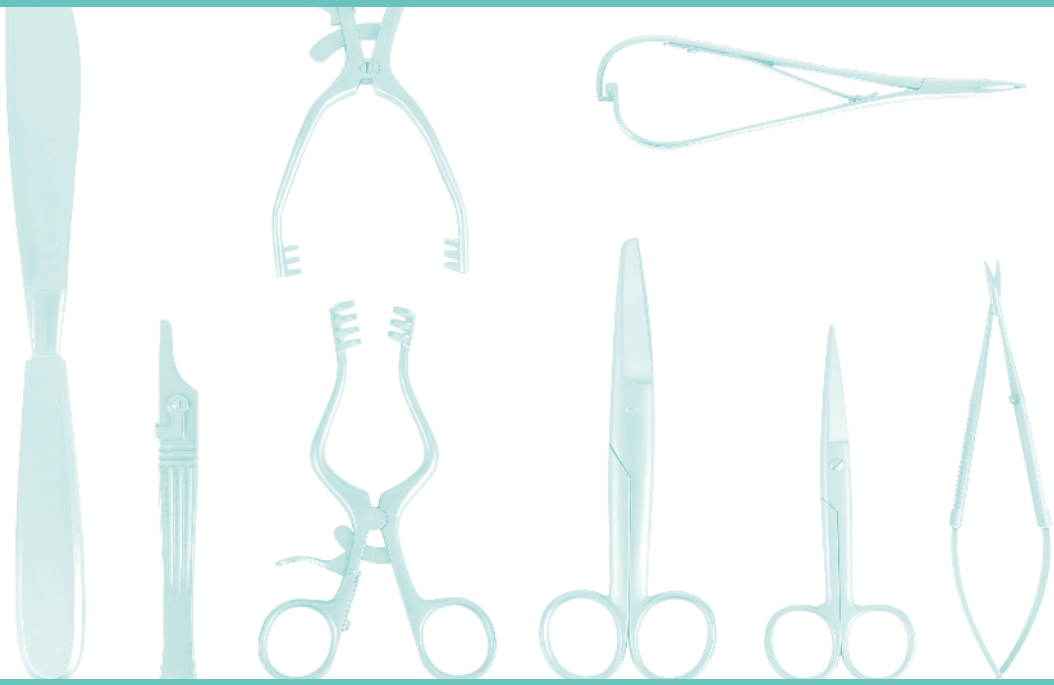
MANAGING DISRUPTIVE BEHAVIOURS IN SURGERY

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

MANAGING DISRUPTIVE BEHAVIOURS IN SURGERY

A Guide to Good Practice



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Quality Improvement, April 2021

1. Introduction

Surgeons are expected to maintain patients' trust in their professional practice, as well as the public's trust in the profession.[1] It therefore follows that behaviour by surgeons and surgical teams that is considered unprofessional or disruptive undermines the trust of both patients and the public. Not only can disruptive behaviours undermine professionalism, such behaviours can cause significant and unnecessary distress to colleagues, can adversely affect patient care and undermine a culture of safety. The Joint Commission in the United States issued a Sentinel Event Alert in 2008, citing evidence that intimidating and disruptive behaviours can, among others things, 'foster medical errors' and contribute to 'preventable adverse outcomes', and should not be tolerated.[2]

The hierarchical structure of surgical teams can often aggravate the problem, with those in position of power more susceptible to overstepping lines of professional behaviour, leaving others feeling hurt, angry or powerless.

The College is clear that surgeons are expected to uphold standards of professionalism and not to engage in disruptive behaviours. Good Surgical Practice asks surgeons to listen to and respect the views of all members of the team, to communicate effectively and respond to any concerns they may have (Box 1).[1] Good practice rests upon collegiality, personal responsibility and a culture of openness, supportive discussion and accountability, to offer safe and effective care to patients. Surgeons have a duty to promote a positive working environment and effective surgical teamworking that enhances the performance of their team and results in good outcomes for patients. This includes tackling discrimination, treating colleagues fairly and not bullying or harassing them, and respecting the principles of equality and diversity across the team.

Box 1: Working collaboratively with colleagues to maintain and improve patient care

Good Surgical Practice, section 3.2, suggests that all surgeons should:[1]

- be aware of the impact of their own behaviour on the people around them
- be mindful that their behaviour serves as a role model to other members of the team and that they should set an example by behaving professionally and respectfully towards all colleagues
- communicate respectfully and refrain from dismissive or intimidating behaviour and inappropriate, offensive or pejorative language, including swearing
- be accessible and approachable to colleagues
- support colleagues who have problems with performance, conduct or health
- challenge counterproductive behaviour in colleagues constructively, objectively and proportionately
- encourage and be open to feedback from colleagues and be willing to reflect on feedback about their own performance and behaviour and acknowledge any mistakes
- take responsibility to act as a mentor to less experienced colleagues. They should also take responsibility to seek a mentor to improve their own skills at any point in their career and particularly when taking on a new role

This can be a challenging area, involving difficult conversations, often about sensitive matters, with sometimes testing individuals. However, failure to confront and actively manage disruptive behaviours allows them to continue, with implications for patient care.

There have been calls for the medical royal colleges and the General Medical Council (GMC) to work together to 'reinvigorate continuing professional development', with focus on 'the most challenging aspects of practice, including having difficult conversations and effective team working'.[4] This good practice guidance reflects this agenda, with a focus on disruptive behaviours, often thought to be a subset of unprofessional behaviour.[5]

ABOUT THIS GUIDE

This guide is intended for all surgeons and members of the surgical team.

It provides practical guidance for surgeons with formal leadership roles, such as medical directors, divisional directors, clinical directors and clinical leads. These surgeons are collectively referred to in this document as 'clinical leaders'.

It also provides advice to surgeons who lead teams, as well as individual surgeons who experience disruptive behaviours in a team member or colleague and are uncertain how to respond.

In addition, it can be useful for individual surgeons who have received feedback that they have demonstrated disruptive behaviour, or a pattern of behaviour that others have found difficult or uncomfortable.

The College encourages all surgeons to reflect upon the contents of this guide and discuss with surgical colleagues and the wider surgical team learning relevant for their own organisation.

2. What is disruptive behaviour?

Any healthcare staff member can display disruptive behaviours, but disruptive behaviours in doctors can be particularly noticeable and problematic. This reflects the power held by senior doctors and the often-hierarchical relationships with other members of the healthcare team.

There is some evidence to suggest that surgeons are more likely to demonstrate disruptive behaviours. Surgeons operate in a unique and complex environment that can be stressful and is often high risk.

The College has previously cited a definition of disruptive behaviour by the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association in 2008,[6] which defines this behaviour as demonstrated when:

inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality healthcare delivery.

This definition was updated in 2016:[4]

Disruptive behaviour occurs when the use of inappropriate words, or actions and inactions, by a physician interferes with his or her ability to collaborate, or may interfere with, the delivery of quality health care or the safety or perceived safety of others.

Some definitions include sexual and other forms of harassment.[7] Examples of disruptive behaviour can be found in Box 2.

Box 2: Examples of disruptive behaviour

A range of disruptive behaviours are identified in the literature, including:

- bullying or intimidation, abusive or offensive language or sarcasm[4,6,8–12]
- loud, rude comments[8]
- outbursts of anger[4,6,9]
- sexual harassment[8,10] and other harassment[4,7,11,13]
- racial, ethnic or sexist slurs[8,10,12,13]
- persistent lateness in responding to work calls or requests[4,6,8,10,13,14]
- throwing instruments or breaking things[6,8]
- use of, or threats of, violence, retribution or vexatious litigation[4,6,8,12,13]
- passive aggression,[8] including refusal to comply with known and generally accepted practice standards,[6,13] intentional miscommunication[12]
- unwillingness to discuss issues with colleagues in a cordial and respectful manner, including handover meetings[8]
- failure to work collaboratively or cooperatively with others[4,13,14]
- mocking, shaming, disparaging or censuring patients, colleagues and others involved in the provision of healthcare[4]
- Unethical or questionable practices

Communication problems, fatigue due to excessive workload and interpersonal issues remain three of the most frequently identified problems, providing fertile ground for behaviour that can impair or derail clinical performance and working relationships.

RCS England Surgical Leadership[5]

KEY CHARACTERISTICS OF DISRUPTIVE BEHAVIOUR

- Disruptive behaviour is rarely a one-off – disruptive behaviour refers to a pattern of behaviour or conduct[4,6,8,9,12,13]
- It has, or has the potential to have, an adverse impact on the healthcare environment[8,9,13] (see section 4 for more on the impact of disruptive behaviour)
- It interferes with the doctor's ability to function well[6]
- It may be demonstrated in a single serious incident – for example, a physical assault of a co-worker[6,8]

Not all instances of behaviour that may seem inappropriate are disruptive. Behaviour that is generally not disruptive:

- Criticism offered in good faith with the intent of improving patient care[6,13,15]
- Making a complaint about a colleague or raising concerns about work practices or lack of care[6]
- A single act of inappropriate behaviour – everyone can have a bad day[12]
- Conflict between individual team members may not necessarily indicate unprofessional behaviour by one individual[8]

WHAT TO DO IF IT IS UNCLEAR?

In some situations, it may be difficult to evaluate whether the behaviour is disruptive. Passive-aggressive behaviour, condescension and sarcasm are often much harder to pin down, because they tend to be subject to personal interpretation.[16] The seriousness with which disruptive behaviour is judged depends on the nature of the conduct, the context in which it occurred, and the consequences that flow from it.[13]

Deciding whether conduct is disruptive may be helped by the individual involved and those he or she works with carefully assessing the impact of the conduct on the ability to deliver patient care.[6] Others warn that the disruptive doctor cannot be relied upon to arrive at a reasonable consensus position about the occurrence of inappropriate behaviours and is more likely to view the behaviours as justified.[12]

Box 3: Common attributes of the disruptive surgical leader[5]

Good Surgical Practice, section 3.2, suggests that all surgeons should:[1]

- Dominant, arrogant, aggressive, egocentric, impersonal and autocratic – being outspoken and often intimidating to other team members
- Inhibiting the learning and development of other team members and trainees by dismissing their questions or challenges
- Neglecting to share important information
- Promoting the existence of factions and rivalries within the team
- Inhibiting constructive feedback or identification of risks to patients
- Treating other non-clinical staff (e.g. management or administrative colleagues) without due courtesy or respect
- Passive disruption, such as persistent non-attendance at key meetings; refusal to abide by decisions agreed by the team; undermining colleagues by criticising them in public; refusal to delegate; failure to carry out proper patient handovers

The Health Quality Council of Alberta suggests a checklist that leaders can use to determine whether a member of the team is demonstrating a pattern of behaviour that is potentially disruptive to the workplace and quality of care.[17] Where more than two of the behaviours in the checklist (Figure 1) are observed in an individual on a continuing basis, it should be a cause for concern.

Is Disruptive Behaviour Threatening Your Team? A Checklist for Teams

Is there someone on your who consistently:
☐ Yells or uses foul, insulting or demeaning language
☐ Is disrespectful, insults or puts down others
☐ Uses negative body language directed to others such as sighing loudly, glaring, gesturing, making faces
☐ Blames others for 'errors' or shames them publicly for negative outcomes
☐ Criticises or belittles the abilities of others
☐ Discounts and/or denies the accomplishments of others
☐ Gossips or spreads rumours about others on the team
☐ Doesn't follow agreed-upon processes or protocols
☐ Says things that are untrue
☐ Says one thing but another or follows through incompletely
☐ Makes unreasonable job demands on certain individuals
☐ Steals credit from others
☐ Uses intimidation tactics (implied or explicit threats of consequences) to gain compliance from others
☐ Threatens others with retribution, job loss or litigation

Figure 1: *Disruptive behaviour checklist.*[17]

> *Disruptive physicians can thrive when they are in control. In settings that are compatible with the physicians' likes and needs, they can function quite well, especially when there are no external constraints on them. In positions of power, they can resort to intimidating tactics to accomplish their agendas.*
>
> **Reynolds (2012)[12]**

3. How prevalent is disruptive behaviour?

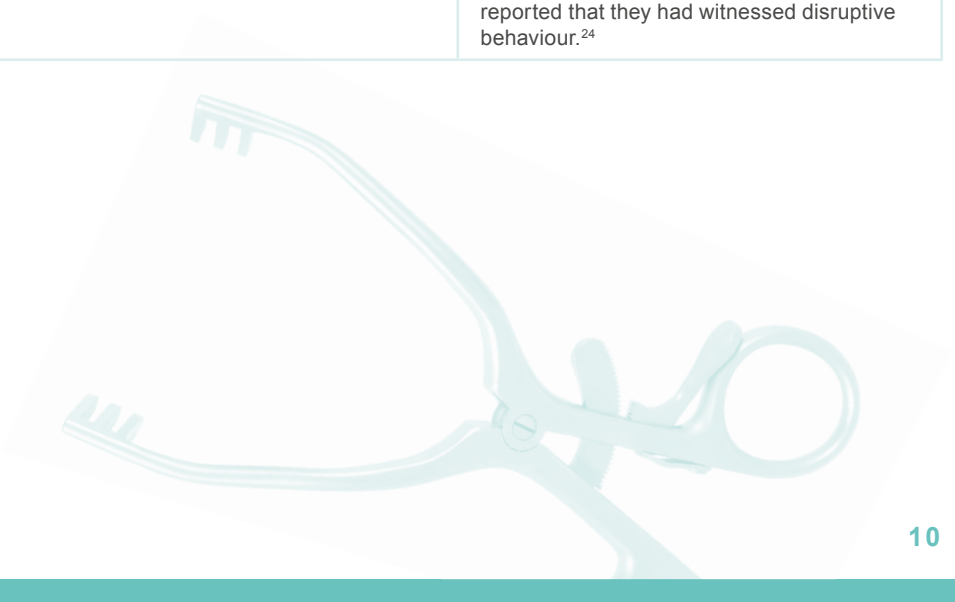
Most surgeons display professional behaviours and high standards of conduct. However, a small minority fall short of these expectations. It is difficult to establish the size of this minority group. There is insufficient data to establish accurately the incidence of disruptive behaviour amongst doctors, including for surgeons. Disruptive behaviour is likely to be under-reported for several reasons, including fear of retaliation and the stigma of reporting a colleague.[2]

There have been several attempts in the literature to quantify the extent of the problem. In the United States, reference is frequently made to a 'best estimate' that 3–5% of physicians present a problem of disruptive behaviour.[18] Most agree that the issue relates to less than 5% of the medical workforce.[19] There are few data available to quantify the problem in the UK. Stewart and colleagues cite data from what was the National Clinical Assessment Service (NCAS), which showed that 56% of 1,198 cases referred to NCAS between 2007 to 2008 involved behavioural concerns or misconduct.[19]

What is known, is that disruptive behaviours in healthcare organisations are not rare,[2] and that a single disruptive doctor can create a hostile work environment and impact negatively on colleagues.[12–14]

> *At one end of the spectrum, a single disruptive physician can poison the atmosphere of an entire unit. More common are everyday humiliations of nurses and physicians in training, as well as passive resistance to collaboration and change. Even more common are lesser degrees of disrespectful conduct toward patients that are taken for granted and not recognised by health workers as disrespectful.*
>
> **Leape et al (2012)[14]**

UK studies	Evidence from further afield
A GMC survey of more than 1,000 doctors found that 40% said some doctors' attitudes **'undermined respect within the profession and prevented effective collaboration'.**[4] A sense that respect for others had diminished as understanding of each other's roles decreased was reported.	Most (89%) doctors and nurses in eight different hospitals in Israel reported witnessing disruptive behaviour either directly or involving others. **Anaesthesia, surgery and emergency care departments were reported to suffer from significantly higher frequencies of almost all disruptive behaviours**, particularly vocal forms such as yelling, cursing and insults.[20]
Just under 23% of more than 2,000 doctors reported to the GMC in 2018 that they had **felt unsupported by immediate colleagues at least once a month.**[21]	Analysis of medicolegal cases handled by the Canadian Medical Protective Association between 2001 and 2010 found that **disruptive behaviours represented 5% of all hospital cases.**[9]
Issues with aspects of teamworking were highlighted in 75 of 100 consecutive invited reviews undertaken by the College. Multidisciplinary teamworking was also found to be an issue, with **erratic attendance by core team members at meetings, uncivil behaviours and lack of respect between members highlighted in 57 of 100 reviews**. In more than half (54%) of the reviews, there were concerns reported about inappropriate individual behaviour or a lack of respect between individuals and within teams.[22]	Nearly half (49%) of College fellows, trainees and international medical graduates reported to the Royal Australasian College of Surgeons that they had been **subjected to discrimination, bullying or sexual harassment**. Nearly three-quarters (71%) of hospitals reported discrimination, bullying or sexual harassment in their hospital in the past five years, with bullying the most frequently reported issue. The problem was found to exist across all surgical specialties and **senior surgeons and surgical consultants were reported as the primary source of these problems.**[23]
	In one US study, 88% of nearly 3,000 nurses and 51% of nearly 1,000 physicians reported that they had witnessed disruptive behaviour.[24]



ARE SURGEONS MORE LIKELY TO BE DISRUPTIVE?

In both qualitative and quantitative survey research, surgeons have been identified as the most frequent instigators of disruptive behaviour in the operating room.[23,28] Factors thought to explain this include personality characteristics and power hierarchies in the operating room.

Compared with other doctors, surgeons are at an increased risk of medicolegal events, including patient complaints and negligence claims. The rate of complaints in Australia has been found to be 2.3 times higher for surgeons than for physicians, where male surgeons were found to be at higher risk of complaints, as were specialists in orthopaedics, plastic surgery and neurosurgery.[29]

Further work is needed to understand disruptive behaviours among surgeons in the UK. All surgeons are expected to uphold standards of professionalism and not to engage in disruptive behaviours. Therefore, any surgeon who displays a pattern of behaviour that departs from these expectations is a cause for concern.

4. The impact of disruptive behaviour

The consequences of disruptive behaviour can be both immediate and long term. Of greatest concern is the impact to safe patient care. There is growing evidence about the direct links between medical errors and behaviour in the operating theatre, and particularly errors around team working and communication.[30]

Hospital staff have been found to perceive links between disruptive behaviours and adverse events, medical errors, and even patient mortality.[24] In one study across 102 US hospitals, 18% of hospital staff reported that they were aware of a specific adverse event that occurred directly as a result of disruptive behaviours.[24]

The College has observed through its invited review service that inappropriate behaviours can have an impact on the standard of surgical care. This includes surgeons in difficulty blaming others, dismissive of concerns raised about them, and becoming entrenched in their position, sometimes becoming 'controlling' or 'arrogant' in their approach and isolated within the surgical team.[22]

There is insufficient evidence to establish the extent of patient harm caused by disruptive behaviours, but it is widely accepted that there is a direct link. Logically, a pattern of disruptive behaviour by a surgeon will impact negatively on clinical situations such as handover on wards or in clinics.8 Further detail for how disruptive behaviours are thought to impact patient care is contained in Box 4.

Several of the risks for patient care arise from the potential for disruptive behaviour to adversely affect multidisciplinary team working. As the complexity of medical care increases, the need for well-functioning team working rises, yet the stresses, demands and distractions for surgeons also continue to mount.[31] Patients are best served by healthcare teams that function harmoniously, in which all team members feel respected for their contributions and empowered to speak freely regarding any patient safety concerns.[7]

Ultimately, disruptive behaviour can undermine a focus on quality improvement by diverting attention away from a learning environment.

> *At its most extreme, such behaviour can destabilise patient care in a variety of ways. It is this problem which makes such behaviour untenable in the professional environment.*
>
> **College of Physicians and Surgeons of Ontario and Ontario Hospital Association (2008)[6]**

Box 4: The impact of disruptive behaviours

Patient care

Contributes to adverse events, medical errors and poorer clinical outcomes, and compromises patient safety[6-8,18,24,28,32-34]

Can cause a shift in attention from the patient to the surgeon[34]

Decreases patient care due to reduced communication and teamwork[7,28]

Undermines clinical decision making[7,28]

Reduces technical performance and can negatively affect procedural skills[28]

Patient confidence

Undermines patient confidence, making patients less likely to ask questions or provide information that may be critical to their care[6]

Diminishes respect for surgeons[34]

Reputational damage for the employing healthcare organisation and the medical profession[8]

Teamwork and collaboration

Team members may avoid the health a professional exhibiting disruptive behaviour, may hesitate to ask for help or clarification or may avoid making suggestions about patient care or management[8,12,13,16]

Colleagues may refuse to consult or assist with surgical procedures[13]

Colleagues choose to leave their job to avoid an atmosphere of stress and tension[13]

Colleagues may defer patient care while waiting for another doctor to come on duty[13]

Negative role modelling for medical students and doctors in training[8,13]

Impact on student interest in surgical careers[34]

Staff morale and productivity

Lowers staff morale[6,12,14]

Increased staff turnover and staff sickness;[12,13,33] difficulties recruiting new staff[13]

5. What causes or exacerbates disruptive behaviours?

Disruptive behaviours are often caused by a complex interplay of work, systems issues, health and personality issues (Box 5).[8] Temporary causes of disruptive behaviour include sleep deprivation, overwork, poor health or stress related to work or to personal matters.[10] Where stressors such as these persist, disruptive behaviour can become more entrenched.

The healthcare environment is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and (particularly in the US context) fear of litigation.[2] In the UK, doctors report that their satisfaction with their work–life balance has deteriorated and many find it challenging to look after their mental health and wellbeing and maintain a clear boundary between work and home.[21]

While the values underpinning professionalism remain constant, 'the context in which those values are played out is always changing'.[3] Many doctors report that the environment in which they work has become more challenging. Professional isolation, fragmentation and poor communication have been highlighted as recurring problems. A GMC survey of more than 1,000 doctors found that nearly half (47%) felt that they would not be able to ask for help if they were struggling with the pressures of their job without being penalised in some way.[3]

Surgeons, like most clinicians, are working in increasingly stressful circumstances. External stressors 'can combine to produce an environment that is ripe for behaviour to become more exaggerated, for strengths to become overplayed in response to extreme pressure, and for such behaviour to cross the line to become counterproductive'.[5] A common pitfall for surgeons is 'perfectionism that goes beyond a necessary attention to detail, and becomes overly critical, highly demanding behaviour'.[5]

Burnout is especially prevalent in surgical specialties, with severe adverse consequences, including substance abuse, disruptive behaviour, absenteeism, depression and suicide.[35] Surgeons also experience continuing exposure to stress. One study exploring the emotional experiences of liver and pancreatic surgeons in the UK found that 'burdensome emotions' are present before, during and after surgery.[36] While the context in which disruptive behaviours occur is relevant, surgeons are always expected to demonstrate professional behaviour.

Box 5: Stressors

Personal issues

- Stress – due to overwork, fatigue, family and personal situations[13]
- Divorce, separation, custody or financial issues[8,13]

Personality issues

- Lacking the skills to constructively express an alternative opinion[8]
- Intractable personality style that creates conflict with others[8,20] such as arrogant, intimidating, controlling, self-centred,[12] compulsive behaviour[37]
- Behaviour modelled on experiences of disruptive behaviour during training[8]
- Personality disorder diagnoses including paranoid, narcissistic, passive-aggressive and borderline types[12]

Health issues

- Substance addiction[8,37]
- Mental illness – especially depression, bipolar disorder, or drug and alcohol addiction[8,37]
- Physical illness – early dementia or chronic illness, pain or sleep deprivation[8]

Work issues

- Relationships with colleagues – bullying, a sick or poorly performing colleague, perceived racism[8]
- Working environment – inadequate staffing or rota issues, multiple jobs, overcommitment,[8] productivity pressures,[14] long hours and conflicting demands[14,20]
- Shift work and changing work patterns making teamworking more challenging[3]

Hickson and colleagues identify six drivers for unprofessional and disruptive behaviour, as shown in Figure 2.[38]

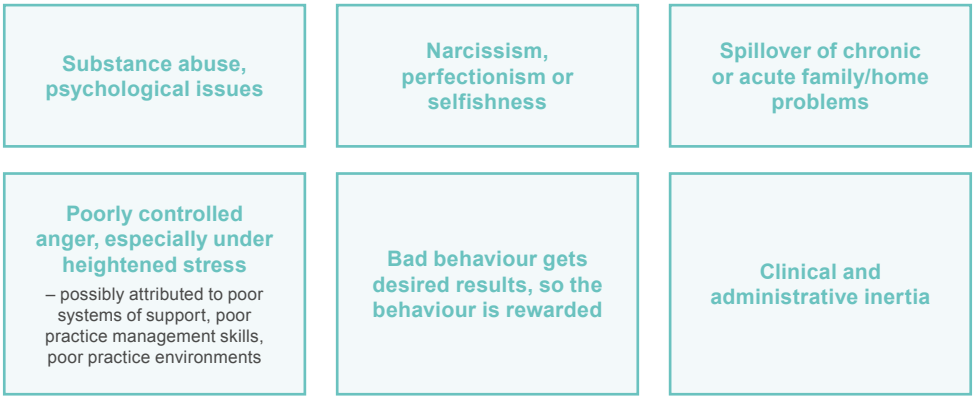


Figure 2: *Six drivers for unprofessional and disruptive behaviour.*[38]

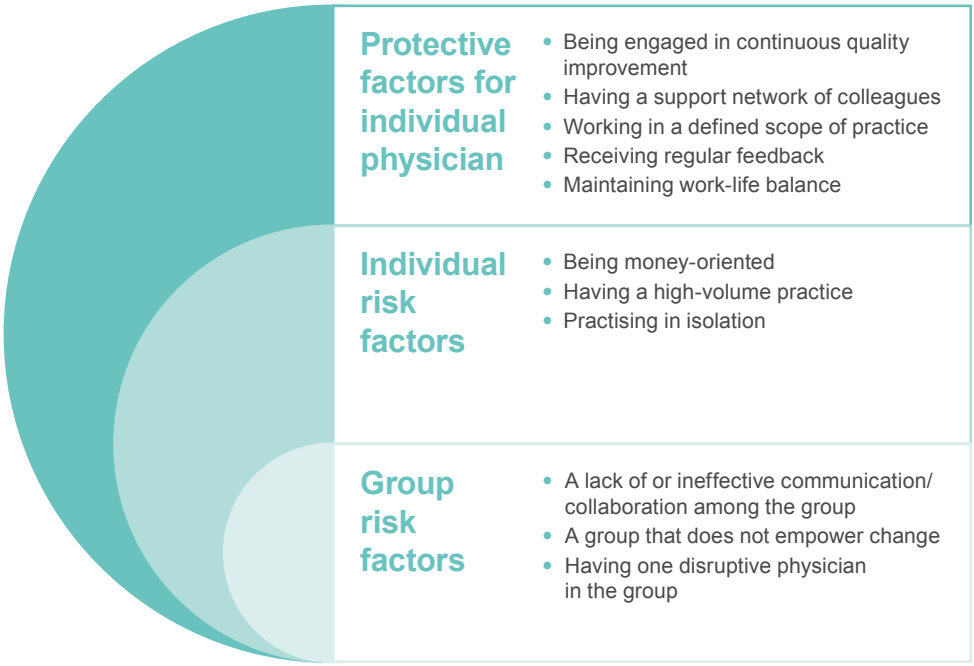


Figure 3: *Risk and support factors for physician performance in Canada.*

Ultimately, the culture and actions of the organisation will influence behaviours within the team. Good team working and supportive, effective leadership will help people air concerns and reduce the risk of a blame culture. It is important not to be isolated – but beware the dead hand of group think.

GMC (2016)[3]

6. How to prevent disruptive behaviours

Preventing disruptive behaviours in the healthcare environment should be the first step.[31,40] Several complementary approaches are advocated for helping to achieve this, of which the key elements are set out below.

MAINTAIN AN UNSWERVING FOCUS ON PROFESSIONALISM

The Royal College of Physicians defines medical professionalism as 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors'.[41]

The medical school curriculum teaches appropriate behaviours and work has been underway to strengthen how professionalism is taught to medical students.[42] This is crucial, as the training of medical students and doctors in training may perpetuate disruptive behaviours. 'Although not intended, medical training by its very nature can serve to encourage disruptive physician behaviour among those who already have personalities that are so inclined'.[12] Belittling or humiliating behaviour by a consultant surgeon towards junior medical staff may lead some to re-enact those behaviours once they become consultant surgeons.

Expectations regarding professionalism should be modelled at induction events for new starters.[38]

DEVELOP A CODE OF CONDUCT SETTING OUT BEHAVIOURAL EXPECTATIONS

Healthcare organisations need to make explicit the types of behaviour considered acceptable and those that are disruptive. The most effective way of doing this is to develop a written code of conduct for all staff and to develop policies and processes for managing disruptive behaviour when it occurs.[2,4,7,8,13,31] This should ensure that all staff understand what is considered disruptive.

Training on a regular basis will be needed to raise awareness of the code, which should also be highlighted at induction events. Staff education should also include the repercussions of disruptive behaviours and the factors that may affect an individual's communication styles and behaviours.[41]

> *Codes are not just about preventing disruptive behaviour. The purpose of a code is to establish the expectations of the institution and its community in the whole realm of personal interactions.*
>
> **Leape et al (2012)[43]**

Box 6: Professionalism in practice

A professional doctor will:

- take pride in doing a job well and pay attention to detail
- take personal responsibility for their actions and consequences
- not be satisfied with a substandard result and will seek to put things right
- be prepared to acknowledge mistakes, learn from them and take appropriate steps to prevent recurrence
- show respect for those who consult them in a professional capacity.

A professional doctor will avoid:

- behaviour that suggests a disregard for the wellbeing of patients or members of the public and/or their dignity and rights
- showing a disregard for the time and effort of those who are relying on them – for example, by consistently bad timekeeping
- selfishness: putting one's own financial or personal interests above all other considerations
- agreeing to undertake a procedure for which the person lacks the necessary training, expertise or competence
- being resistant to feedback or maintaining one's continuing professional development

CLARIFY EXPECTATIONS AROUND TEAMWORKING

Effective teamworking is an essential underpinning of safer patient care. The College has called for surgeons to receive leadership and team management training, and for all clinicians, medical and non-medical, to be taught teamworking skills and attend teambuilding training courses.[45] Others place emphasis on creating a culture of respect, as necessary for becoming 'a safe, high-reliability organisation that provides a supportive and nurturing environment and a workplace that enables staff to engage wholeheartedly in their work'.[43]

It is the consultant surgeon's responsibility to develop an effective team in the clinical setting through leadership and teambuilding. However, all members of the surgical team and the wider multidisciplinary team have an obligation to support each other to deliver patient care in the wards, clinics, theatre, community setting and following discharge.[45]

Effective teams need space to come together and reflect on how things are working. Doctors have highlighted a need for safe spaces to bring teams together to discuss issues and prevent them from stacking up.[3]

DEMONSTRATE CLINICAL LEADERSHIP COMMITMENT

In helping to prevent disruptive behaviours, clinical leaders need to be sensitive to the unintended effects that institutional structures, policies and practices can have on patient care and on staff.[15] Other ways they can support a preventative approach include:

- reinforcing clear expectations of the behaviours expected by the organisation
- modelling professionalism and appropriate behaviours with patients, colleagues and others
- demonstrating a transformational leadership style, which is associated with improved team behaviour, reflecting that transformational leaders exhibit more behaviours supportive of others and are less frequently observed demonstrating negative behaviours[46]
- supporting other clinical leaders in dealing with disruptive behaviour[9]
- learning how to talk effectively to doctors about disruptive behaviour, from informal discussion to formal interventions[9]
- encouraging a visible commitment to professionalism at board level

Box: 7 Early warning signs

The Canadian guidebook for managing disruptive physician behaviour identifies behaviours or activities that should heighten concern about an individual's professionalism or wellbeing.[6]

These include where the individual:

- refers emotionally to personal upset over recent events originating in the workplace or in their personal life
- deviates from the workplace/professional norm in inappropriate dress or conduct
- fails to show respect for others in the workplace and/or patients
- blames others for problems
- suspects the actions and motivations of others
- threatens to harm self or property
- violates or challenges work restrictions and policies such as failing to be on time for meetings and clinics

Early intervention where such warning signs are observed could help to avoid disruptive behaviours from becoming entrenched

DEVELOP SURVEILLANCE AND REPORTING SYSTEMS

Creating an environment in which staff, patients and others can report concerns of disruptive behaviour is essential to preventing such behaviours from flourishing.[8]

Feedback from patients should play an important role in maintaining professionalism and alerting leaders to behaviours that could be disruptive. Patient feedback is likely to be more influential in terms of impacting on an individual doctor's performance if it is specific, collected through credible methods and contains narrative information.[47] Consultant surgeons already collect 360-degree feedback, including from patients, as part of the annual appraisal process, which should help to identify problems early.

Information from complaints and clinical incidents is another important surveillance mechanism for detecting unprofessional behaviours.[19] Patient complaints are a valuable source of information about behaviours, as well as the environments that may promulgate disruptive behaviours.[37] One study found that patients whose surgeons have large numbers of unsolicited patient observations (complaints) in the 24 months prior to the patient's operation were at increased risk of surgical and medical complications.[48] A surgeon's ability to communicate respectfully and effectively with patients and colleagues should therefore be core to efforts to promote patient safety.

The process for reporting concerns of disruptive behaviour must provide a consistent, non-biased approach to evaluating each incident and ensuring there is a follow-up plan of action.[40]

> *The most effective surveillance tools for detecting unprofessional behaviour are the eyes and ears of patients, visitors, and health care team members.*
>
> **Hickson et al (2007)[38]**

ADOPT 'ZERO-TOLERANCE' OF DISRUPTIVE BEHAVIOURS

Much of the literature highlights the value of adopting a zero-tolerance approach to disruptive behaviours.[2,8,24] Such an approach is important in creating a culture that is not accepting of disruptive behaviours.

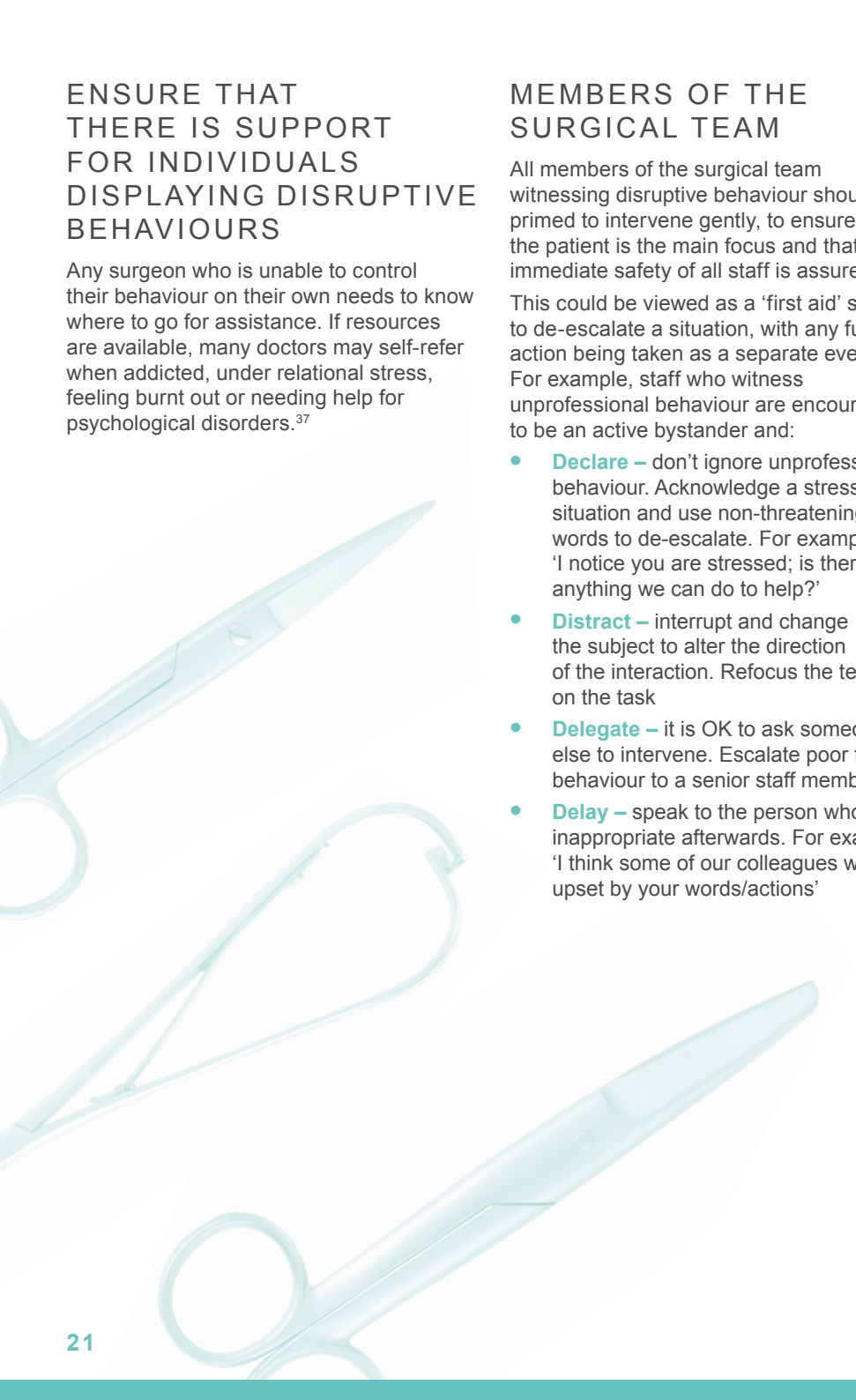
Policies for managing any breach of the code of conduct should make clear what will happen if staff fail to meet behavioural expectations.[31] The policies should hold all team members accountable for modelling desirable behaviours and should enforce the code consistently and equitably among all staff, regardless of seniority.[2]

All processes must comply with current employment law and should include a systematic approach to recording the behaviour.[8] Medical staff policies regarding disruptive behaviours should be complementary and supportive of the policies for non-physician staff.[2] Surgeons and surgical team members should adhere to the same code of conduct as part of fostering 'a cooperative, collegial working environment' within the healthcare team.[7] The process for responding to breaches of the code of conduct must be perceived by all parties to be fair.[43]

The policies must protect staff who report disruptive behaviours, as well as patients and their families who are involved in, or witness, inappropriate behaviour.[2]

ENSURE THAT THERE IS SUPPORT FOR INDIVIDUALS DISPLAYING DISRUPTIVE BEHAVIOURS

Any surgeon who is unable to control their behaviour on their own needs to know where to go for assistance. If resources are available, many doctors may self-refer when addicted, under relational stress, feeling burnt out or needing help for psychological disorders.[37]



MEMBERS OF THE SURGICAL TEAM

All members of the surgical team witnessing disruptive behaviour should be primed to intervene gently, to ensure that the patient is the main focus and that the immediate safety of all staff is assured.

This could be viewed as a 'first aid' step to de-escalate a situation, with any future action being taken as a separate event. For example, staff who witness unprofessional behaviour are encouraged to be an active bystander and:

- **Declare –** don't ignore unprofessional behaviour. Acknowledge a stressful situation and use non-threatening words to de-escalate. For example: 'I notice you are stressed; is there anything we can do to help?'
- **Distract –** interrupt and change the subject to alter the direction of the interaction. Refocus the team on the task
- **Delegate –** it is OK to ask someone else to intervene. Escalate poor team behaviour to a senior staff member
- **Delay –** speak to the person who was inappropriate afterwards. For example: 'I think some of our colleagues were upset by your words/actions'

Expected behaviours of all surgeons

Meet Good Medical Practice – paragraphs 35, 36, 37, relating to working collaboratively with colleagues, are particularly relevant to this issue, as is paragraph 46, with respect to being polite and considerate to patients.[49]

Meet the GMC's Leadership and management for all doctors – especially paragraphs 4, 5, 6, 7, 8 and 13 relating to: working with others and team; respecting the leadership and management roles of other team members; working effectively with colleagues from other health and social care disciplines; tackling discrimination, treating colleagues fairly and not bullying or harassing them; follow and keep up to date with your organisation's policies about employment, equality and diversity; encouraging team members to cooperate and communicate effectively with each other; and taking action to deal with problems arising from poor communication or unclear responsibilities.[50]

Be guided by the RCS England good practice guide The High Performing Surgical Team – which highlights that members of high-performing teams, among other things, encourage contributions of all members and ensure that the views of new and junior members are taken into account, show respect for the role, expertise, competence and contributions of allied disciplines and healthcare providers, respect the leadership of the team, show a commitment to team work in the best interest of the patient.[30]

Follow advice from the Canadian Medical Protective Association – to remain self-aware and assess your behaviour with colleagues, other healthcare providers and patients.[9]

Additional expectations of clinical leaders

Meet the GMC's Leadership and management for all doctors – you must actively advance equality and diversity by creating or maintaining a positive working environment free from discrimination, bullying and harassment. You must make sure that your organisation's policies on employment and equality and diversity are up to date and reflect the law.[50]

Leading by example, you should promote and encourage a culture that allows all staff to contribute and give constructive feedback on individual and team performance. You should make sure that systems are in place to achieve this.[50]

You must make sure that there are clear and effective procedures for responding to concerns about colleagues' conduct, performance or health. This includes referring them to occupational health or other services, where appropriate, and making sure that staff are aware of these procedures.[50]

You should be prepared to discuss constructively and sympathetically any work problems that the people you manage may have. You must deal supportively and, where possible, openly with problems in the conduct, performance or health of the people you manage.[50]

You must make sure that people you manage have access to support for any health or performance problems they have. You must make sure that people are not unfairly discriminated against because of their health or disability.[50]

7. How to manage disruptive behaviours

Early identification and intervention are essential when it comes to managing disruptive behaviours. Ignoring inappropriate conduct will result in the problem persisting and becoming entrenched. Disruptive behaviour needs to be confronted and addressed before it takes hold.

Everyone should feel able to draw attention to any disruptive behaviour, particularly where it has the potential to impact on patient safety and effective team working – see Box 8 for the expectations of surgeons in raising concerns. The GMC has launched a pilot programme to give doctors training in tackling unprofessional behaviours from colleagues.[51] The training will be delivered in at least 14 sites by the GMC's Regional Liaison Service.

In terms of what should happen next, there is broad agreement that a tiered, staged approach should be taken, with an emphasis on remediation.[6,9] The importance of taking a consistent approach to managing disruptive behaviours, regardless of the seniority of the practitioner, is a recurring theme.

Concerns have been raised that healthcare organisations often fail to deal effectively with disruptive behaviour and there is a perception that doctors, especially those with a high value to the organisation, are treated more leniently than other staff.[19]

> *The response to the complaint must be titrated to the nature of the incident and the physician's history with the institution. Intolerance of unprofessional behaviour does not mean that punitive action is required. It does mean that some action is required.*
>
> **College of Physicians and Surgeons of Ontario and Ontario Hospital Association (2008)[6]**

Box 8: What every surgeon must do

GMC's Raising and acting on concerns:

- All doctors have a duty to raise concerns where they believe that patient safety of care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisation in which they work
- You must follow the procedure where you work for reporting adverse incidents and near misses
- You must be clear, honest and objective about the reason for your concern. You should acknowledge any personal grievance that may arise from the situation, but focus on the issue of patient safety
- You should also keep a record of your concern and any steps that you have taken to deal with it
- All doctors have a responsibility to encourage and support a culture in which staff can raise concerns openly and safely[52]

RCS England's guide on Surgical Leadership:

- Constructive feedback is essential in helping colleagues to become more aware of when their behaviour is becoming counterproductive and adversely affecting morale, performance or even patient safety
- You should ensure that you create the opportunity for a trusted colleague or other team members to tell you if they are concerned about your behaviour, either towards them or others[5]

The approaches for dealing with disruptive behaviour share some common themes:[19]

- making expectations explicit by having a code of conduct supported by appropriate policies
- ensuring robust board support for clinical leaders in implementation
- support and training for those dealing with disruptive behaviour
- screening for health and personal issues
- proactive surveillance systems
- dealing consistently and transparently with infringements
- dealing with lower-level aberrant behaviour early
- having a graduated set of responses (informal, formal, disciplinary, regulatory) depending on the severity of the incident (Box 9)
- making resources available to help those displaying, and those affected by disruptive behaviour

Box 9: Questions to ask about an incident of disruptive behaviour

The College of Physicians and Surgeons of Ontario and Ontario Hospital Association suggests the following questions to understand the incident:[6]

- Did this incident represent a change in the physician's previous behaviour pattern?
- Does the potentially problematic behaviour appear to be increasing in frequency?
- Was the behaviour accompanied with an appropriate degree of emotion?
- Does the behaviour appear to be broadening in scope over time to include more than one 'index' behaviour?

Arrange a face-to-face meeting to discuss problematic behaviour – these conversations can be difficult and making them effective is critical.[6]

Plan well for the meeting – consider the setting, whether it would be advisable to have a third party attend, how long the meeting will last, and the desired outcome.

Follow the format of a performance appraisal – thank the doctor for attending, lay out the rules of engagement, begin with a statement of recognition of the things that the doctor does well, provide full details of the concerning incidents, close with a discussion of the steps to be taken to measure success and plan the next meeting.[6]

Avoid trying to soften the message – by mixing it with complimentary statements or using an overly familiar tone.[53]

GRADED RESPONSES TO MANAGING DISRUPTIVE BEHAVIOURS

The Vanderbilt University School of Medicine in the US has advocated a model for addressing disruptive behaviour focused on four graduated interventions:[38]

1. **Informal conversations for single incidents –** including the 'cup of coffee conversation'. There are exceptions, such as when the law mandates reporting the event and/or provides sanctions for engaging in prohibited behaviour. At Vanderbilt, training in having a 'cup of coffee conversation' is based on the principles of sharing bad news.
2. **Non-punitive 'awareness' interventions when data reveal a pattern that sets the individual apart from their peers –** the pattern must be presented by an authority figure or, in some circumstances, by a peer.
3. **Leader-developed action plans if patterns persist –** a small proportion of professionals seem unable or unwilling to respond to an awareness intervention and require an 'authority intervention'.
4. **Imposition of disciplinary processes if the plans fail –** including restrictions on practice or even termination of contract.

There is a concern that informal solutions, such as a 'quiet chat' may avoid actively resolving the problem.[10] However, others argue that addressing disruptive behaviour in a relaxed, informal setting is most likely to result in a desirable outcome.[31]

The College of Physicians and Surgeons of Ontario and Ontario Hospital Association refers to reports of disruptive behaviour as complaints.[6] Their report recommends that, for a single complaint about a relatively minor breach of behavioural standards, an informal approach would be best. Where the behaviour is particularly offensive or representative of a problematic pattern 'a more formal approach will be required and more serious consequences are likely to follow'. An overview of their staged approach is set out in Figure 4.

Stage one	Stage two	Stage three
The kinds of behaviour that might require a stage one intervention include a **single/limited instances of relatively mild disruptive behaviour**, such as use of inappropriate language, an outburst of anger, demeaning comments or intimidation, a single instance of throwing/ breaking objects, refusal to follow hospital policies. The appropriate response will depend on how serious the behaviour is, the context, and the physician's response. **Whatever the outcome, a note should be retained on file about the** discussion held with the physician.	A stage two approach is most often required **after stage one interventions have failed to result in sustained behavioural changes**. In order to determine how best to change the behaviour, there needs to be some understanding of what is causing or contributing to it. An external assessment may be helpful. **Once the underlying cause of the problem has been identified, the organisation and the physician should agree on the next steps.** A therapeutic approach may be required, for example to address stress management or addiction issues. In other cases, a more educational approach will be effective.	Stage three describes **inappropriate behaviour that has persisted or escalated despite intervention.** For example, physical assault or sexual advances towards colleagues; behaviours attributable to impairment caused by mental illness or substance use; and behaviour that contravenes laws and/or gives rise to an obligation to report the behaviour to the police or regulators. The process for review and discussion with the physician still apply. In addition, **the behaviour must be brought to the attention of senior authorities and formality of process is needed due to the possibility that restrictions on practice may be needed.**

Figure 4: *College of Physicians and Surgeons of Ontario and Ontario Hospital Association staged approach.*

The College of Physicians and Surgeons of Alberta has a four-stage process, recommending specific responses to each stage of behaviour (Figure 5).[13]

Stage one	Stage two	Stage three	Stage four
(low severity)	(moderate severity)	(medium to high severity)	(high severity)
First report of disruptive behaviour (although may not be first incident).	Repeated stage one behaviour, despite intervention; escalation in frequency and severity; sexualised behaviour (even if the first incident).	Persistent disruptive conduct beyond moderate severity; serious conduct that raises concerns of harm to the individual or others.	Behaviour beyond stage three that includes threats or attempts to harm self or others, significant legal liability, immediate risk of patient injury.

Figure 5: *College of Physicians and Surgeons of Alberta four-stage process.*[13]

NHS Resolutions' Practitioner Performance Advice (PPA; formerly the National Clinical Assessment Services) provides guidance on how to conduct a local performance investigation.[54] Every organisation should have performance procedures, which comply with relevant legislation and guidance. Managers should be trained to use the procedures, supported by investigators and case managers. The PPA guidance is for those considering whether an investigation is needed to determine whether there is a performance problem requiring action.

An investigation will usually be appropriate where case information suggests that the practitioner may:

- pose a threat or potential threat to patient safety
- expose services to financial or other substantial risk
- undermine the reputation or efficiency of services in some significant way
- work outside acceptable practice guidelines and standards

An investigation should be unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious

An investigation may be unnecessary in the following situations:

- the practitioner may agree that the concerns are well-founded and agree to cooperate with required further action (however, if the issues raised are serious enough an investigation may still be warranted)
- there is confirmed or suspected ill health (although ill health does not, by itself, rule out investigation)
- the concerns are being investigated by another agency

Further detailed guidance on how to manage an investigation is contained in the source material.

REMEDIATION FOR THE DISRUPTIVE SURGEON

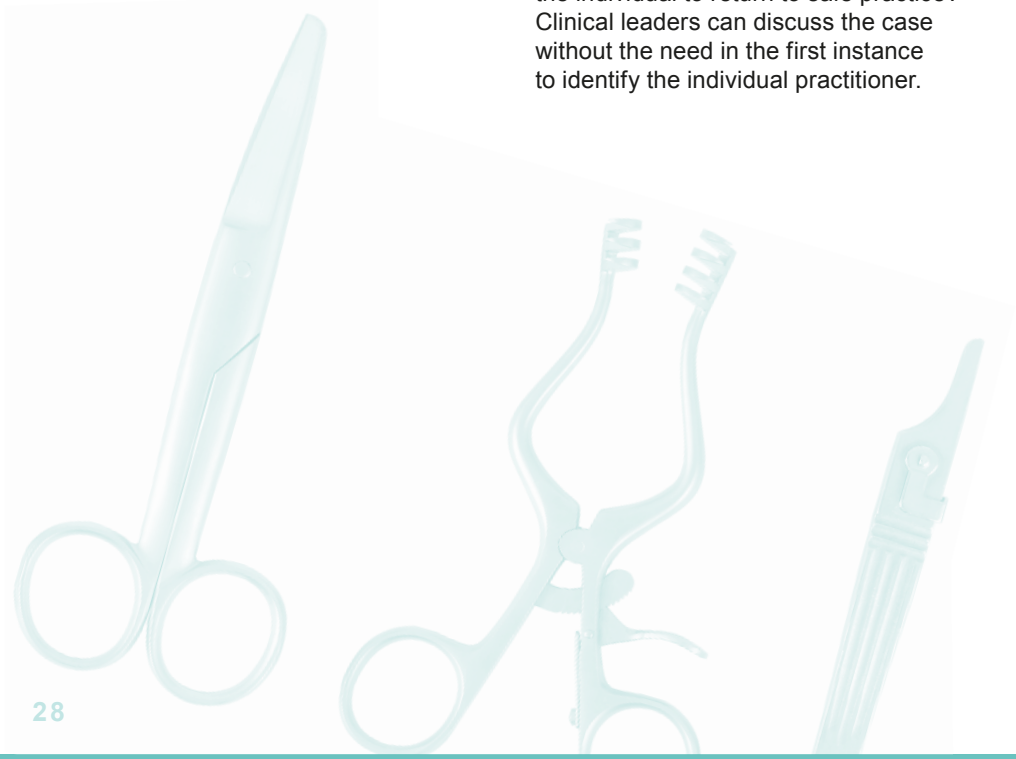
The goal in managing disruptive behaviours should be to enable the individual to change their behaviour and continue practising. Plans for remediation must be explicit, with clear markers, deadlines and methods of monitoring.[43]

Further training programmes are one option to address concerns. Disruptive individuals often lack insight into the impact of their behaviour on others, and educational interventions can be effective in changing disruptive behaviour.[37] Coaching physicians with disruptive behaviours has been successful in increasing accountability to professional standards and most physicians have responded well to small group experiential learning process.[37] A programme of remediation may include psychological training to help the individual develop new coping skills.[53]

The PPA provides guidance on approaches to working with practitioners for whom further training may be helpful.[55] It can also provide external advice to support internal efforts to manage disruptive behaviours. The PPA service receives around 1,000 requests for advice from healthcare organisations each year. It offers advice on:

- the application of local performance management procedures
- good practice in relation to local case management and investigation
- identifying options available to resolve the concerns raised
- signposting other sources of support

In some cases, assessment and intervention services are offered.[56] NHS Resolution advises contacting the PPA service 'as early as possible' so that 'concerns about practice are identified and resolved early, to prevent harm and increase the opportunity for the individual to return to safe practice'.[57] Clinical leaders can discuss the case without the need in the first instance to identify the individual practitioner.



CRISIS INTERVENTION

In situations where patient safety is directly threatened by a physician's behaviour, the surgeon should be immediately removed from the situation. Examples where crisis intervention is required might include instances when:

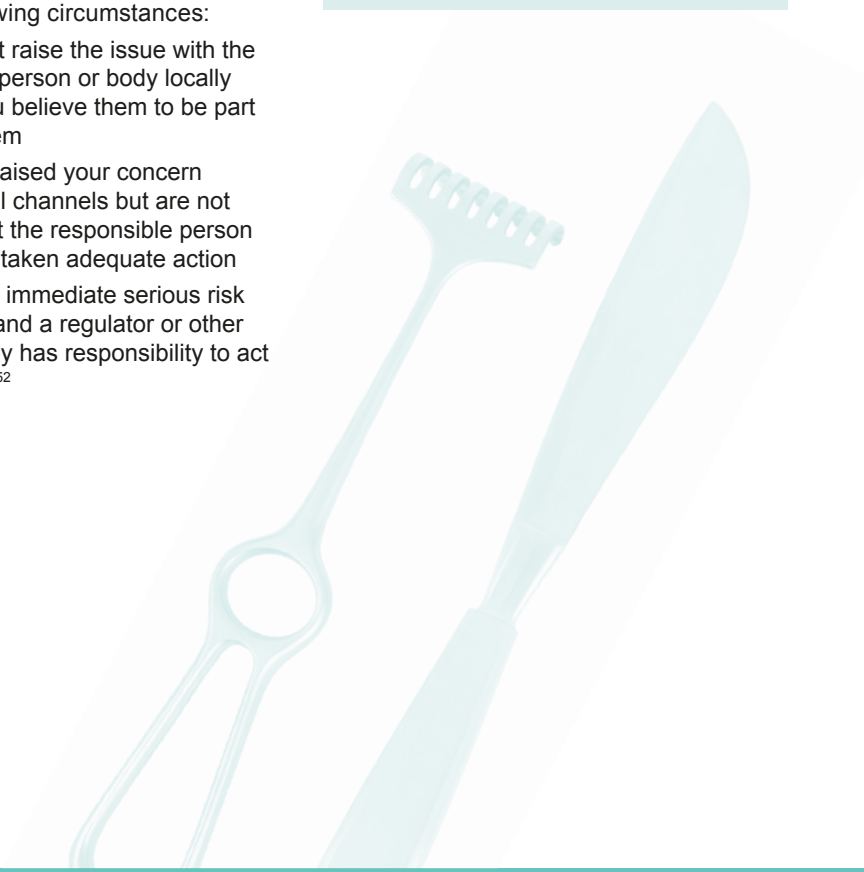
- the physician is so distressed or out of control that they pose a safety risk to other workers in the environment
- the physician threatens to physically harm themselves or others
- the behaviour appears to create unacceptable legal liability
- the behaviour poses an immediate threat to patient care[6]

The most serious cases will need the attention of the GMC, which advises that a concern should be referred to a regulatory body in the following circumstances:

- if you cannot raise the issue with the responsible person or body locally because you believe them to be part of the problem
- if you have raised your concern through local channels but are not satisfied that the responsible person or body has taken adequate action
- if there is an immediate serious risk to patients, and a regulator or other external body has responsibility to act or intervene[52]

Failing to address unprofessional behaviour simply promotes more of it. Besides being the right thing to do, addressing unprofessional behaviour can yield improved staff satisfaction and retention, enhanced reputation, professionals who model the curriculum as taught, improved patient safety and risk-management experience, and better, more productive work environments.

Hickson et al (2007)[38]



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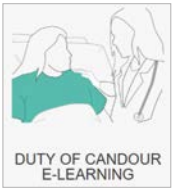
Further reading and supporting resources

The GMC provides a decision-making tool to help doctors know how to raise a concern about patient safety. The online tool works through a flowchart (as shown in the image)

GMC. Raising and acting on concerns flowchart. https://www.gmc-uk.org/ethical-guidance/learning-materials/raising-and-acting-on-concerns-flowchart



The RCS England offers a duty of candour e-learning module that supports its written guidance and outlines the steps that surgeons should take to ensure that the principles of the duty of candour are at the forefront of everyday work

RCS England. Duty of candour. https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/duty-of-candour

Resource Toolkit: Managing Disruptive Behaviour in the Healthcare Workplace, by the Health Quality Council of Alberta builds on previous work by the College of Physicians and Surgeons of Alberta and contains templates, checklists and tools to support behaviour-related initiatives.

Healthcare Quality Council of Alberta. Managing disruptive behaviour in the healthcare workplace: resource toolkit. https://hqca.ca/health-care-provider-resources/frameworks/managing-disruptive-behavior-in-the-healthcare-workplace-provincial-framework

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