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Responding to Behaviors that Undermine a Culture of Safety

CME Information

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Learning Objectives

The case studies and risk management recommendations presented in this CME enduring material will support your ability to:

- Identify and respond to physician behaviors that undermine safety in the healthcare setting
- Access resources for managing physician stress, anger and drug or alcohol problems

Target Audience

Healthcare providers, medical executive committees, hospital administrators

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Introduction

Disruptive behavior by professionals in the healthcare setting is well documented as a serious threat to quality care and patient safety. The stress, anger and frustration resulting from such behavior can impair concentration, impede communication and negatively affect staff relationships, undermining coordination and collaboration within the healthcare team.[1] A recent survey conducted by the American College of Physician Executives found that 97% of the physician and nurse respondents had experienced problematic behavior in the workplace, most commonly including raised voices, swearing, inappropriate joking, degrading comments and refusal to work collaboratively.[2] A 2003 Institute for Safe Medication Practices (ISMP) survey reported that almost half of the respondents felt they had been pressured to dispense or administer a drug that negatively impacted patient safety; and 40% of respondents reported having been intimidated into silence about questionable medication orders from a physician who had a reputation for abusive behavior.[3] In another study, 17% of hospital staff had personal knowledge of an adverse event occurring because of disruptive behavior.[4] To ensure quality, promote a culture of safety and diminish medical liability exposure, healthcare organizations, physician practices and individuals must be prepared to address problem behavior among members of the healthcare team.

To provide strategies for managing the patient safety and professional liability risks associated with disruptive behavior, this *Claims Rx* presents a case study based on a NORCAL Mutual closed claim. The strategies include:

- Recognizing disruptive behavior
- Confronting disruptive colleagues and co-workers
- Communicating what is acceptable and unacceptable behavior through policies, training and enforcement
- Creating a reporting/surveillance system
- Consistently and promptly responding to reports of disruptive behavior
- Consistently enforcing disruptive behavior policies and procedures
- Monitoring behavioral compliance and/or adherence to corrective measures
- Creating an environment that is less likely to trigger disruptive behavior

Healthcare providers are encouraged to consider these strategies when creating, implementing and enforcing disruptive behavior policies and procedures.

Case Study

"Dr. Warner" is a board-certified obstetrician. In December 2000, he was granted privileges at "Valley Hospital." Over the next couple of years, both formal and informal complaints about his behavior were submitted by staff, physicians and patients to various individuals, committees and administrators associated with the hospital. The complaints included:

- 20 reports by patients, with allegations ranging from sexual misconduct to threatening to bring a lawsuit against a patient who requested a different doctor
- 12 reports from staff detailing instances of him raising his voice , making demeaning comments, making sexual comments during surgery and throwing instruments
- 17 reports of surgical delays directly caused by him

In response to these complaints, Dr. Warner was regularly counseled by the chief of staff, physician advisors and the nursing director. At various times, it was suggested that he take anger management courses, obtain psychological counseling and attend communication workshops. Although he freely admitted that he had anger management problems, he never undertook to address this issue. He felt that the sources of his problems included inadequate block time in the operating room and problems with obtaining patient information from the medical record department and his colleagues. His frustration was compounded by his feeling that no one was addressing his complaints about these issues. He also believed that he was an excellent practitioner, and his record of satisfactory outcomes excused his "minor" behavioral issues.

In addition to the behavior that resulted in formal and informal complaints, Dr. Warner regularly got into heated arguments about various issues with staff physicians. (Two of these physicians were on the medical executive committee or MEC.) He had followed up a number of these disputes with written formal complaints to the chief of staff.

In 2003, Dr. Warner applied for reappointment to the medial staff/renewal of his staff privileges. The MEC denied the application, citing substandard professional performance and unprofessional behavior that put patients at risk and disrupted the operations of the hospital. Dr. Warner was advised that his privileges were summarily suspended as of that afternoon.

Dr. Warner hired a lawyer and appealed the suspension. Almost immediately, Dr. Warner began berating the staff at his attorney's office. His first attorney quickly refused to continue representing Dr. Warner. Another attorney was retained, who after personally suffering the verbal abuse of Dr. Warner and hearing staff complaints of abuse, also refused to continue representing him. Ultimately, Dr. Warner permanently lost his privileges at Valley Hospital.

Discussion

In the foregoing case, it took almost two years for the hospital to take action formally against Dr. Warner. Lack of clear medical staff and hospital policies and procedures left the hospital exposed to a potential lawsuit if it terminated his privileges. In addition to a lack of clear policy, the hospital's attempt to dismiss Dr. Warner was complicated by the following:

- Disruptive behavior reports had not been submitted to the hospital performance improvement committee (or another designated committee) as they came in, which precluded a coordinated and timely response to Dr. Warner's behavior.
- Although Dr. Warner had been advised to seek counseling and anger management, there had been no follow-up and there was no written policy outlining consequences for noncompliance with corrective measures.
- Two MEC members had personal conflicts with Dr. Warner, which allowed him to argue that the manner in which his privileges were denied violated his due process rights as set out in medical staff bylaws.

Risk Management Recommendations: Physicians

Losing privileges is obviously a serious problem for any physician. In some cases, like the one above, the loss of privileges was probably warranted. In others, however, the physician has been unfairly targeted for what the American Medical Association (AMA) refers to as "appropriate behaviors," such as reasonable patient advocacy; patient care improvement recommendations; participation in medical staff operations, leadership or activities; or competing with the hospital for business.[5] Dr. Warner's behavior, however, was inappropriate and he failed to recognize that his behavioral issues were causing serious problems. He could have helped himself.

The causes of disruptive behavior are varied. In many instances, as in the situation in this case study, the root cause of the problem was poor anger/stress management. In other cases, however, disruptive behavior results from a psychiatric (e.g., intermittent explosive disorder), medical (e.g., organic brain disorder) or addiction-related condition. Regardless of the etiology, a medical society or state licensing board "physician health program" (PHP) may be able to provide resources.

Physician Health Programs

In most states, medical societies and licensing boards run PHPs for dealing with problematic behavior by physicians (i.e., behavior that may negatively affect patient care and may be related to a mental, physical or addiction-related condition). Listed below are the PHPs from the states in which NORCAL Group companies insure physicians.

Alaska:
Physician Health Committee
907-561-9644
www.aksma.org/committees.asp

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("Risk Management Recommendations: Physicians"... continued from page 3)

Arizona:
Monitored Aftercare Program
480-284-6024
www.greenbergandsucher.com

California:
The California Medical Board discontinued its Diversion Program for Impaired Physicians. California physicians can obtain information about available physician health services from the California Medical Association's Physicians' Confidential Line: 650-756-7787 (Northern California) or 213-383-2691 (Southern California).

Delaware:
Physicians Health Program
302-658-7696
www.medicalsocietyofdelaware.org/PhysiciansHealth/tabid/392/Default.aspx

New Mexico:
New Mexico Monitored Treatment Program
505-271-0800
www.monitoredtreatment.com

Pennsylvania:
Physicians' Health Programs
717-558-7819
www.foundationpamedsoc.org/PHP/PHPrograms.aspx

Rhode Island:
Physicians Health Committee
401-331-3207
www.rimed.org/physician-health-program.asp

These programs are resources available to anyone who has concerns about the behavior or well-being of a physician, including administrators, state medical boards, colleagues, family members, patients or even the physician her/himself, who may self-refer, as many physicians do. However, physicians who are disruptive often do not recognize their impact on others and usually do not believe they need remediation or treatment. Self-referrals from this group are therefore uncommon. Referral by the hospital or other third party can be especially helpful when the consequences of failing to address the issue are stated clearly; the physician then more readily cooperates with the process as a result.

Anger Management Programs

Many disruptive physicians do not suffer from medical conditions; like Dr. Warner, they are unable to appropriately manage anger and frustration. And in some states, a PHP will not be equipped to handle physician issues that do not result from a mental, physical or addiction-related condition. In those cases, referral to an anger management program can be helpful. In response to the new Joint Commission Disruptive Physician Practice Standards discussed below, a large number of anger management programs for "disruptive physicians" have arisen; however, there are no laws that regulate these programs. Consequently, it is important to carefully research a chosen program's legitimacy. A state-by-state list of anger management providers can be accessed on the National Anger Management Association Web site at: http://namass.org. Click on "National Anger Management Specialist Directory" (accessed 1/13/2010).

Physician Remedies to Unfair Discipline

There are two sides to every story. Physicians have a right to fight decisions to terminate or limit their privileges — whether or not the limitation/termination is legitimate. In addition to administrative remedies, a physician may have grounds to bring an independent legal action against a hospital that has wrongly terminated or limited his or her privileges. For example, physicians have prevailed in defamation, antitrust and anti-SLAPP (Strategic Lawsuit against Public Participation) lawsuits against the parties who wrongly limited their ability to practice.

Risk Management Recommendations: Physician Practice Management/ Medical Executive Committee/ Hospital Administration

Every healthcare organization and physician practice needs to be able to identify and eliminate disruptive behavior.

Create and Enforce a Written Disruptive Behavior Policy

Managing disruptive behavior requires a coordinated effort based on written policies and procedures that

Joint Commission Disruptive Physician Standards

Developing a disruptive-behavior policy is not only a good risk management tactic; doing so is required for certain entities by the Joint Commission. In July 2008, the Joint Commission issued Sentinel Event Alert 40, "Behaviors that undermine a culture of safety." A new leadership standard (LD.03.01.01) went into effect January 1, 2009, that addresses disruptive and inappropriate behaviors in two of its elements of performance (EP):

EP 4: "The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors."

EP 5: "Leaders create and implement a process for managing disruptive and inappropriate behaviors."

The Joint Commission also added interpersonal skills and professionalism as part of the core competencies in the credentialing process.*

American Medical Association's (AMA) Response

In response to the Joint Commission's sentinel event alert, the AMA adopted policy H-225.956, "Behaviors that Undermine Safety," which urges medical staffs to develop and implement their own code of conduct in medical staff bylaws, and calls for hospitals to additionally have a code of conduct that applies to board members, management and all employees.† The AMA created a model code of conduct that can be inserted in medical staff bylaws. It is available on the AMA Web site at: www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf (accessed 1/18/2009).

Resources

* Joint Commission. Sentinel Event Alert. Issue 40, July 9, 2008. *Behaviors that undermine a culture of safety*. Available on the Joint Commission Web site at: http://www.jointcommission.org/SentinelEvents/Sentineleventalert/sea_40.htm (accessed 1/21/2010).

† AMA. *Disruptive Behavior*. Available on the AMA Web site at: http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.shtml (accessed 1/21/2009).

cover reporting, confrontation, documentation, response, outside consultation, reprimand, follow-up, monitoring and support for subject physicians. The successful management of physicians who are reported for disruptive behavior requires "common sense, compassion, respect, and good planning."[6] A proactive, positive approach can benefit everyone.

Online samples of disruptive behavior policies are available from a number of sources, including:

AMA. *Model Code of Conduct*. Available through the AMA Web site at: www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf (accessed 1/18/2010).

California Medical Association (CMA). *Model Medical Staff Bylaws*. Available through the CMA Web site at: www.cmanet.org/PUBLICDOC.cfm?docid=133&parentid=131 (accessed 1/20/2010).

Greater Cincinnati Health Counsel. *Medical Staff Professional Conduct Policy*. Available through the GCHC Web site at: www.gchc.org/Portals/3/docs/Prof.%20Work%20Tool%20Kit/medstaffconduct.pdf (accessed 1/20/2010.)

A code of conduct should apply to all employees and credentialed providers, who should be required to review and sign it, indicating that they will abide by it. Physicians should not be singled out and treated more harshly than employees.

Define Disruptive Behavior

What constitutes disruptive behavior (e.g., throwing instruments, swearing) and what does not constitute disruptive behavior (e.g., criticizing someone in a reasonable manner with the objective of improving patient care) should be made very clear in a code of conduct

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or similar policy.[6] There is no universally accepted definition of disruptive behavior. The AMA defines disruptive behavior as "personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively." It also includes "conduct that interferes with one's ability to work with other members of the health care team."[5]

Overt examples of disruptive conduct include:

- Swearing
- Calling staff members or colleagues a pejorative name
- Making sexual comments
- Telling racially or ethnically oriented jokes
- Yelling at people
- Throwing things[2,8]

But disruptive behavior can also be covert or indirect, for example:

- Criticizing staff or colleagues in front of patients or other members of the healthcare team
- Criticizing a patient's treatment in his or her medical record (e.g., the physician writes in the progress notes for a consultation, "I wasn't called in until today..." or "I wouldn't have wasted time doing ...")
- Not responding to repeated calls (e.g., not answering a page or not calling back staff who have left a message about a patient's condition because it is not convenient)
- Responding poorly to corrective actions[2,8]

It is important to define both overt and covert or indirect disruptive behavior in policies and procedures, so that instances of disruptive behavior can be clearly identified and the most appropriate corrective action can be undertaken. It is equally important to remember that a person with a difficult personality does not necessarily deserve to have his or her privileges limited. Definitions should not facilitate unwarranted discipline.

Educate Team Members about Disruptive Behavior Policies and Procedures

All members of the healthcare team should be aware of the code of conduct/policy and the disruptive behavior definitions it contains. Everyone should be aware of the connection between disruptive behavior and its adverse effect on patient safety. Studies that have documented a connection between the two include the following:

- Rosenstein A, O'Daniel M. Survey links disruptive behavior to negative patient outcomes. *OR Manager*. 2005 Mar;21(3):1, 20, 22.
- Institute for Safe Medication Practices (ISMP). *Survey on workplace intimidation*. (2003). Available on the ISMP Web site at www.ismp.org
- Rosenstein A, O'Daniel M. Impact and implications of disruptive behavior in the perioperative arena. *J Am Coll Surg*. 2006 Jul;203(1):96-105.

Leaders who are expected to enforce the code of conduct/policy should be educated about the process for addressing disruptive behavior, the legal ramifications of limiting a physician's practice and the legal protections available to both parties in such an action.[8]

Disruptive behavior training does not have to occur in a vacuum. It can be integrated into basic business etiquette and communication skills training.[9]

Ensure Disruptive Behavior Reporting

Disruptive conduct affects performance up and down the chain of command. One goal of a disruptive behavior policy is to create a safe and supportive environment where everyone knows what is reportable and feels equally empowered to make a report. Research indicates that many instances of disruptive behaviors are not reported because the would-be reporter is afraid of reprisal.[2] To increase reporting compliance, the Joint Commission recommends making the process confidential and including non-retaliation clauses in policy statements.[9] On the other hand, it is important to have a process in place to gauge the reliability of reports. For example, an antagonistic relationship between two members of the healthcare team can result in malicious reporting.

Promptly Investigate Reports of Disruptive Behavior

It is important to investigate and intervene as quickly as possible. A physician who has behaved inappropriately probably recognizes it. If the behavior is addressed quickly, there may be a greater chance of the physician being amenable to corrective action. Designate an investigative process through the medical staff structure and identify a specific point person. Nursing staff can follow the chain-of-command procedure. Prompt response also reassures witnesses and those reporting that the problem is being addressed pursuant to the policy. Confidentially interviewing the person who reports will let him or her know that the complaint is being taken seriously. Set deadlines to keep the process moving. [9]

Rely on Outside Evaluation when Necessary

Usually, a Physicians Well-Being Committee (PWBC) can provide an initial review of the reported behavior and determine whether the provider has a physical or mental health problem that warrants intervention. But sometimes it is difficult to conduct an objective and unimpeachable assessment in-house. An outside evaluation helps assure the physician and the medical staff and/or administration of fairness and objectivity. The resulting report is also evidence that the physician received due process, and it can serve as an educational check on the policies and procedures of the medical staff and/or administration.

Plan an Intervention

When the decision has been made to perform an "intervention," or meeting in which the physician in question will be confronted with his or her unacceptable behaviors, the team should plan every step, considering the effects and consequences of planned actions. The planning, goals and outcomes of an intervention should be carefully documented. While there are no hard and fast rules, this team should be inter-professional (e.g., one that involves representatives from medical, nursing, administrative and any other areas that might improve the process).[8] In some circumstances, confronting a physician reported for disruptive behavior may need to be rehearsed in advance.[9]

Perform an Intervention

Intervention is a necessary step in addressing disruptive behavior and need not necessarily be unpleasant if it is well prepared and skillfully carried out. A disruptive behavior policy should provide for the creation of an environment for an intervention that feels safe and supportive. Treat the issue as a problem with a physician's behavior, not a problem with the physician. In other words, a physician who has engaged in "disruptive behavior" should not be labeled a "disruptive physician."[9]

Collegial intervention is a good place to start. During the intervention, the physician should be given:

- A detailed explanation of the behavior reported
  - Being mindful of confidentiality
- A citation to the relevant aspect of the policy or code of behavior
- An explanation of how the reported behavior is inconsistent with the policy/code of conduct
- Information on resources for corrective behavior (e.g., anger management, communication seminars, PHP programs)
- A clear understanding of the consequences of future disruptive behavior or noncompliance with corrective measures[9]

Ambivalence towards disruptive behavior is an identified barrier to reporting. For the relevant culture to change there must be no tolerance for egregious behavior. Everyone who behaves inappropriately has to be treated equally, including excellent practitioners, friends of the key administrative leaders or the MEC, and physicians who generate significant income for the institution or practice.[8] That everyone will be treated equally should be clear in the policies and procedures. On the other hand, overzealous policies and procedures can wind up targeting a person with a difficult personality — one who, while not particularly enjoyable to work with, is not necessarily impacting patient care negatively.

Additionally, regardless of how many times a physician is reported for disruptive behavior, the response to the incident should be appropriate to the seriousness of the behavior (e.g., a physician who repeatedly uses profanity can be treated differently from a physician who gets into a fist fight with a colleague). A single, mild incident may not merit referral; the collegial

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("Risk Management Recommendations: Physician Practice Management"... continued from page 7)

interview by the chief medical officer or department chief may suffice. But healthcare providers with a single egregious incident should be referred, as should a doctor with a pattern of disruptive behavior. Thus, policies and procedures must allow some flexibility in dealing with a variety of personalities and circumstances. In some cases, the most prudent course will be to involve legal counsel for guidance.[9]

It should be noted that in many states (including California) disciplinary actions based on physician conduct are reserved exclusively to the medical staff, not hospital administration.[10] The AMA advocates this view.[7]

Follow Up on Interventions and Actively Monitor Compliance with Corrective Measures

An initial intervention without follow-up will generally not put an end to disruptive behavior. Disruptive behavior tends to be triggered by unfortunate but ongoing circumstances in the healthcare environment (e.g., lack of equipment, understaffing, fatigue, underlying illness, depression and/or stress). A physician who has been reported should know he or she is being monitored for compliance. This not only reinforces a zero-tolerance environment, but it also sends the message that the disruptive behavior policy is being taken seriously.[2]

Effective Communication in a Culturally Diverse Workforce

Effective communication among all members of the healthcare team facilitates collaboration, continuity of care and can result in fewer adverse events.‡ Much has been written about cultural competency between patients and providers, but there is little to guide members of the healthcare team who struggle with cultural differences among themselves.

Individuals from diverse backgrounds can have profoundly different methods of communicating. It is important for all members of the healthcare team to recognize and validate different communication styles. Consider the following strategies for enhancing communication among a diverse healthcare team:

- Support the fact that no two people are the same and that there is more than one way to perform a task correctly.
- Honor differences and use them to advance the goals of the healthcare team.
- Focus on the positive aspects of diversity within the team; for example, diversity can enhance creativity and improve communication with diverse patient populations.
- Learn about team members' backgrounds, cultures, and professional values; it can enhance your own skills and abilities.
- Consider a new idea based on its merits, not on who presented it.
- Avoid making comments that direct negative attention to another team member's unique characteristics.[§,∞,Ω]

As cultural competency increases, it should become easier for you to understand and/or constructively criticize a culturally different provider's practices that are perceived to diminish the quality of patient care.

Resources

‡ O'Daniel M, Rosenstein A. Ch. 33, Professional Communication and Team Collaboration. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Edited by Ronda G. Hughes. 2008. Available on the Agency for Healthcare Research and Quality (AHRQ) Web site at: www.ahrq.gov/qual/nurseshdbk/docs/O'DanielM_TWC.pdf (accessed 1/21/2010).

§ Clark, PG. Quality of life, values and teamwork in geriatric care: do we communicate what we mean? *The Gerontologist* (1995)35:402-411.

∞ Fisher K, Rayner S, Belgard W. *Tips for teams: A ready reference for solving common team problems*. New York: McGraw-Hill. (1995).

Ω Gupta, S. *Training Soapbox: Achieve Cultural Competency*. February 10, 2009 Available on the Sales and Marketing Web site at: www.salesandmarketing.com/msg/content_display/training/e3id4a71ae8a147530396e23cade55d5d55 (accessed 1/21/2010).

Conclusion

Disruptive behavior compromises patient care and increases professional liability risk. Although disciplining a healthcare provider for disruptive behavior can be difficult for a variety of reasons, it must be done in a timely, organized and fair manner. Individual providers who struggle with anger/frustration management must also take responsibility for their disruptive behavior and seek help. Providers, MEC members and administrators are encouraged to consider the risk management recommendations offered in this article to create a culture of safety for patients and a supportive and productive environment for all members of the healthcare team.

Endnotes

1 Rosenstein A, O'Daniel M. Impact and implications of disruptive behavior in the perioperative arena. *J Am Coll Surg*. 2006 Jul;203(1):96-105.

2 Weber, DO. Poll results: Doctors' disruptive behavior disturbs physician leaders. *The Physician Executive* 2004: 30 (4) 6-14. (2004). Available on the ACPE Web site at http://net.acpe.org/resources/publications/OnTargetDisruptivePhysician.pdf (accessed 1/18/2010).

3 Institute for Safe Medication Practices (ISMP). *Survey on workplace intimidation* (2003). Available on the ISMP Web site at: www.ismp.org (accessed 1/21/2010).

4 Rosenstein A, O'Daniel M. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. *Am J Nur* 2005;105:54-64.

5 AMA. *Model Code of Conduct*. Available on the AMA Web site at: www.ama-assn.org/ama1/pub/upload/mm/21/medicalstaffcodeofconduct.pdf (accessed 1/18/2010).

6 Neff, K. E. Ch. 4, Understanding and managing physicians with disruptive behavior. *Enhancing physician performance: Advanced principles of medical management*. Reprinted in *On Target: Managing Disruptive Physician Behavior*, American College of Healthcare Executives, 2000. Available on the ACPE Web site at http://net.acpe.org/resources/publications/OnTargetDisruptivePhysician.pdf (accessed 1/18/2010).

7 AMA. *Code of Medical Ethics*. E-9.045-Physicians with Disruptive Behavior. Available on the AMA Web site at: www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.shtml (accessed 1/21/2010).

8 ECRI. Healthcare Risk Control. Executive Summary. Medical Staff 8. Supplement A. March 2009 *Disruptive Practitioner Behavior*.

9 Joint Commission. Sentinel Event Alert. Issue 40, July 9, 2008. *Behaviors that undermine a culture of safety*. Available on the Joint Commission Web site at: http://www.jointcommission.org/SentinelEvents/Sentineleventalert/sea_40.htm (accessed 1/21/2010).

10 California Medical Association (CMA). *Disruptive Behavior Involving Members of the Medical Staff*. CMA On-Call Document #1241. January 2009. Available on the CMA Web site at www.cmanet.org (accessed 1/21/2010).

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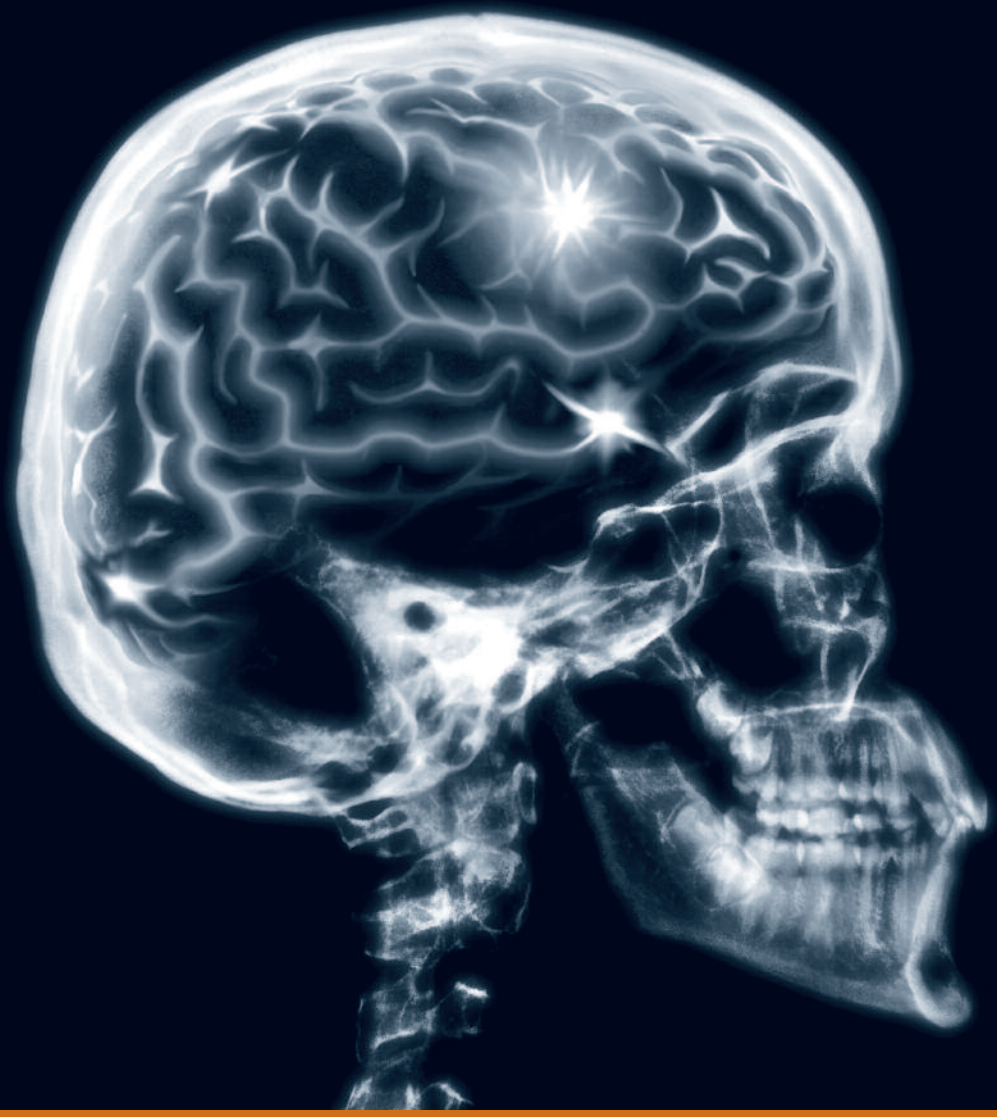

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   ☐ Not applicable ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Very applicable

2. **Application of Risk Management Strategies:**
   To demonstrate your ability to apply or utilize the risk management recommendations herein, please rate the strategies you plan to implement or currently utilize in your practice (check your selection for each):

	Never	Seldom	Sometimes	Often	Frequently
Recognize and confront disruptive behavior in your healthcare setting.	☐	☐	☐	☐	☐
Report disruptive behavior to appropriate person or committee.	☐	☐	☐	☐	☐
Recognize disruptive behavior in yourself and access resources for physician support (e.g., Physician Health Programs run by medical societies, wellness programs, stress or anger management courses), when a potential exists to affect patient care negatively due to conduct.	☐	☐	☐	☐	☐

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