Ethical Management of Disrespectful, Disruptive, Uncivil, and Unethical Colleagues: Consequences for Patient Safety, Health Care Team Wellness and Morale, and Workplace Retention

Under normal circumstances, health care professionals treat one another with genuine respect so as to promote an environment of collegial cooperation. However, occupational therapists and occupational therapy assistants may sometimes practice their profession under adverse conditions when health care professionals show a lack of respect for one another. At the extreme of disrespectful conduct is brazenly disruptive and uncivil behavior. This type of interaction can cause workplace chaos by undermining health care team effectiveness, client or patient safety, and practitioner morale and wellness (Rosenstein & O’Daniel, 2008).

This Advisory Opinion addresses the nature and causes of disrespectful, disruptive, uncivil, and unethical behavior by health care practitioners. Consequences of such behavior for health care organizations, practitioners, and clients are discussed. Recommendations are made for the ethical management of these behaviors, including guidance from the Occupational Therapy Code of Ethics (2015) (referred to as the “Code”; American Occupational Therapy Association [AOTA], 2015) and additional strategies to address these issues. In rare cases, employment termination may be the only justifiable management action to preserve organizational integrity and a culture of safety.

DEFINITION

How is disruptive behavior defined? The Joint Commission (2008) described disruptive and intimidating behavior as including “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities” (p. 1). Of course, most definitions of disruptive behavior acknowledge that these behaviors should be viewed along a spectrum of frequency and intensity (American Medical Association [AMA], 2009). Such behaviors are often habitual and can adversely affect information transfer, which makes it difficult for health care teams to work
together in an effective manner. This problem can lead to substandard care. The Joint Commission (2008) went so far as to assert that “all intimidating and disruptive behaviors are unprofessional and should not be tolerated” (p. 1). However, the AMA reminds us that “criticism that is offered in good faith with the aim of improving care” (p. 2) should not be considered disruptive behavior.

UNDERMINING BEHAVIORS
Instances of health care practitioners, including occupational therapy personnel, being verbally intimidated, abused, threatened, or assaulted by other health care practitioners have been well documented in the literature (DuPree, Anderson, McEvoy, & Brodman, 2011; Leape & Fromson, 2006; Leape et al., 2012a, 2012b; Porto & Lauve, 2006). Disruptive behaviors by occupational therapy and other health care practitioners affect safe and effective care of clients. In the past, such behavior was often tolerated when the practitioner was particularly talented or was a high revenue generator for the health care organization (Porto & Lauve, 2006; Sutton, 2007). However, as the patient safety movement gained momentum in the early 2000s, research studies and journal articles began to appear in the literature demonstrating that disruptive behaviors were a serious threat to client or patient safety and quality assurance (DuPree et al., 2011; Leape & Fromson, 2006; Leape et al., 2012a, 2012b; Porto & Lauve, 2006; Rosenstein & O’Daniel, 2008; Saxton, Hines, & Enriquez, 2009).

This issue has drawn the attention of the Joint Commission, which accredits and certifies health care organizations and programs in the United States. The Joint Commission (2012a) developed Standard LD.03.01.01, which requires, among other rules, that leaders create and maintain a culture of safety and quality by mandating development of a code of conduct defining behaviors that undermine safety, a process for managing these behaviors, and the establishment of a team approach for staff.

Disruptive behaviors include both overt and passive actions. Overt behaviors include shouting, swearing, throwing objects or slamming doors, arguing inappropriately, being rude or bullying, interrupting or talking over someone, and violating physical or sexual boundaries (Leape et al., 2012b). The most egregious behavior is an assault—that is, exhibiting such threatening behavior toward another person that he or she experiences significant fear of bodily injury or some other severe harm. More subtle behaviors, such as humiliation, belittlement, crude
or racially motivated jokes, and dismissive insults, also are overt.

Power differentials between colleagues can also be disruptive. A higher status person may try to wield unjustified power over a lower status person (Sutton, 2007). In the practice of health care, passive disruptive behaviors include deliberate refusal to answer or delay in answering colleagues’ or subordinates’ pages, messages, or real-time questions; refusal to take on certain tasks for the purpose of annoying; delegation of demeaning tasks in lieu of normal duties; or resistance to any form of collaboration or cooperation (Joint Commission, 2008; Leape et al., 2012b).

An offending colleague who is impulsive, callous, harassing, or narcissistic can often create situations in which other practitioners fall prey to these behaviors. Colleagues who exhibit such behaviors may have low self-awareness and a lack of emotional intelligence (Goleman, 1998). Feeling the brunt of this kind of anticollegial behavior can siphon warmth and kindness from even the most empathetic, compassionate, and caring practitioner. Likewise, working in an environment in which these behaviors become routine may lead to diminishment of the joy and fulfillment in a practitioner’s health care vocation, which gives meaning to his or her life and that of others.

**CONSEQUENCES FOR PATIENT SAFETY, HEALTH CARE TEAM WELLNESS AND MORALE, AND WORKPLACE RETENTION**

There are many aftereffects of disruptive behaviors, such as the impact on health care team wellness. Practitioners may experience physiological and psychological effects, such as headaches, sleep disturbances, depression, and burnout (Munoz & Silva, 2012). High levels of stress and other health symptoms can trigger visits to the physician or a counselor or require use of over-the-counter or prescription medications.

Practitioners who routinely medicate may themselves become impaired in their ability to care for patients. Practice while impaired is a safety hazard for patients and also a violation of Principles 2A and 2C of the Code, which states that occupational therapy personnel shall “avoid inflicting harm” (AOTA, 2015, p. 3) as well as “take appropriate action to remedy personal problems and limitations that might cause harm to recipients of service, colleagues . . . or others” (p. 3).

Disruptive behavior also greatly inhibits effective teamwork because it causes a lack of
colllegiality, cooperation, and respectful communication. Conduct and accountability are important for accurate information transfer, collaboration, and healthy workplace relationships (Rosenstein & O’Daniel, 2005). Suppressing communication from others undermines a culture of safety, resulting in client or patient harm. Imagine an attending physician was accusatory and verbally abusive to an occupational therapist for calling at night. A likely outcome would be that the patient’s condition was not addressed, and there was no follow-up by the physician as promised, which resulted in delayed wound care and severe sepsis. As this example illustrates, it is easy to understand why faulty communication is considered one of the top root causes of substantial harm or death to patients (Joint Commission, 2013).

Furthermore, disruptive behavior can affect job satisfaction and workplace retention. Researchers have found a significant correlation between verbal abuse and the intent to look for another job or tender resignation (Sofield & Salmond, 2003). Finally, high staff turnover is costly to the organization.

**MANAGEMENT OF DISRUPTIVE COLLEAGUES**

Regardless of the etiology of disruptive behavior, its curtailment is necessary for well-functioning health care delivery. It is imperative that occupational therapy practitioners are provided with guidelines, strategies, education and training, resources, and administrative support to ethically manage disruptive colleagues, to maintain a civil workplace, and to foster a culture of safety. After all, it is the practitioner’s ethical obligation and duty to ensure the safety and well-being of his or her patients.

Ethical management includes guidance from codes of ethics, codes of conduct, policies and procedures, and reporting mechanisms. Strategies and methods, such as transformational learning through remediation, retraining, and behavior modification coaching, can be effective in addressing disruptive behavior (see Exhibit 45.1). These management approaches can also be used in academia, where there is a dearth of information on how to deal with disruptive behaviors that occur between colleagues who educate students in occupational therapy programs.

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1 *Transformational learning* is a process whereby practitioners learn to change their “meaning schemes (specific beliefs, attitudes, and emotional reactions)” (Mezirow, 1991, p. 167) by engaging in critical reflection on their experiences and actions, which, in turn, leads to a perspective transformation. Transformational learning can also be the experience of being able to shift basic premises of thought and emotion by “undoing” or “reversing” racial and gender bias, sexism, and other oppressive attitudes and uncivil behaviors that disrupt the workplace.
Exhibit 45.1. Examples of Transformational Learning Programs to Curtail Disruptive Behavior

**Communication and teamwork training** programs have been developed to assist practitioners in improving communication and teamwork skills. One well-known program developed by the U.S. Department of Defense and the Agency for Healthcare Research and Quality is called TeamSTEPPS (Agency for Healthcare Research and Quality, 2013). This program is known to foster highly effective communicative, collaborative, and civil teams. Health care practitioners learn fundamental skills to bring about a nonantagonistic environment in which safer client care can be delivered. Another popular communication program, SBAR: Situation, Background, Assessment, Recommendation (Safer Healthcare, n.d.), is used to support the principles of teamwork and collaboration in regard to roles, responsibilities, trust, and active involvement to foster patient safety.

**Remediation and retraining** programs have emerged that offer nonstigmatizing interventions, remediation, and transformative learning for noncompliant and habitually disruptive team members (Samenow et al., 2013, p. 118). Several of these programs, such as the ACEP ProBE Program (Center for Personalized Education for Physicians, n.d.), are educational intervention in ethics programs with an emphasis on disruptive behavior. Educational programs are regularly provided in several geographic locations throughout the United States. They were originally developed for physicians but now serve health care professionals from all disciplines, including occupational therapy.

**Behavior modification coaching and anger management** have been shown to have promise for practitioners who require remediation. Coaching with behavioral strategies helps practitioners make long-term behavioral change. Two programs are the AIMS: Anger Intervention and Management Services (American Association of Anger Management Providers, n.d.) and the PACE Anger Management Program for Healthcare Professionals (Physician Assessment and Clinician Education Program, n.d.). The AIMS program provides assessments designed to determine each client’s functional skill level for anger, stress, communication, personal change orientation, and emotional intelligence. After the assessment, an individualized goal and coaching action plan is developed. The PACE program includes empathy and emotional intelligence training, education in transforming conflict into cooperation, behavioral and coping mechanisms, and the development of a personalized plan of action for committing to change.

*Note.* None of the programs listed in Exhibit 45.1 is endorsed by AOTA. Rather, they are examples of programs that have been used by several licensure boards, professional organizations, and health care professionals.

**PROFESSIONAL CODES OF ETHICS**

Disruptive behavior can create situations in which an ethical problem or dilemma arises. For example, an occupational therapist may lose concentration and focus while being harassed or
badgered by a disruptive colleague and subsequently make a mistake that harms a client. Likewise, the aggrieved provider, because of anxiety and apprehension, may fail to speak up about an observed or potential patient safety issue because of fear of eliciting a verbal outburst that might result in ridicule, reprisal, or worse.

Principle 6 of the Code clearly states that “occupational therapy personnel shall treat . . . colleagues, and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p. 7.) Codes of ethics for other healthcare professions likewise have provisions in their documents that provide directives for collaboration, respectfulness, and integrity in relationships with colleagues and other health care professions (AMA, 2012; American Nurses Association, 2010; American Physical Therapy Association, 2010).

ORGANIZATIONAL SYSTEMS

In 2009, the Joint Commission (2012b) developed an accreditation standard addressing the need for health care organizations to develop a code of conduct, a reporting and surveillance system, and zero-tolerance policies and procedures with clear definitions for acceptable, disruptive, and inappropriate behavior. According to Principle 4L of the Code, occupational therapy personnel should “collaborate with employers to formulate policies and procedures in compliance with legal, regulatory, and ethical standards and work to resolve any conflicts or inconsistencies” (AOTA, 2015, p. 5).

The Code provides guidance to the profession to ensure that the development of a code of conduct or policies and procedures in the organization supports appropriate behaviors that align with principles in this document. For example, Principles 4E (Justice) and 6J (Fidelity) require adherence to professional standards and practices. Principle 4E involves maintaining “awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (p. 5). Principle 6J involves using “conflict resolution and internal and alternative dispute resolution resources as needed to resolve organizational and interpersonal conflicts as well as perceived institutional ethics violations” (p. 7).

Finally, transformational training and coaching intervention programs (see Exhibit 45.1) can be used to foster practitioners’ recognition, awareness, and modification of disrespectful and disruptive behavior as well as improve their communication skills.
**DISPUTE RESOLUTION AND MEDIATION**

Principle 4K of the Code clearly states that occupational therapy personnel should “report to appropriate authorities any acts in practice . . . that are unethical or illegal” (AOTA, 2015, p. 5). The responsibility to report is part of the self-regulation mandate of being a professional. Reporting can provide the impetus for a supervisor or other administrator to intercede. In this regard, as noted above, Principle 6J provides guidance by encouraging “use of conflict resolution and internal and alternative dispute resolution resources . . . to resolve organizational and interpersonal conflicts as well as perceived institutional ethics violations (p. 7).

Conciliation between the parties to the disputes can include mediation. Many organizations have human resources departments that provide effective employee mediation and arrange for a qualified and neutral contact person to coordinate the mediation. A neutral mediator facilitates a mutually agreeable solution to a dispute, as crafted by the parties themselves. A guiding principle of mediation is respect for the disputants. Mediation is particularly useful when the issues are complicated by a strong emotional event, when maintaining a professional or work relationship with the other party is important, when the parties doubt their own ability to work out the problem, or when many people are involved or indirectly affected (Kovach, 2010; Nolan-Haley, 2013).

An advantage to mediation is that what transpires during the session is kept confidential. Each party is given a chance to tell his or her story from his or her own perspective without interruption. This allows each party to hear and learn how the other sees things. The mediator helps the parties identify their respective interests and encourages them to avoid taking positions while disentangling relationship issues from substantive ones (Kovach, 2010). As each party has a chance to express his or her point of view, the mediator listens for points of commonality. The objective is to help the parties identify options that are mutually agreeable while also addressing their respective interests (Kovach, 2010).

**CASE 1: LAUREN AND JILL**

Jill is a tenured occupational therapy professor who has been routinely criticized for being too harsh on students. In addition, students are not doing well on the National Board for Certification in Occupational Therapy (NBCOT®) exam in the content area in which Jill is
responsible for teaching.

Jill regularly invites guest lecturers to speak in the foundational course she teaches in a master’s occupational therapy program. For the past several years, Jill has invited Lauren, a junior, nontenured faculty member in her department, to guest lecture in the course. Even though Lauren receives complimentary verbal feedback from the students on her lectures and has good faculty evaluations, Jill has been critical and dismissively rude to her about her teaching approaches and once aggressively challenged her innovative ideas openly in a faculty meeting. Since the first time Lauren lectured in the class, Jill has not observed her subsequent lectures. Lauren, however, always provides lecture content to Jill either before or after the lecture and contributes exam questions for the course.

This year, Lauren was informed that the students would be tested on the content she taught the day after her lecture. As a result, she verbally reviewed exam questions at the end of her lecture. Lauren felt this was an appropriate teaching and learning strategy, because she knew the students had just been exposed to the new content and would be tested on it the following day. After class, Jill saw a student in the hallway and inquired about the lecture. The student reported that class was “great,” because she had all the answers to the questions for the upcoming exam. Jill inquired further, and the student revealed that Lauren had verbally reviewed the exam questions. On the morning of the exam, without speaking to Lauren, Jill wrote an email to several department members about what she thought had occurred. She accused Lauren of being an incompetent educator and of not caring about student learning or the educational standards of the department or the institution. She further accused Lauren of engaging students in “academic dishonesty” by verbally reviewing her own exam questions with them. Later that day, Jill confronted Lauren in a public hallway while Lauren was speaking to other faculty members. Lauren asked to have the discussion at a later time. Jill pointed her finger at Lauren and forcefully stated that she didn’t have time to discuss this later and the discussion would occur now.

While still in the public hallway, Jill began with the same accusations she had included in the email, verbally berating Lauren for the teaching strategy she had chosen. Although Jill stated that she wanted to discuss Lauren’s concerns, her body language, dismissive gestures, and finger pointing did not match her actions. Jill offered Lauren the opportunity to provide her side of the story but didn’t listen and continued to make accusations. Jill raised her voice during this interaction and appeared to be disinterested in Lauren’s rationale for the use of question review at
the end of the lecture. Jill stated that she had removed all of Lauren’s questions from the exam and would not be evaluating students’ knowledge on the content that Lauren had taught.

Jill further stated that she would be taking this situation to the department chair and did not know whether she would allow Lauren to teach in her course for the remainder of the semester. Lauren asked Jill what she could do to rectify the situation. Jill neither answered nor appeared interested in problem resolution, rather exerting her power and remaining inflexible to Lauren’s attempt at reparation and compromise. The next day, the department chair became aware of the conflict after a couple of faculty members who witnessed Jill’s angry outburst in the hall notified her. Jill’s email to several faculty members, which was filled with criticism of Lauren, was forwarded to the chair by other concerned faculty members.

Analysis

Principle 2 of the Code (Nonmaleficence) can be of guidance in this case; it states that “occupational therapy personnel shall refrain from actions that cause harm” (AOTA, 2015, p. 3). The principle of Nonmaleficence is grounded in the practitioner’s responsibility to refrain from causing harm, inflicting injury, or wronging others.

Jill tried to intimidate Lauren by using accusatory gestures, angry intonation, and a power play. Jill, a tenured faculty member, tried to use the imbalance in power to her advantage, preying on what she perceived as a weaker, nontenured faculty member. She purposefully demeaned and openly humiliated Lauren in front of other faculty members in a public hallway.

Principle 6, Fidelity, states that “occupational therapy personnel shall treat . . . colleagues and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p. 7). Jill demonstrated a lack of respect and discretion by speaking to Lauren in front of other faculty members. Principle 2F (Nonmaleficence) also addresses the need to avoid situations in which “a practitioner [or] educator . . . is unable to maintain clear professional boundar- ies” (p. 3). Jill has certainly crossed boundaries by using threatening, angry statements and finger-pointing gestures with a faculty colleague and fellow employee.

Jill also has been publically critical and dismissive of Lauren’s teaching approach during some past faculty meetings. It is clear that the departmental administration should intervene, given the nature of these disruptive and intimidating behaviors. Principle 6J of the Code provides guidance by encouraging “use of conflict resolution and internal and alternative dispute resolution resources
as needed to resolve organizational and interpersonal conflicts” (AOTA, 2015, p. 7).

To address and possibly resolve this conflict, the department administrator decided to meet first with Jill and Lauren individually. Information garnered from these meetings could help the administrator gain perspective and manage the dispute. It was apparent from the first meeting that Jill felt threatened. Lauren signified in the meeting that she was willing to write the exam questions after rather than before her next scheduled lecture to ensure that no exam questions would be reviewed. In addition, Lauren indicated that if Jill preferred, she could prepare the lecture materials, handouts, and PowerPoint presentations for the upcoming lectures and provide them to Jill to present herself.

However, when the three meet together to attempt resolution, Jill ignored Lauren’s efforts at cooperation and deescalation. At this point, the department administrator was responsible for reminding Jill that there is zero tolerance for disruptive behaviors in the organization and that she is accountable for her inappropriate behavior. In such instances, Principle 1 (Beneficence) of the Code can be a guide by stating a concern for personnel well-being, including protecting and defending the rights of others. In this situation, the department administrator must take action to protect the rights of the publicly intimidated and humiliated faculty member. Justice, as defined in Principle 4, sets the parameters for promoting fairness and equitable and appropriate treatment of people with whom one interacts.

In this case, various codified guidelines can help define acceptable behavior standards and support ethical decisions in the determination of appropriate action. Although Jill might have had various mitigating circumstances (e.g., poor student performance on the NBCOT exam) that elicited anxiety and distress, these do not justify disrespectful, disruptive, or uncivil behavior directed toward a colleague. Because Jill has been known to exhibit this behavior on several occasions, a formal and clearly outlined corrective action plan must be implemented by the department administrator. It would be beneficial for Jill to learn and implement strategies to help her manage anxiety, express emotions appropriately, and prevent inappropriate or disruptive behavior.

A remediation option would give Jill the opportunity to participate in a transformational learning program (see Exhibit 45.1). Studies have shown that people who participate in a transformational learning program benefit from this type of intervention to foster professional behaviors and constructive interactions (see, e.g., Samenow, et al., 2013). Of course, an
alternative to remediation is employment termination. However, intervention and commitment to change are more desirable.

CASE 2: SHEILA AND MARGARET

Margaret, an experienced occupational therapist, has been a clinical supervisor for the past 15 years. Although a competent clinician, she has a reputation for being particularly hard on students and new graduate practitioners. Her colleagues report that she tells many students and newly minted therapists that they are not a good fit for the profession and that she has doubts in their ability to practice competently. She is proud of her behavior because she feels she has a professional duty to weed out inferior and incompetent practitioners to protect patients.

A notable incident involved Sheila, a recent graduate from the state university’s master of occupational therapy program. At the beginning of her employment, Sheila was given just 2 days of orientation with Margaret and another therapist, who observed her as she treated patients, after which she was given a full caseload.

Within weeks, it became apparent that Margaret was giving Sheila a difficult time. Margaret seemed to lack understanding of entry-level skills: Her expectations were high but unrealistic, and her criticism was too harsh. During a treatment team meeting, Sheila was presenting a case, and Margaret ridiculed her in front of her colleagues. There was an incident in which Sheila was working with a patient and explaining the treatment plan. Margaret, who was observing, interjected her opinion about the treatment plan in front of the patient. This outburst humiliated Sheila and caused the patient to lose trust and confidence in her; the patient subsequently requested another therapist. Sheila explained to Margaret that the treatment proposed was in line with current standards and evidence-based practice. Margaret scoffed and countered that she had been practicing for 25 years and her patients recovered just fine and that this was just something Sheila had learned in school that did not apply in the “real world.” Margaret told her that she was “below average for an entry-level practitioner.”

Sheila continued to receive discouraging comments and destructive criticisms from Margaret, such as, “I think you have a comprehension problem.” In addition, Margaret kept on questioning Sheila’s intelligence with disparaging comments, such as, “How did she get to this clinical level?” It became apparent to several department members that Sheila’s self-confidence was suffering from Margaret’s “supervision” and that this was interfering with her performance. Margaret was
overheard talking to her fellow coworkers in the lounge, complaining about Sheila and doubting that she could pass her probationary period. This situation had fractured the department and caused a decline in morale, but no one had confronted Margaret about her toxic and destructive behavior. A few of Sheila’s colleagues went to the executive director of patient services to complain about Margaret’s overbearing behavior and their positive observations regarding Sheila’s knowledge and skills. However, after the executive director spoke with Margaret, Margaret retaliated against the employees she thought went above her.

Analysis

Margaret’s intimidation of Sheila seems to be a well-honed pattern of behavior. Margaret has enjoyed her senior clinician status and asserts her power over those who are new or less experienced. She has demonstrated a consistent and intentional pattern of harassment by making demeaning remarks to novices regarding her doubt as to their ability to practice competently and even has insinuated that the novice may not be a good fit for the profession. Margaret is exhibiting inappropriate behaviors lacking in fidelity. This action violates Principle 6 of the Code, which addresses fidelity as it relates to collegial relationships. The Fidelity principle specifically states that “occupational therapy personnel shall treat . . . colleagues and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p.7). Principle 6L provides guidance to occupational therapy personnel to “refrain from actions that reduce the public’s trust in occupational therapy” (p. 7). Margaret’s intimidating and derogatory comments in front of a patient regarding Sheila’s treatment approach resulted in the patient losing trust and asking that services be provided by another therapist. In addition, questioning Shelia’s intelligence is a hindrance to performance, and the derogatory comments are untrue, with no evident basis in fact. Principle 5G (Veracity) specifies that “occupational therapy personnel shall be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance” (p. 6).

Several of Sheila’s colleagues think the overt performance criticisms and prejudgment of students and entry-level practitioners are destructive and unfair. They view Margaret’s performance evaluation as biased, subjective, and not grounded in fact. Margaret has been modeling poor behaviors instead of mentoring and supervising. She is viewed as irresponsible and shortsighted for not fostering professional growth and development and is not meeting the requirements of her job. Margaret’s colleagues think the unwarranted performance criticisms and
intimidating behaviors have fractured the department’s morale, which has resulted in job
dissatisfaction and poor retention of qualified personnel. The resulting high employee turnover
has cost the organization not only in productivity and monetary terms but in health care team
wellness and effectiveness.

Because Margaret has been known in the past to retaliate if she believes someone has
complained about her, her coworkers are afraid to report these behaviors. If employees cannot be
empowered by the organization’s leadership to do the right thing by requesting that disruptive
behavior be addressed, then these behaviors will result in entrenched and intractable problems that
undermine teamwork effectiveness, patient safety, and job satisfaction. Development of an
organizational process to address these issues and support appropriate employee conduct is
critical.

In the case of Sheila, the executive director must ensure adherence to the Code and to ap-
propriate organizational policies and procedures to manage disruptive behavior effectively. A
code or policy is effective only if supported at the highest level of the organization. Therefore, the
executive director must proactively and immediately respond to and investigate complaints.
Effective surveillance mechanisms are needed to affirm or deny disruptive behaviors. If such
behavior is confirmed, a performance improvement plan with clear timelines and expectations
must be developed. Consequences of failure to meet the expectations should also be clearly
defined. Finally, all health care team members should be given the opportunity to be properly
trained and remediate deficiencies before employment termination is considered (see Exhibit
45.1).

CONCLUSION
The key to curtailing disrespectful and disruptive behaviors is to follow the Code; institute an
organizational zero-tolerance policy; and garner administrative support for building a culture of
respect, civility, and safety. Failure to do so can create significant consequences that are
detrimental to occupational therapy personnel’s well-being, patient care outcomes and safety, and
job retention and satisfaction. In the end, ethically managing disruptive behaviors can lead to
significant personal, collegial, and patient benefits.
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