Addressing Disruptive Nurse-Physician Behaviors: Developing Programs and Policies to Improve Outcomes of Care

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Medicine is a complex science, and health care is a complex system. Because of this complexity, it is crucial that health care providers are knowledgeable, well-trained, collaborative and fully understand their roles and responsibilities in providing high quality care. Technical competencies are gained through continued education and training, assuring that providers maintain their skills and are up to date with the latest trends in health care treatment and diagnosis. Competency is assured though mandated requirements and certifications for continued education and through the process of credentialing and re-credentialing for requested privileges. Interpersonal competencies are more difficult to enforce. Communication competencies are gained more from exposure and experience than through didactic learning. There are few if any standardized courses teaching medical professionals basic communication and interpersonal relationship skills. Given a less than friendly training environment, it is not surprising to see the frequent occurrence of confrontational relationships resulting in disruptive events. In an effort to provide a positive health care environment that assures safe, high-quality patient care, organizations need to assess nurse-physician relationships and their effect on heath care delivery and develop policies and procedures to support appropriate standards of behavior.

Background

Stories about difficulties in nurse-physician relationships have circulated for years. Many of these incidents have been documented in the medical literature, but until recently most of these reports focused on individual experiences, observations or anecdotal stories, rather than research-based data analysis.[1-4] In an effort to uncover the prevalence and significance of disruptive behaviors, we conducted research on the impact of physician disruptive behavior on nurse satisfaction and retention and first reported our results in the June 2002 issue of the

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American Journal of Nursing.[5] In this study, we found that disruptive physician behavior had a significant negative impact on nurse satisfaction and morale and played a significant role in nurse turnover.

The second phase of our research focused on the frequency and significance of both physician and nurse disruptive behaviors and their impact on patient outcome. Results from this research were published in the January 2005 issue of the American Journal of Nursing.[6] In this study we found a high frequency of both physician and nurse disruptive behaviors. We also found a direct correlation between staff perceptions of disruptive behaviors and levels of stress, frustration, loss of concentration, impaired communication and information transfer. There was a direct linkage of disruptive behavior to a high incidence of adverse events, medical errors, and compromises in patient safety, quality, mortality and staff satisfaction. Our research is ongoing.

We found that disruptive behaviors and impaired relationships are not unique to physicians and nurses, but occur across all levels of health care organizations. Furthermore, disruptive events are more likely to occur in high stress areas such as the OR, ICU, or ED setting.[7] Our results suggest that human issues play a strong role in affecting patient safety and quality of care, implying that providers need to be better trained in effective communication and collaboration skills.

Disruptive Behaviors: Inciting Events

Disruptive behaviors occur for a multitude of reasons. Many of these behaviors can be attributed to reactions based on basic personality traits, while others result from acute incidents.

Factors influencing these behaviors are directly related to values, perceptions and experiences related to age, gender, culture and ethnicity.[8-10] Many of these behaviors can be traced back to exposures and experiences gained during childhood, adolescence and early adult years. Later on, many of these behaviors are molded through training or work experiences. This is particularly true for physicians, for whom the traditional training experience starts out with a sense of isolation and reduced self-esteem and ends with the need to become more domineering and self-reliant in order to make expedient, decisive decisions. These experiences breed autocratic, dictatorial character traits, which damage team dependencies based on collaborative relationships, back-and-forth communication and the exchange of information.

On top of personality style is the inciting event. Inciting events are provoked by real time confrontational situations that affect one's mood and sensitivities. From the nurse's perspective, a common inciting event which stimulates disruptive responses by physicians comes from an unexpected call about order clarification, change in patient status, issues related to patient disposition, or any question about diagnosis or treatment plans. Physicians are perceived as being hurried, pre-occupied or distracted, and many times look at a nurse inquiry as an intrusion. Behavioral responses by nurses to these situations vary depending upon the influence of the above-mentioned factors, but many often result in antagonistic feelings leading to a compromised communication exchange. Of note, our research has shown that the incidence of nurse-to-nurse disruptive behaviors is equal to the incidence of nurse-to-physician disruptive behaviors.[6]

From the physician's perspective, a common inciting event stimulating physician dis-

ruptive responses occurs when the physician questions the necessity of the call, has concerns about nurse competency, or becomes frustrated with the nurse's inability to effectively describe the patient's condition or a request for action. Sometimes awakened in the middle of the night or interrupted from patient care activities, physicians quickly get irritated when the reason for the call is unclear, the nurse in unprepared, or is unable to deliver the message in an effective manner. Regardless of the cause, disruptive events are deleterious to staff and patients, and every effort should be made to prevent their occurrence.

Stopping Disruptive Behaviors: Recommended Strategies

The ultimate objective in dealing with disruptive behaviors is to prevent disruptive events from occurring. While it may be difficult to change personalities or personal values, situational awareness, perceptions and reactions can change.

These objectives can be achieved through the implementation of a series of different programs and policies designed to provide institutional awareness and commitment, training and education, and policies and procedures that set standards and expectations to hold people more accountable for their actions. These programs and policies need to be endorsed and championed by senior management and enforced consistently across all levels of the organization. (See Table 1 on next page.)

The first strategy is self-awareness. Health care organizations need to assess the status of nurse-physician-staff relationships at their own institutions in an effort to uncover the frequency of disruptive relationships and their impact on staff satisfaction and patient care. A variety of survey tools are available, including the tool we developed at VHA West Coast. The VHA West Coast tool specifically addresses the frequency of disruptive behaviors by discipline, medical specialty and service unit; the impact of disruptive behaviors on behavioral factors affecting levels of stress, concentration, communication and information transfer; and the linkages of disruptive behavior to adverse events, medical errors, patient safety, quality, mortality, and staff satisfaction. It also provides a comment section where respondents can go into more detail describing the environment or witnessed events. Information about one's own organization, shared in a confidential manner with all relevant stakeholders, provides the entry point for understanding and engagement.

To date more than 5,000 participants from over 100 hospitals across the nation have completed the VHA West Coast survey. Follow up inquiries have shown that most of the organizations have used these results to jump start the process of getting people involved to work together to improve staff relationships at their hospitals. Many organizations have repeated the survey and the majority have reported definite improvements in communication, staff relationships, and satisfaction levels and have noted a reduction in the frequency and intensity of disruptive events.

The next phase is education. Education can be delivered at several different levels. First would be a general overview of the situation and the need for action. These sessions can be presented at staff or department meetings or can be discussed at the committee or task force level. On a more comprehensive level, focused educational courses or workshops on phone etiquette, language skills, communication skills, conflict management, assertiveness training, diversity training or team building are all of

Table 1. Recommended Strategies

I. Awareness
a. Self Assessment
II. Education
a. General sessions
b. Courses and training workshops
c. Communication tools
d. School training
III. Policies
a. Code of Conduct
b. Disruptive Behavior
c. Zero tolerance policy
d. Incident Reporting
IV. Cultural and Organizational Commitment
a. Leadership support
b. Champion endorsement
c. Coaching, reinforcement and rewards

value. It is recommended that organizations support these educational programs with specific communication tools like those utilized in crew resource management training programs, such as the SBAR (Situation, Background, Assessment, Recommendation) tool, the STICC (Situation, Task, Intent, Concern, Collaborate) tool or other scripted texts or checklists that reinforce communication efficiencies.[11-12] These programs should be made available to all members of the organization, including physicians and nurses in training. The ultimate goal would be to introduce courses on interpersonal skills, collaboration and team training at the medical school and nursing school levels, where students from various disciplines would come together and role play in an effort to gain a better appreciation of everyone's roles and responsibilities as part of the health care team.

Specific policies and procedures need to be developed to support behavioral standards of care. These policies come under the umbrella of Code of Conduct, Code of Ethics or Standard Behavior policies, which should outline appropriate behavioral standards and expectations and the ramifications if these standards are not met. In order for these policies to be effective, they need to be consistent and applied equitably across all levels of the organization. There should not be one policy for physicians, another for nurses, and another for other employees. These policies should include specific criteria and procedures for handling disruptive individuals. Many organizations now require physicians to sign off on agreeing to comply with written behavioral policies at the time of staff appointment and/or recredentialing. All members of the organization need to be committed to a zero-tolerance policy reinforced by a non-punitive confidential reporting environment. Having these efforts supported by clinical and administrative champions will go a long way in assuring the success of these programs.

The primary goal of any disruptive behavior program is to prevent the incident from occurring. Despite the best intentions, disrup-

tive events will still occur. In this situation a process needs to be in place to address acute situations. The ideal solution would be to confront the disruptive individual in a professional and respectful manner in an effort to diffuse the situation in real time. If the situation does not allow for an immediate resolution, the event should immediately be reported to the appropriate manager or supervisor. Many organizations have developed a specific structure for handling disruptive complaints, while others still utilize the traditional incident reporting system. In either case, reports must be held confidential and follow-up action must be taken with appropriate feedback given to the reporting individual.

Follow-up action requires discussing the situation with the offender. The conversation must focus on the behavioral event itself and not the surrounding circumstances. In many cases, a simple discussion will be enough to resolve the situation. In other cases, particularly with repeat offenders, recommendations should be made for specific educational courses or in some cases professional counseling. For those individuals who are unable to adhere to appropriate standards of behavior, employment should be terminated. For physicians, the situation is a little more complicated. In most cases physicians are not employees of the organization, and they voluntarily admit their patients to the hospital. Because of this, there is frequently a reluctance to bring these issues up with physicians. But the situation is changing. Given the environment of staff shortages, hospital reputation, fear of litigation and potential compromises to patient safety and quality of care, hospitals can no longer afford to ignore the issue. More and more we are seeing physicians who have had their privileges revoked after due process review because of disruptive behaviors and their risk to employee and patient safety, even if the physician is a high volume admitter.

Awareness and education are wonderful tools, but their effects are usually short lived. In order to reinforce the desired effects, there needs to be an ongoing effort to sustain momentum. Compliance with behavioral performance expectations needs to be ingrained as a way of doing business. Members of organizations who are passionate about the issue should be encouraged to become champions who proactively interact with their peers to promote the importance of appropriate behaviors. Continued reminders through meetings, debriefings, posters, newsletters, and recognition and reward programs will also go a long way in sustaining the desired effects. Any opportunity to teach, coach or mentor individuals should be viewed as a positive learning opportunity to discuss alternative strategies for achieving desired outcomes.

Conclusion

Disruptive behaviors can have a profound effect on organizational dynamics. Compromised relationships between staff members significantly affect satisfaction and morale, with negative consequences like high turnover, tarnished reputation, and in some cases financial liability for severe events.[13,14] Of greater concern is how disruptive relationships increase feelings of frustration, anger and antagonism and reduce willingness to communicate, collaborate and exchange information necessary for patient care. Disruptive relationships can heighten stress, increase distraction and impede concentration, resulting in a higher likelihood of medical errors. Overall, there is a strong linkage between disruptive relationships and the occurrence of adverse events and

compromises in patient safety, quality of care, and clinical outcomes. At the policy level, the organization needs to develop, implement and enforce policies that outline appropriate behavioral standards backed by a zero-tolerance policy for non-compliance. To be truly effective, these policies and procedures need to be supported by appropriate educational, training and coaching programs and backed by leadership and an organizational commitment to a culture that endorses professional standards of behavior as a core value. 

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