ANDRES BALCZAR

BAD MEDICINE

Managing the Risks of Disruptive Behaviors in Health Care Settings

BY ALAN H. ROSENSTEIN

In any organization, disruptive behaviors can lower morale, impede operational efficiency, reduce productivity and potentially compromise production capacity and product quality. Most organizations recognize the risks associated with these types of behaviors and take the necessary steps to address them appropriately. You would think that in health care, where the primary product is quality and quantity of life, there would be no exception. Unfortunately, this is not always the case.

To gain a better appreciation of disruptive behaviors in the health care setting, it is important to get a better understanding of what these behaviors are, why they occur, what the barriers are to addressing them and the risks to the organization, staff and patients if these behaviors are not managed consistently and effectively.

Disruptive behavior in health care is defined as any inappropriate behavior, confrontation or conflict, ranging from verbal abuse to physical or sexual harassment, that can negatively impact patient care. For many, what first comes to mind is the tantrum-throwing surgeon or the aggressive, bullying nurse, but most disruptive behaviors involve verbal abuse—condescending, disrespectful, demeaning or insulting comments—rather than direct physical harassment. Either way, these behaviors can profoundly affect staff performance and patient care.

Research has shown that 3% to 5% of physician and nursing staffs at hospitals exhibit disruptive behaviors. While the actual number of physicians and nurses responsible for these episodes is small, the impact is not. Studies have shown that more than 95% of those involved in a disruptive event feel stressed, intimidated or unable to concentrate, inhibiting their ability to effectively collaborate and communicate patient medical concerns. More than half of those surveyed felt these events led to medical errors and compromises in patient safety and quality of care.

Cause and Effect

Disruptive behaviors in health care are nothing new. For years, they have been tolerated as a normal part of doing business and largely kept off the radar. Because of a hidden “code of silence,” spectators

often look the other way. The hierarchical structure of most health care organizations puts physicians on top and in charge. They are responsible for directing patient care. They give orders and do not expect to be questioned. Additionally, many administrators fear that antagonizing physicians who are high-income earners for the organization will lead them to take their patients elsewhere for treatment.

Physicians' training also contributes to the problem. Medical education focuses on achieving technical and knowledge competency and is often conducted in a bureaucratic hazing type of environment that breeds autonomy and autocracy. As a result, health care providers have safeguards in place when it comes to clinical competency, but they are not really prepared to address issues related to misbehavior.

Left unchecked, disruptive behaviors can have a devastating effect on organizational dynamics and patient care. At the system level, it can result in poor staff morale, which may lead to increasing problems with turnover and retention. It also might result in poor patient satisfaction and a tarnished public reputation. At the patient level, compromised working relationships that impede communication, collaboration, information transfer and task completion may adversely impact patient care and lead to medical errors, compromises in quality and patient safety, and even deaths.

Shift in Perspective

Looking the other way and hoping it goes away is not a viable solution. Organizations need to grasp the seriousness of the situation and take appropriate action in a consistent and efficient manner. This requires a multistep process.

First and foremost, there must be a leadership commitment to providing the best patient care. All levels of the organization from the board to administrative and clinical leadership to front line staff must commit to a zero-tolerance policy when addressing disruptive behaviors.

In 2009, the Joint Commission mandated that hospitals have a written policy for addressing disruptive behaviors as one of its leadership standards for hospital accreditation. As part of the mandate, organizations must implement an effective incident-reporting policy and follow-up process to assure that all incidents are reviewed and evaluated in a non-biased and consistent manner.

Policy and structure only go so far, however. The organization needs to develop an effective intervention process to address each complaint and make appropriate recommendations. There are three basic levels of intervention, driven by the seriousness and frequency of disruptive events.

The first level is a more informal approach involving a conversation with the disruptive party about the specifics of the event. It is critical to raise awareness of the impact and implications based on the perceptions of the parties involved.

The second level is a more formal intervention where specific recommendations are made to prevent repeated episodes. This may require a warning that these events will not be tolerated and may include specific recommendations for additional training in stress management, anger management, conflict management or diversity management. Investigations and recommendations should always entertain the underlying possibility of alcohol or substance abuse, and some individuals may benefit from coaching or counseling.

The third level deals with more severely resistant individuals who require comprehensive behavioral assessment and adjustment. In some cases, suspension of privileges or termination may be the only viable option.

Preventing Disruptive Behavior

Most physicians and nurses don't plan to be disruptive from the start—other factors get in the way. By understanding what causes people to behave the way they do, it may be possible to prevent these events from occurring. Physicians, nurses and other health care employees are a valuable resource, so it is important to help them adjust appropriately to the changing medical environment.

The first set of factors that influence disruptive behavior are internal. Age (generation), gender, culture and ethnicity, training, and other life experiences all shape individual values, perceptions and behaviors.

The second set of factors are external. Changing forces in the health care environment affected by health care reform, growing exposure and accountability, and changing models of care have added levels of complexity that can cause dissatisfaction, frustration, stress, burnout and depression for those who just want to practice good patient care.

For many, what first comes to mind is the *tantrum-throwing surgeon or the aggressive, bullying nurse,* but most disruptive behaviors involve *verbal abuse—condescending, disrespectful, demeaning or insulting comments—rather than direct physical harassment.*

Internal factors are hard to change, but administrators can provide educational seminars and workshops highlighting the different values and preferences of individual groups to help coworkers interact more effectively and enhance work relationships. Courses on diversity management, sensitivity management, generational gap preferences, cultural sensitivity and personality traits may all be effective, depending on the organization's needs.

Seeking Emotional Intelligence

Medical training is an area ripe for improvement. As mentioned previously, medical training is plagued by tradition and a bureaucracy that seeks out applicants who major in the medical sciences and puts them through a grueling process of education that emphasizes knowledge and technical competency delivered in an autocratic manner. As a result, many physicians suffer from a low level of "emotional intelligence," which may impede interaction with colleagues, staff, patients and families.

Some more progressive medical schools have recognized this liability and are seeking students who have majored in the humanities or social sciences. They have also introduced new programs that emphasize development of personal and team collaboration skills to promote a more interdisciplinary approach to patient care. Even the MCATs (Medical College Admission Tests) have introduced questions on humanities and social sciences as part of the entrance exam in an effort to move away from testing only on math and science.

It is also important to improve the lines of communication and collaboration between all members of the health care team. New technology and medical specialization add increasing levels of complexity to medical care that require a better understanding of everyone's roles and responsibilities to coordinate effective care.

Many organizations have begun developing special initiatives and training programs that promote effective

THE VALUE OF A MEDICAL STAFF RISK MANAGEMENT CHECK-UP

by Ann Whitehead

While a patient's overall level of satisfaction depends largely on interactions with the physician, the office staff plays a large role as well. Physicians rely heavily on office staff to manage many important functions, and staff has a significant influence over both patient safety and patient satisfaction. They can also help reduce medical liability and promote good patient outcomes.

According to research published in the *Journal of the American Medical Association*, the risk of claims in a physician's office is related to communication, patients' unhappiness with physician-patient interaction, and access, care or treatment that does not meet expectations. Many lawyers will tell you that happy patients do not sue their doctors. Office staff plays an integral part in the patient's experience and feelings toward the physician. Thus, the value of communication and follow-through are extremely important for staff to understand and practice.

In 2009, a review of closed professional liability claims data showed that 52% of all paid medical malpractice claims involved events in the outpatient setting, and two-thirds were claims involving major injury or death. Over the last 10 years, some of the most widely documented ambulatory medical errors fall into six categories:

- Medication: prescriptions for incorrect drugs or incorrect dosages
- Diagnostic: missed, delayed and wrong diagnosis
- Laboratory: missed and delayed tests, errors in follow-up on results with patients
- Clinical knowledge: lack of knowledge, skill and general performance on the part of clinicians
- Communication: miscommunication from doctor to patient, doctor to doctor or in the office
- Administrative: errors in scheduling appointments and managing patient records

Aside from clinical knowledge, five of the six categories pertain to errors usually caused by insufficient or poorly performing office systems. Historically, risk management education has targeted physicians and hospital staff, but the importance of educating medical office staff has recently been brought to the forefront. A risk management education program created specifically for medical office staff that covers key areas like informed consent, medication management, effective office communication, patient education, tracking and recall, and medical record management can promote and improve patient satisfaction, reduce liability and improve patient outcomes. Each staff member should recognize that they have a significant role in preventing error and, just as in any other corporate setting, everyone should think of themselves as a risk manager. ■

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communication techniques and team collaboration skills to support this process. This is particularly important for physicians. As leaders of the health care team, doctors need to better communicate and coordinate care with their peers, nurses, case managers, and patients and their families. In some cases, this means helping physicians develop effective skills to hold difficult conversations around sensitive issues, such as dealing with end-of-life care and aggressive care alternatives.

The growing amount of stress and burnout among nurses and physicians also merits attention. More than half of the workforce has reportedly been affected, leading many nurses and physicians to leave their positions, retire prematurely or even change professions. Organizations must recognize the toll this is taking on staff and try to take action proactively. This may involve providing support for certain operational issues such as workloads, scheduling, on-call hours, committee work or administrative tasks. This may also relate to providing support for emotional or behavioral issues that affect personal wellness or work-life balance.

First, Do No Harm

Disruptive behaviors in any organization are a serious issue. In health care, the situation is complicated by a multitude of factors related to tradition, changing responsibilities and priorities, care segmentation, hierarchy, employment structure and divergent financial incentives, which all make it difficult to address. Raising levels of awareness, developing programs that focus on proactive approaches to improve patient care and enabling behaviors that enhance work relationships, communication and collaboration are more effective than programs that focus on post-event intervention and that take a more punitive approach to resolution.

The ultimate goal in a health care setting is to provide safe and effective patient care. Physicians, nurses and other members of the team who are allowing their own disruptive behavior—or that of others—to interfere with this objective need to receive the necessary assistance to correct the problem so that they can fulfill their promise to "first, do no harm." ■

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