Managing Disruptive Physician Behaviour: First Steps for Designing an Effective Online Resource

Colla J. MacDonald*

Faculty of Education, Cross appointed with the Faculty of Medicine;
Senior Researcher with Elizabeth Bruyere Research Institute.
University of Ottawa, Canada
E-mail: cjmacdon@uottawa.ca

Douglas Archibald

Faculty of Education
University of Ottawa, Canada
E-mail: darch080@uottawa.ca

Derek Puddester

Faculty Wellness Program
Faculty of Medicine
University of Ottawa
451 Smyth Road Ottawa ON K1H 8M5, Canada
E-mail: wellness@uottawa.ca

Sharon Whiting

Health/Hospital Services
Faculty of Medicine
University of Ottawa
451 Smyth Road Ottawa ON K1H 8M5, Canada
E-mail: whiting@cheo.on.ca

*Corresponding author

Abstract: Interviews with physician leaders from hospitals in a mid-sized Ontario City were conducted to determine their needs with regard to managing disruptive physician behaviour. These findings were used to inform the design of a two-day skill-development workshop for physician leaders on disruptive behaviour. The workshop was evaluated using a modified version of the *Learner Experience Feedback Form*, which was built to align with *W(e)Learn*, http://www.ennovativesolution.com/WeLearn/ a framework developed to guide the design, delivery, development, and evaluation of online interprofessional courses and programs (MacDonald, Stodel, Thompson, & Casimiro, 2009). The surveys gathered information related to the content, media, service, structure, and outcomes of the workshop. The findings from the focus group interviews and workshop evaluation identify physician leaders' needs with regard to

disruptive behavior and were used to inform the design of the world's first Online Physician Health and Wellness Resource http://www.ephysicianhealth.com/ an open access learning resources currently being used globally, in 91 countries. The resource was the recipient of the winner of the International Business/Professional 2010 International eLearning Award. The findings demonstrated the importance of conducting a needs analysis and using a framework to guide the design, delivery and evaluation of effective online healthcare education.

Keywords: Healthcare education; Online learning; Disruptive behaviour; Physician health

Biographical notes: Colla Jean MacDonald is a Full Professor in the Faculty of Education, cross appointed with Faculty of Medicine, Senior Research Elizabeth Bruyere Research Institute at University of Ottawa. Dr. MacDonald's area of specialization includes eLearning and Healthcare Education. Dr. MacDonald has designed many online resources including two courses that have won the international WebCT award. She has published extensively in eLearning.

Douglas Archibald is a PhD Candidate in Healthcare Education at the University of Ottawa.

Derek Puddester is the Director, Faculty Wellness Program, and Associate Professor, Psychiatry, in the Faculty of Medicine at the University of Ottawa.

Sharon Whiting is the Assistant Dean Health/ Hospital services, Associate Professor, Pediatrics, University of Ottawa.

1. Introduction and Theory

Disruptive behaviour - Any inappropriate conduct, whether in words or action, that interferes with, or has the potential to interfere with, quality health care delivery (CPSO, 2008).

Disruptive behaviour can cause breakdowns in communication and collaboration among physicians and other healthcare workers that can lead to medical errors, adverse events, and near misses resulting in reduced patient care quality (Leape & Fromson, 2006). It can also lead to recruitment and retention issues, impact worker's health and well being, patient safety, organization outcomes, and societal outcomes (Shamian & El-Jardali, 2007). For example, Rosenstein (2002) reported that over 30% of 1121 respondents indicated they know of a nurse who had left a hospital as a result of disruptive physician behaviour. Another 24% said they knew nurses who had changed schedules, shifts, even departments to avoid certain physicians. Rosenstein and O'Daniel (2005) noted that staff relationships are critical to healthcare delivery and that disruptive behaviour has a very strong negative influence. Disruptive behaviour can lead to loss of a physician's hospital privileges (Ross, Taylor, & Canady, 2009), and contributes to litigation risk by promoting patient dissatisfaction (Hickson & Etman, 2008).

Disruptive physician behaviour takes many forms including verbal (insults, yelling), physical (touching, hitting), environmental (gossip, emails), and systemic (hijacking meetings, inappropriate demands/complaints). The behaviour may be long

standing or it may be more recent in onset. Anger may be expressed in sudden outbursts or subtly with persistent verbal abuse (Kaufmann, 2001).

Disruptive behaviour is an example of physician performance problems that should be thought of as symptoms of underlying disorders (Leape & Fromson, 2006; Kaufmann, 2001). Kaufmann indicated that it is a way of acting based on personal experience (ie. stress, family illness, divorce) habit, internal discomfort or illness. Changes in the healthcare environments have created considerable stressors for physicians (Dunn, Arnetz, Christensen, & Homer, 2007). Stressors can include time restrained patient care, lack of resources, and malpractice litigation to name a few. All of which can possibly lead to disruptive physician behaviour. Disruptive behaviour cannot be understood "apart from the physicians personal and professional context" (Kaufman, 2001, p. 53) and needs clinical assessment.

Leape and Fromson (2006) have indicated that the prevalence of disruptive behaviour is about 3-5 percent and in the United States alone 0.5% of physicians have been disciplined for performance issues resulting in 1739 having their licenses revoked. The literature suggests disruptive physician behaviour is on the rise and is being tolerated less because of higher expectations for effective behaviour (Physician Manager Institute, 2009).

In April 2008 as a response to the growing literature and concern about disruptive behaviour in the workplace the College of Physicians of Ontario (CPSO) and the Ontario Hospitals Association (OHA) developed a guidebook for managing disruptive physician behaviour. This guidebook can be found on the CPSO website (www. cpso.on.ca). However, further resources and support for physicians are needed (Leape & Fromson , 2006). The purpose of this study was to identify physician leaders' needs with regard to disruptive behavior so that informed decisions can be made when planning and implementing policies, procedures and educational programs (online and face-to-face) to support managing disruptive physician behaviour.

2. Methodology

Understanding the needs of end users is a prerequisite to effectively planning any online learning event (MacDonald, Stodel, & Coulson, 2004). For pre-qualification learners, differing course schedules, discipline-specific evaluation procedures, and various practical training requirements are examples of constraints. Different challenges include workloads, staff shortages, shift work, and differing levels of education, literacy, experience, and seniority. Curriculum planners should conduct a diagnostic evaluation to determine learners' needs in terms of content, media, and service; learning styles and preferences; background experience; current knowledge; learning goals; and support.

Awareness of cultural, social, and individual factors that could influence the learning experience are important to pinpoint in order to create strategies and tools to make the program flexible (available anywhere and anytime); accessible (access to computers); feasible (length of program and learning segments); and convenient (online access to resources, registration, support) (MacDonald, Stodel, Farres, Breithaupt, & Gabriel, 2001). Therefore, our first step was to do a formal needs analysis with end users.

Three focus group interviews, involving 19 physician leaders from hospitals in a mid-size Ontario city, were conducted with the purpose of identifying their needs related to preventing and managing disruptive physician behaviour. The physician leaders were

department chairs, associate deans, program directors, and chief of staffs from various programs and departments with a medical school and city hospitals. The interviews lasted approximately one hour and were audio-taped and then transcribed verbatim. The interview protocol can be seen in Appendix A.

Qualitative data analysis was guided by Merriam (1998) and Bogdan and Biklen (1998). In the initial step of the analysis, the transcripts were read and reread and a preliminary list of relevant emergent categories developed. Once the categories reflected "the recurring regularities or patterns in the study" (Merriam, 1998, p. 181), data was assigned to themes so that the researchers were satisfied that such assignments reflected the needs and views of the participants. These structures were then developed and coded in each interview and similarities and differences between and among interviews were identified. Direct quotations from these interviews are used in this paper to preserve the voice of the participants.

The findings from the focus group interviews were used to guide the development of a joint University/Canadian Medical Association two-day workshop for physician leaders. The workshop was evaluated using a modified version of the *Learner Experience Feedback Form*, (see Appendix B) which was built to align with *W(e)Learn)*, (see Appendix C) a framework developed to guide the design, delivery, development, and evaluation of online healthcare courses and programs (MacDonald, Stodel, Thompson, & Casimiro, 2009). The purpose of the survey was to gather information related to the content, media, service, structure, and outcomes of the workshop. Information regarding their needs for an online program was also gathered. The survey took about 15 minutes and was completed by 20 of 27 participants (74%). Nine of the physician leaders who participated in the focus group interviews also participated in the workshop. The findings from the focus group interviews and workshops supported each other and can be used to make informed decisions and recommendations to guide planning and implementing policies, procedures and educational programs to support managing disruptive physician behaviour and they also informed the design of the award winning online physician health program (http://ephysicianhealth.com/).

3. Findings

Focus Group Interviews

There were inconsistencies and even contradictions between and among physician leaders with regard to the need of a regional policy in relation to disruptive behaviour. When asked to discuss their views and experiences related to disruptive behaviour policies, several themes emerged. These themes are discussed in the ensuing sections.

The existing situation. Physician leaders were certain their faculties, hospitals and organizing bodies have standards, codes and policies with regard to disruptive behaviour but admitted being unfamiliar with, uncertain how to access, and unclear on the procedures for implementing them. Physician leaders reported having cross appointments with different hospitals and organizations which complicates dealing with disruptive behaviour incidents. One participant explained:

> We now have 3 masters… the university, the hospital and the LHIN*. So when an incident occurs what path does it takes? Is this supposed to be something that amalgamates everything so there's one book to read from or one flight manual? (department chair # 1)

Participants reminisced about situations where they were involved in disciplinary procedures and stated the current policies need to be improved to better equip administration to deal with difficult individuals. One physician leader explained that the standards did not empower the faculty to deal with unacceptable behaviour the way they would have liked. …I think what exists currently needs to be fortified" (department chair #2).

Some physician leaders suggested it was important to consider the local culture and felt there would be resistance to a standard approach being implemented "LHIN wide". One proposed solution was to blend local and provincial strategies but with universal standards to which no one is exempt. One participant suggested using the College of Physicians and Surgeons of Ontario (CPSO) as a resource:

> There is a great deal of expertise at the Ontario College of Physicians….. Is there a way to tap into that, get the benefits and not trigger an immediate cascade of events …that we can consult, without necessarily disciplinary action [taking place]. (program director #1)

Physician leaders made it clear that having a standardized approach is not necessarily one office where you have people on call. "People won't show up there! You have to be able to act on the spot" (department chair #7). Others were adamant that 'standards are standards' regardless which part of the province the physician is located. They discussed how it could be irritating and redundant to re-create what already exists. "The CPSO does it [has policies] and so do faculties. So it would be a waste of time to reinvent it" (program director #1). One physician leader suggested what is needed is a province wide standard common for all 14 LHINs. "I'm a little unclear as to why disruptive behaviour would be different amongst the LHINs. …To say that someone in southern Ontario has a different standard than someone in eastern Ontario doesn't make a lot of sense to me" (department chair #1).

Although several participating leaders acknowledged that cultural and local issues are important, one participant cautioned, "We have to balance that with the fact that with local culture, medicine has often protected perhaps even compensated for sub-standard behaviour" (program director #1). Participants were not in agreement on whether these standards, codes and policies should be province wide, LHIN wide, or for each institution.

Synchronization of policies. Participants felt it was essential to harmonize anything developed at the LHIN level with the CPSO standards. The physicians reported that no matter what the local characteristics of any problem-solving solutions are, the CPSO will eventually be involved. One physician described his perspective:

> Yes, we need the LHIN solution, but we probably need the trans-LHIN solution or a provincial solution …Everything has to be consistent with the CPSO, because what happens is the legal counsel for the person ultimately goes that route. (department chair #4)

Similarly, participants suggested strategically aligning disruptive behaviour policies with the CanMEDS framework which is a medical education initiative made of seven roles to improve patient care (RCPSC, 2009). Participants felt there would be no interest for faculties unless you bring the CanMEDS role in and make it part of the curriculum and part of your grand rounds.

Participants reported "there is no lack of codes", and divulged that they did not know which code supersedes others. They said they needed a guide to enable them to assimilate all the various codes of conducts. Some physician leaders were concerned that

without greater integration of these policies and mechanisms, without at least acknowledging one another, there is a high potential for organizations to pass the buck and for people to fall between the cracks. A physician provided an example of two organizations 'passing the buck'.

> There was an incident I remember vividly… one side said that it is the hospital's fault because it happened in the hospital, the other said that the 'at fault person' was a student so it is the university's problem. Nobody really wanted to own the problem. But there was a problem. (program director #2)

Participants stated that policies and procedures need to be transparent between and among organizations. They also stated that the boundaries are blurred between and among the different organizations to which they belong. Finally, participants felt no matter what policies are synchronized, adopted, or adapted it would be good to have the procedures set up before the event ever occurs. "Because when an event occurs you are just chasing your tail and reacting to it. [Being prepared] in advance, maybe you would [make better decision] than during the heat of it" (department chair #2).

Defining disruptive behaviour. Physician leaders articulated that one of the confusing issues to developing standards and procedures is that there are 'overlapping mechanisms and definitions'. One physician leader stated:

> What is intimidation, what is harassment, what is disruptive physician behaviour? What is reportable to CPSO? What is criminal and should be reported to the police? Is it on-off, is it repetitive incidents? How do you define this particular behaviour? (program director #2)

Participants said a clear distinction needed to be made between standards that fall under 'disruptive physician behaviour' and those that fall under 'professionalism'.

> You can be annoying or you can threaten someone's life… if you don't have the mechanism to say you've crossed the line, then it doesn't matter what kind of rules you have… When does it hit a threshold to say, 'I'm sorry you're going to have to leave'? (department chair #1)

When asked what is meant by disruptive behaviour one participant said, "It could be words. It could be actions. It could be inaction. It could impact most grievously on patients… it can affect non-physicians, physicians, public...unrelated to patients" (department chair #6). A second physician elaborated, "any behaviour, non-behaviour …or inactions that can create either hostile, fearful or dysfunctional environments so that the services of the individual in the unit are not carried out effectively" (associate dean #2). Physician leaders said they need clarification on what disruptive behaviour is, details describing the rules and procedures for meeting acceptable professional expectations and behaviours and tools to be able to deal with a situation when an individual does not follow the rules. "When you tell them how they are to behave then it is easier to say well, this is out of line" (program director #3).

Awareness/visibility. A major concern participants expressed was that the disruptive behaviour standards are not made explicit. "The expectation is you are told when you join a faculty …you are given the document. Probably most people don't remember it or ever look at it. So there isn't a sharing process" (program director #1). Physician leaders conversed about the need to develop strategies to ensure the standards are made clear.

Some physicians were cynical that new hires would read a copy of the standards even if they were provided with them. One leader suggested reading policies were something you only do when something goes wrong. "It is …like your furnace... if it is working you don't go read the manual once a year. When the furnace breaks then you run around and figure out what is going on" (department chair #2). Physician leaders concede that the vast majority of physicians regard themselves as honourable and full of integrity and probably would not read a long policy document. Suggestions were made for a short description outlining the overall expectations, then directing them to the detailed information available on the website or in a pamphlet.

> When someone comes on staff they have a lot of other things to worry about - clinic, patients, their families and they're going to check off 'I read it', but they are not going to read it. (department chair #1)

Physician leaders felt having new staff and students sign an agreement would increase the likelihood of the documents being read. Moreover, participants reported that by having faculty and students read and agree to abide by the set of rules would provide physician leaders with a certain level of recourse when dealing with difficult situations. "I think when we come back and say, "Look you didn't follow these rules and you said that you would" (associate dean #1).

Participants all agreed that the existing standards are not shared effectively and that steps should be taken to ensure that faculty and staff are made aware of what the standards are and how to gain access to them.

> Just putting it on a website won't do it. Or putting it on a page and handing it out … or making it part of a package is not going to work. I think it either has to be a sit-down lecture module or in the case of staff every five years a web event that you have to go through. (associate dean #2)

Managing colleagues. Physician leaders commented that one of the biggest challenges is the fact that they are managing colleagues. Physicians pointed out that managing 'their own' is even more sensitive when working in a small department. "If it is a small department with only 10 people– it is very difficult" (department chair #2). They also noted that the situation can be awkward when the person displaying the disruptive behaviour is in an authority position. They felt if they had someone qualified and impartial outside their institution they could consult it would be more effective and efficient. One participant suggested creating an ombudsman position that concerned or affective parties could consult with for guidance and advice. Other participants were concerned about creating yet another position and more money for things that fortunately don't occur very often. A major concern for all physician leaders was finding solutions without unnecessarily creating additional layers of bureaucracy.

> We need written guidelines but we also need a sounding board that does not trigger an irreversible process. Does that mean it would be served by an ombudsman, or …are there ways of approaching this without having to have an office? (department chair #3)

Some physician leaders felt that many situations should be handled by the chief of staff. In many instances simply communicating with the person may be all that it takes.

> Sometimes it's just reinforcing that your next step is appropriate. As long as it's somebody you can trust. I don't think every time you go to see the chief of staff it has to be something that initiates an irreversible paper trail. (department chair #5)

Physicians said if the situation became larger in scope then the process would involve getting further assistance from other sources.

Physician leaders were adamant that whatever the issue related to disruptive behaviour "…do not let it go" (department chair #7). If the behaviour makes people feel uneasy or has generated uneasiness in the environment it should be dealt with as part of the prevention. "It is as complex as human nature can be. … One of the important elements is that you should not try to cover up. If it is very serious you have to send a signal to the disrupter" (department chair #7). Physician leaders agreed if it is not dealt with, the behaviour will reoccur. However, they were quick to point out that if there is a recurrence, then a clear choice and a pattern has been demonstrated.

Physician leaders said that how a situation is handled and which group you get involved to help all depends on 'who does what to whom'. Each case is different and it would be very difficult to have a 'one size fits all' system. One participant provided an example to explain his position:

> If a surgeon yells at the nurse in the OR that is dealt with by the OR committee. If that surgeon goes outside and yells at a pathologist, then that is no longer the OR committee that decides to suspend that surgeon. If this guy goes home and does something …now what do we do? I don't think it would all be very clear in the system we have now. (department chair #2)

Education. Physician leaders agreed that the solution to making the disruptive behaviour standards explicit is education. "It is my experience that many of these issues happen at low levels so there is an opportunity for education and resolution, conflict or escalation" (program director #3). It was suggested if physicians are permitted to get away with minor infractions they can become progressively more adversarial and disruptive. Participants suggested education should begin in medical school. Another strategy proposed was to focus and celebrate good behaviour in order to diffuse bad behaviour "so one can celebrate the positive" (department chair #6).

Although the general consensus was that education is the solution for preventing, reducing, and/or eradicating disruptive behaviour, the question of how to best design or implement an educational process remains. Physician leaders suggested the training could be web-based so that it is easy to access and that it must be mandatory. One participant suggested having a yearly online certification. Participants felt the online resource could be part of the re-certification along with individual performance reviews. "…make sure they were completing this code of conduct on a yearly basis and they know the expectations. So it goes back to educating them" (associate dean #1).

Another aspect of education discussed was the idea of encouraging physicians to 'whistle-blow' by anonymously reporting disruptive behaviour and being confident there will be no repercussions for them.

> I think it is really important to instill in the education program that we all have to be watchful and look out for one another and that there are no repercussion for someone that sees and reports something that they perceive is going against the code. (associate dean #1)

There was general agreement that physicians need to be educated on (a) how to access resources, (b) their mandate with regard to disruptive behaviour situations, (c) the complexity of related confidentiality issues, and (d) if they have an option to choose to get involved if they witness something disruptive.

Support mechanisms. Several physician leaders emphasized they felt they need tools, strategies and support systems that can be used to identify disruptive behaviour issues early and rectify situations before they escalate or cause a physician to loose their privileges and/or income. They explained the problem is that the policies become pretty generic in terms of 'what to do'. Specifically, participants reported they want clear step-by-step guidelines on how to handle situations as soon as they observe something or hear rumours. They want a checklist or a guideline to ensure they keep an accurate record, proper documentation and a clear outline for remediation. One participant stated what they need is "…very clear guidelines as to how to proceed with remediation, probation, and dismissal" (program director #4).

Physician leaders repeatedly emphasized the need for support mechanisms for physicians who were in trouble (psychological, psychiatric or emotional).

> …if the signs are there and the resources are not and then somebody snaps...threatening people. While we want to punish those people we have to be mindful that these people are in trouble and need help and we want to help them. (program director #3)

Physician leaders suggested having a website as a preventative strategy where you can quickly and conveniently access information such as who to call and what potential interventions are available. Participants pointed out that this kind of clear documentation would be helpful when dealing with awkward situations of disciplining their colleagues. "…it is helpful to just say, 'You know I'm really sorry but this is how I must proceed. These are the rules and this is what the faculty tells me I have to do" (associate dean #1).

Participants perceived that a lack of resources was one of the biggest problems associated with disruptive behaviours.

> It's one thing to talk about what's going wrong but it is another thing to be able to talk about how to make it right. There is little else in terms of resources for the individual to improve his anger management. That is a very shallow well to dip from and do an effective intervention. (associate dean #2)

Physician leaders provided more examples of the 'shallow well' syndrome. "There are conflict resolution courses offered once a year. So if you happen to get into trouble in September you have to wait until April to take a course. So it is that shallowness that...is so frustrating" (associate dean #2). Participants discussed the need to have enough resources to be proactive in order to be preventative.

Leadership development. Physician leaders reported that leadership plays a major role in ensuring disruptive standards are made explicit and that certain incidents are addressed immediately and in an appropriate fashion. Participants communicated there is no formal training to become a medical leader. "…we hand out these leadership positions and adopt them in ways that are seldom obvious. ... It is all hapless chance" (associate dean #2). Physician leaders emphasized that someone in a supervisory or directorship role needs a set of skills to perform effectively. Moreover, participants pointed out the need for financial support for leadership training. "So that each level of leadership [needs to be] given the time and resources necessary to acquire the skills for that position to make them more effective in terms of their role" (associate dean #2).

Finding the balance. Physician leaders pointed out that the landscape is changing with regard to accreditation standards and behaviours that are no longer acceptable. "We must maintain a learning environment that is conducive to learning. So even those 'one offs' or 'two offs' minor altercations or situations that are perceived as suboptimal

become significant…" (associate dean #1). Similarly, participants pointed out that a huge culture change has taken place with regard to disruptive behaviour during their careers and that the bar has been raised as to expectations and lowered with regard to what is tolerated.

> I started my training with people throwing their instruments across the room – that doesn't happen anymore. To have people screaming – that isn't tolerated anymore. …Maybe it is a societal change. As people in society we have far more sense and respect for each other (associate dean #2).

Conversely a couple of physician leaders cautioned against 'over-policing' resulting in regressing to the mean and the learning environment becoming bland and ordinary. Similarly, one physician worried that critical evaluation may become considered harassment. "My evaluation would become that I pass everybody. I'm a nice guy, so nobody's going to complain about me because I'm not going to do anything" (program director #4). Physicians were referring to the kind of behaviour that might be regarded as intimidating but helped the student perform better. "…we've gotten to the point that we're afraid to push because it's easier not to" (department chair #4).

Physician leaders agreed there was no problem with pushing students to do their best as long as it is done in a respectable manner that isn't condescending.

Participants acknowledged they live in an era with incredible scrutiny from students, patients, the public and the colleges. The need for a standardized approach, tools and documents are needed even more today than in the past in order to be accountable. "There are a lot of people outside who are watching who need to see that these [standards] are clear and that this is enforced" (program director #1).

Learning Experience Feedback Form

Generally, the findings from the *Learning Experience Feedback Form*, completed by the workshop participants, supported the findings of the prior focus group interviews. Moreover, the findings further identify and confirm the physician leaders' needs with regard to disruptive physician behaviour. Physician leaders found that the workshop dealt with many of the issues raised in the interviews. Overall, participants enjoyed the workshop and gained new knowledge, resources, and skills to help them manage disruptive physician behaviour. A summary of the Outcomes can be found in Appendix D.

4. Practical Implications

It is clear from the analysis of data from both the focus group interviews and the workshop that understanding and implementing disruptive behaviour standards is complex. The process is complicated because physicians belong to multiple organizations each with their own set of standards, policies and codes. Moreover, physician leaders admitted being unfamiliar with the existing standards, codes and policies, uncertain how to gain access to them, and unclear on the procedures and processes for implementing them. This finding supports Kaufmann (2005) on the importance of having a visible code of conduct and consulting physicians with regard to the development of it.

Physician leaders suggested it would be helpful to have an ombudsman position so that they could consult an expert for guidance without the threat of further proceedings. This view is supported by Pfifferling (1999) who advocates for "outside leverage" to begin the corrective process. Finally, participants pointed out that a huge culture change has taken place with regard to disruptive behaviour during their careers and that the bar

has been raised as to expectations and lowered with regard to what is tolerated. This finding reinforces reports regarding change in the healthcare workplace with regard to disruptive behavior and tolerance (Dunn et al., 2006; Leape & Fromson, 2006).

Health professionals strive to provide excellent service and are committed to meeting the needs of patients and families. Complementing this commitment, evidence has shown that healthy workplaces improve recruitment and retention, worker's health and well-being, quality of care and patient safety, organization outcomes, and societal outcomes (Shamian & El-Jardali, 2007). By sharing our findings related to the needs of physician leaders with regard to disruptive physician behaviour, we hope other physician leaders, administrators and healthcare institutions will benefit when planning and implementing policies, procedures and educational programs to assist with managing disruptive physician behaviour. These findings were also instrumental in guiding the design of the award winning bilingual online module to assist physician leaders in managing disruptive behaviour (http://ephysicianhealth.com/). The findings also demonstrated the importance of conducting a needs analysis and using a framework to guide the design, delivery and evaluation of effective online healthcare education. This is one small step toward healthcare providers and their patients being safer, staff satisfaction and retention improving, and consequently quality of care improving.

In conclusion, the following practical implications emerged from the findings of this study:

- Clarification on what disruptive behaviour is, details describing the rules and procedures for meeting acceptable professional expectations and behaviours and tools to be able to deal with a situation when an individual does not follow the rules are needed.
- Specific strategies for communicating and sharing expectations are needed.
- Support mechanisms for prevention and implementation are needed.
- Existing policies and procedures need to be synchronized and coordinated between and among existing organizations.
- Tools, strategies and support systems are needed to identify disruptive behaviour early and rectify situations before they escalated or cause a physician to lose his/her privileges and/or income.
- Clear guidelines on how to handle situations and an appropriate plan for remediation are needed.
- Make professionalism strategies part of undergraduate medical training.
- Physicians need to be educated on how to access resources, their mandate with regard to disruptive behaviour situations, the complexity of related confidentiality issues, and if they have an option to choose to get involved if they witness something disruptive.
- Education is the solution for preventing, reducing, and/or eradicating disruptive behaviour and could be web based or lecture and that it must be mandatory.
- A needs analysis is an important prerequisite to ensure online healthcare education resources address end users needs.
- Using a framework as a quality standard to guide the design, delivery and evaluation of online healthcare education will increase the likelihood of success.

References

1. Bogdan, R.C., & Biklen, S.K. (1998). *Qualitative research for education* (3rd ed.). Toronto: Allyn & Bacon.

2. College of Physicians and Surgeons of Ontario and Ontario Hospital Association. (2008). *Guidebook for managing disruptive physician behaviour*.

3. Dunn, P., Arnetz, B., Christensen, J., & Homer, L. (2007). Meeting the imperative to improve physician well-being: Assessment of an innovative program. *Journal of General Internal Medicine, 22(1),* 1544-1552.

4. Hickson, G., & Etman, S. (2008). Physician practice behaviour and litigation risk: Evidence and opportunity. *Clinical Obstetrics and Gynecology*, *51(4),* 688-699.

5. Kaufmann, M. (2001). Recognition and management of the behaviourally disruptive physician. *Ontario Medical Review*, *68(4),* 53-55.

6. Kaufmann, M. (2005). Management of disruptive behaviour in physicians: a staged, rehabilitative approach. *Ontario Medical Review, 72(10),* 59-63.

7. Leape, L., & Fromson, J. (2006). Problem doctors: Is there a system-level solution? *Annals of Internal Medicine, 144,* 107-115.

8. MacDonald, C.J., Stodel, E.J., Thompson, T-L., & Casimiro, L. (2009). W(e)Learn: A framework for interprofessional education. *International Journal of Electronic Healthcare*. *5(1),* 33-47.

9. MacDonald, C.J, Stodel, E.J., & Coulson, I. (2004). Planning an eLearning dementia care program for healthcare teams in long-term care facilities: The learners' perspectives. *Educational Gerontology: An International Journal, 30(10),* 1-20.

10. MacDonald, C.J, Stodel, E.J., Farres, L.G., Breithaupt, K., & Gabriel, M.A. (2001). The Demand-Driven Learning Model: A framework for web-based learning. *Internet and Higher Education, 4(1),* 9-30.

11. Merriam, S.B. (1998). *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass.

12. Pfifferling, J. (1999). The Disruptive Physician: A Quality of Professional Life Factor. *Physician Executive, 25(2),* 56-61.

13. Physician Management Institute. (2009). *Managing disruptive physician behaviour*. Ottawa, Canada.

14. Royal College of Physician and Surgeons of Canada. (2009). *The CanMEDS Physician Competency Framework*. Available from the Royal College of Physician and Surgeons of Canada Web site, http://rcpsc.medical.org/canmeds/index.php.

15. Rosenstein, A. (2002). Nurse-physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing, 102(6),* 26-34.

16. Rosenstein, A., & O'Daniel, M. (2005). Disruptive and clinical perceptions of nurse –physician relationships. *American Journal of Nursing, 105(1),* 54-64.

17. Rosenstein, A., & O'Daniel, M. (2008). Managing disruptive physician behaviour: Impact on staff relationships and patient care. *Neurology, 70,* 1564-1570.

18. Ross, I., Taylor, L., & Canady, J. (2009). The disruptive physician: Righteous maverick or dangerous pariah? *Plastic and Reconstructive Surgery, 123(1),* 409-415.

19. Shamian, J., & El-Jardali, F. (2007). Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice. *Healthcare Papers*, *7*, 6–25.

Appendix A

1. How do you define or understand disruptive behaviour?
2. Should there be a LHIN-wide standardized approach to Disruptive behaviour? If so, how should it be funded? Does your department or institution have a code of professional conduct for physicians?
3. How is this code shared with and agreed upon by physicians?
4. How are violations of the code managed? Is there a policy/procedure to guide your efforts?
5. What resources are available to you to help identify, manage, and rehabilitate, a colleague with disruptive behaviour? Which of these resources have you used?

Appendix B

Learning Experience Feedback Form

The information you provide here will be kept completely confidential. Results will be reported in a group format and no individually identifying information will be included. Only the Evaluation Team will have access to this information.

To put our data into context, please tell us your role_____

Please rate how much you agree or disagree with the following statements by circling the answer that best reflects your experience with the Disruptive Behaviour Workshop:

	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
Content					
The objectives of the workshop were made clear.	1	2	3	4	5
The workshop was well organized.	1	2	3	4	5
The workshop was too long.	1	2	3	4	5
The workshop was of appropriate depth and breadth.	1	2	3	4	5
The workshop was relevant to my job.	1	2	3	4	5
The workshop included information that I will find useful when dealing with disruptive behaviour in the workplace.	1	2	3	4	5

	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
The workshop included information that I will be able to use to deal with situations at work.	1	2	3	4	5
The workshop contained an appropriate number of team activities.	1	2	3	4	5
The workshop had strong links between theory and practice.	1	2	3	4	5
The workshop addressed learning situations similar to those I face at work.	1	2	3	4	5
The workshop covered current best practices in disruptive behaviour.	1	2	3	4	5
The workshop presented current research on disruptive behaviour practice.	1	2	3	4	5
Delivery					
I received useful feedback from the facilitators.	1	2	3	4	5
I received useful feedback from the other participants in the workshop.	1	2	3	4	5
There was direct interaction with the facilitators.	1	2	3	4	5
The workshop was presented in an interesting manner.	1	2	3	4	5
The workshop was presented in an interactive manner.	1	2	3	4	5
I received regular feedback on my progress throughout the workshop.	1	2	3	4	5
The choice of technological tools included in the workshop facilitated my learning.	1	2	3	4	5
The choice of technological tools included in the workshop supported the workshop objectives.	1	2	3	4	5
There was sufficient variety in the way the content was presented.	1	2	3	4	5
Service					

	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
Registration for the workshop was convenient.	1	2	3	4	5
The facility where the workshop was held was appropriate.	1	2	3	4	5
The food and beverages at lunch and breaks met my expectations.	1	2	3	4	5
I received sufficient information about the workshop before I arrived.	1	2	3	4	5
Facilitators responded quickly to suggestions made by the learners.	1	2	3	4	5
Facilitators responded quickly to complaints made by the learners.	1	2	3	4	5
Facilitators were knowledgeable about disruptive behaviour.	1	2	3	4	5
Structure					
The workshop respected my current knowledge and experience.	1	2	3	4	5
The workshop kept my interest.	1	2	3	4	5
The workshop built my confidence in understanding how to deal with disruptive behaviour.	1	2	3	4	5
The workshop built my confidence in understanding the elements of disruptive behaviour.	1	2	3	4	5
The workshop contained realistic and relevant examples/cases.	1	2	3	4	5
The workshop allowed my opinions to be considered.	1	2	3	4	5
There was a positive learning environment.	1	2	3	4	5
The expectations were made clear.	1	2	3	4	5
There were opportunities for self-reflection.	1	2	3	4	5

	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
There were opportunities for self-evaluation.	1	2	3	4	5
The evaluation exercises highlighted the steps I must take to further my learning.	1	2	3	4	5
Outcomes					
I enjoyed the experience.	1	2	3	4	5
I learned strategies to deal with colleagues/staff members who display disruptive behaviour.	1	2	3	4	5
I have gained new knowledge about disruptive behaviour.	1	2	3	4	5
As a result of participating in this workshop I can accurately define disruptive behaviour.	1	2	3	4	5
As a result of participating in this workshop I can use common language related to disruptive behaviour.	1	2	3	4	5
As a result of participating in this workshop I can access resources that will help me resolve any conflicts that may occur with my colleagues/staff.	1	2	3	4	5
As a result of my participation in this workshop I will apply new knowledge and skills in my workplace.	1	2	3	4	5
As a result of participating in this workshop I can explain the strategies for dealing with disruptive behaviour with my colleagues.	1	2	3	4	5
As a result of participating in this workshop I know the steps I should take if I see signs of disruptive behaviour in the workplace.	1	2	3	4	5
As a result of my participation in this workshop I will initiate new ideas and/or projects in my workplace.	1	2	3	4	5
As a result of my participation in this workshop I will request changes be made in my organisation.	1	2	3	4	5

Complete the following statements/questions:

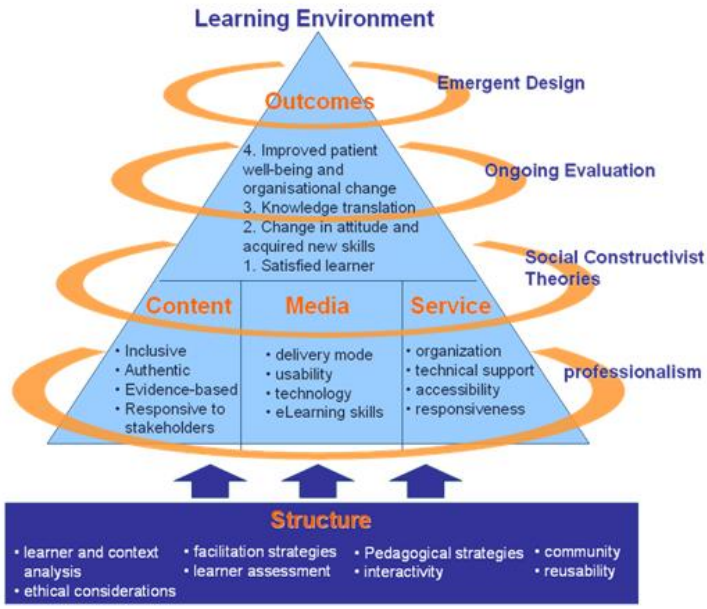
1. The two most important things I learned during the workshop were

2. As a result of participating in this workshop I will try to incorporate the following into my practice/work…
3. The workshop could be improved by…
4. I found the workshop learning activities to be…
5. Would you recommend the workshop to other health professionals? Why or Why not?
6. Would you like to the information and resources from the workshop available to you and your staff/colleagues online?
7. If so, what features should an online program have?

THANK YOU for your time and feedback.

Appendix C

The W(e)Learn Framework (MacDonald et al., 2009)



Appendix D

Table 1. Participants' responses to the outcome items in the Learner Experience Feedback Form (N=20).

	Min[a]	Max	Mean	SD
I enjoyed the experience.	4	5	4.55	.510
I learned strategies to deal with colleagues/staff members who display disruptive behaviour.	3	5	4.25	.550
I have gained new knowledge about disruptive behaviour.	3	5	4.25	.639

As a result of participating in this workshop I can accurately define disruptive behaviour.	3	5	4.05	.510
As a result of participating in this workshop I can use common language related to disruptive behaviour.	3	5	4.00	.577
As a result of participating in this workshop I can access resources that will help me resolve any conflicts that may occur with my colleagues/staff.	3	5	4.11	.567
As a result of my participation in this workshop I will apply new knowledge and skills in my workplace.	3	5	4.21	.535
As a result of participating in this workshop I can explain the strategies for dealing with disruptive behaviour with my colleagues.	4	5	4.05	.229
As a result of participating in this workshop I know the steps I should take if I see signs of disruptive behaviour in the workplace.	3	5	4.16	.501
As a result of my participation in this workshop I will initiate new ideas and/or projects in my workplace.	3	5	4.11	.737
As a result of my participation in this workshop I will request changes be made in my organisation.	3	5	4.16	.688

[a]Response options: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

*Local Health Integration Networks (LHIN) are non-profit organizations that work with regional health providers (hospitals, healthcare centres, long term care facilities, etc.) to plan, integrate, and fund their service priorities.