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ORIGINAL RESEARCH

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Disruptive & Clinical

Perceptions of

Overview: Providing safe, error-free care is the number-one priority of all health care professionals. Excellent outcomes have been associated with procedural efficiency, the implementation of evidence-based standards, and the use of tools designed to reduce the likelihood of medical error (such as computerized medication orders and bar-coded patient identification). But the impact of work relationships on clinical outcomes isn't as well documented.

The current survey was designed as a follow-up to a previous VHA West Coast survey that examined the prevalence and impact of physicians' disruptive behavior on the job satisfaction and retention of nurses (see "Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention," June 2002). Based on the findings of that survey and subsequent comments on it, the follow-up survey examined the disruptive behavior of both physicians and nurses, as well as both groups' and administrators' perceptions of its effects on providers and its impact on clinical outcomes.

Surveys were distributed to 50 VHA hospitals across the country, and results from more than 1,500 survey participants were evaluated. Nurses were reported to have behaved disruptively almost as frequently as physicians. Most respondents perceived disruptive behavior as having negative or worsening effects, in both nurses and physicians, on stress, frustration, concentration, communication, collaboration, information transfer, and workplace relationships. Even more disturbing was the respondents' perceptions of negative or worsening effects of disruptive behavior on adverse events, medical errors, patient safety, patient mortality, the quality of care, and patient satisfaction. These findings suggest that the consequences of disruptive behavior go far beyond nurses' job satisfaction and morale, affecting communication and collaboration among clinicians, which may well, in turn, have a negative impact on clinical outcomes. Strategies aimed at reducing the incidence and impact of disruptive behavior are recommended.

Key words: nurse and physician relationships; disruptive behavior; clinical outcomes; adverse events; patient safety; errors; psychological and behavioral variables

Nurse–physician relationships have been shown to have a significant impact on the job satisfaction and retention of nurses[1,2]; in combination with other workplace factors, disruptive behavior contributes significantly to increased workplace stress and burnout and strongly influences nurses' job satisfaction and decisions to leave the profession.

Concerns looming over the nursing shortage are staff unavailability and the inability of members of the care team to work together and the impacts of these on patient outcomes. Several recently published studies show a correlation between reduced nurse staffing and undesirable clinical events. One of these studies, published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), reported that 24% of sentinel events (defined as "unanticipated events that result in death, injury, or permanent loss of function"[3]) could be attributed to a problem with either nurse staffing, communication gaps, a lack of teamwork, or other "human factors" (defined as "the interrelationships between humans, the tools they use, and the environments in which they live and work"[4]). A 2002 study in the *New England Journal of Medicine* showed that nurse staffing and nurses' time at the bedside affect lengths of hospitalization and the incidences of urinary tract infections, gastrointestinal bleeding, sepsis, pneumonia, and failure to rescue.[5] A 2002 study in the *Journal of the American Medical Association* showed a correlation between

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Behavior Outcomes:

Nurses & Physicians

Nurses, physicians, and administrators say that clinicians' disruptive behavior has negative effects on clinical outcomes.

The goals of the current study were to assess perceptions of the impact of disruptive behavior on nurse–physician relationships and to determine what physicians, nurses, and hospital administrators believe to be its effects on several variables that affect patient care. The psychological and behavioral variables studied were stress, frustration, concentration, team collaboration, information transfer (the conveyance of specific results or observations), and communication. The clinical outcomes examined were adverse events, errors, patient safety, the quality of care, mortality, and patient satisfaction. (The IOM, drawing on the work of James Reason, defines *error* as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." An *adverse event* is "an injury resulting from a medical intervention" and "is not due to the underlying condition of the patient."[7]) For the purposes of this study, disruptive behavior was defined as any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment.

nurse staffing and both surgical-mortality and failure-to-rescue rates.[6] And as a 2000 Institute of Medicine (IOM) report that focused on medical errors and patient safety stated, "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system."[7]

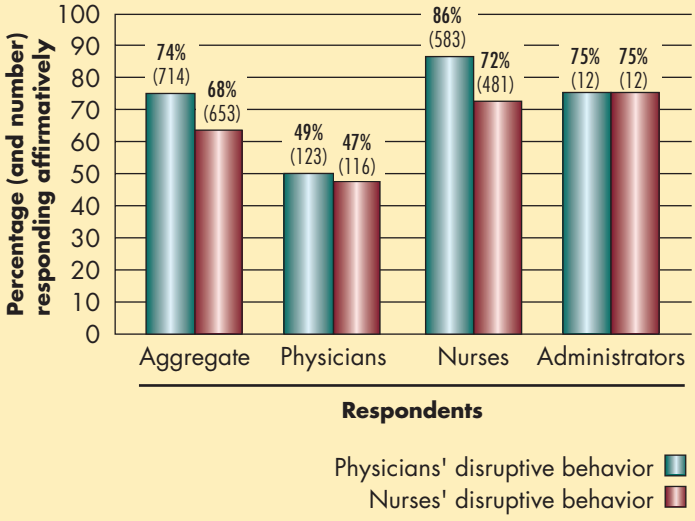
The number of studies reporting the effect of working relationships and team dynamics on outcomes is relatively small. Several studies have demonstrated the benefits of effective collaboration among team members, finding a relationship between improved teamwork and improved outcomes, but these studies were limited to ICUs and EDs.[8-13] Other studies, not specific to unit or department, have shown a link between improved communication and collaboration and improved patient outcomes.[14, 15] And an extensive review of studies on nurse–physician collaboration contained in the Cochrane Library, conducted by Zwarenstein and colleagues, revealed that while a number of studies suggest strategies for improving collaboration, no strong studies of the actual impact of such interventions exist yet.[16]

METHODS

The current survey expands on some of the issues covered in the initial VHA West Coast survey on nurse–physician relationships. (All of the issues and trends noted in the original survey remained consistent in the responses to this one.) New topics introduced in the current survey included the disruptive behavior of nurses, the influence of gender on the tendency to exhibit disruptive behavior, and the perceived impact of disruptive behavior on psychological and behavioral variables and clinical outcomes.

Design. A convenience sample survey was conducted by VHA West Coast, one of 18 regional divisions of VHA, Inc., a network of community-owned health care systems with more than 2,200 member facilities—more than one-fourth of the community-owned hospitals in the country. A previous survey conducted by VHA West Coast examined the effect of disruptive physician behavior on nurse satisfaction and retention (see "Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention," June 2002).[1]

Figure 1 Respondents (Nurses, Physicians, and Administrators) Who Witnessed Disruptive Behavior in Physicians and Nurses*



*Respondents who did not identify themselves by job title are included only in the aggregate group; therefore, the aggregate subtotals are larger than the sums of nurse, physician, and administrator subtotals.

Sample. The survey was first distributed in August 2003 and is ongoing. It was sent by e-mail to each hospital's chief medical officer, chief nurse officer, and chief executive officer, with an introductory letter asking them to distribute the survey to RNs, physicians, and administrators at their hospitals. The current analysis incorporates data from surveys returned through January 2004 and includes results from 50 VHA member hospitals across the country, ranging in size from large, metropolitan, academic centers to small, rural, nonprofit community hospitals. There were a total of 1,509 respondents in the study. Of these, 1,091 (72%) identified themselves as RNs, 402 (27%) identified themselves as physicians, and 16 (1%) identified themselves as executive-level administrators. Of the 1,433 respondents who identified their service area, 500 respondents (35%) said they worked in a medical service, 318 (22%) in a surgical service, 250 (17%) in an ICU, and 178 (12%) in an ED; 187 (13%) identified their service area as "other."

Instrument. The survey instrument was designed by the investigators, with input from other VHA staff members and outside consultants, to determine perceptions of the effects of disruptive behavior on psychological and behavioral variables among health care workers and on negative clinical outcomes. It incorporated feedback from the first survey's respondents, who recommended asking about the disruptive behavior of nurses and the influence of gender on the tendency to exhibit disruptive behavior. The survey consisted of 21 items. It contained multiple choice and yes-or-no questions; 5- and 10-point scales; and open-ended questions. The survey instrument was reviewed and tested internally by a subgroup of physicians and nurses from VHA hospitals to establish face validity.

Data analysis. Subtotals of the "sometimes," "frequently," and "constantly" responses were combined to determine the percentage of participants who perceived negative psychological and behavioral effects and negative clinical outcomes as common results of disruptive behavior. Responses were further analyzed to assess differences in the perceptions of nurses, physicians, and executives. Tests of statistical significance were performed using a one-way, between-groups analysis of variance (ANOVA) and post hoc comparisons using the Tukey HSD test to explore the experience of each group—nurses, physicians, and executives—with regard to psychological and behavioral variables and clinical outcomes resulting from disruptive behavior.

Direct quotations of responses to open-ended questions were categorized by potential severity of impact on patient care, with ICU admission, intubation, medical error, and patient death being the most serious consequences.

RESULTS

Quantitative data are presented as numbers and percentages based on the number of respondents who provided an answer to each question. (Note that some did not respond to all questions.)

The occurrence of disruptive behavior among nurses and physicians. (See Figure 1, at left.) Of the 965 respondents to the question *Have you ever witnessed disruptive behavior from a physician at your hospital?* nearly three-quarters said yes. Of the 675 nurses who responded to the question, 86% said they had witnessed it, and of the 249 physicians who answered the question, almost half said they had witnessed it in their peers.

Of the 960 respondents who answered the question *Have you ever witnessed disruptive behavior from a nurse at your hospital?* 68% (653) said yes. Notably, of the 664 nurses who answered this question, 72% (481) reported having seen other nurses' disruptive behavior, while 47% (116) of the 245 physicians who answered this question said they had. When asked *What percentage of physicians would you say exhibit disruptive behavior at your hospital?* more than half of the 1,452 who responded thought that the percentage of physicians who exhibit such behavior was in the 1%-to-3% range. And 60% of the 1,447 respondents to *What percentage of nurses would you say exhibit disruptive behavior at your hospital?* thought the percentage was in that range (see Figure 2, page 57).

Of the 1,416 respondents who answered the question *How often does physician disruptive behavior*

occur at your hospital? 22% answered "weekly," 26% answered "1 to 2 times per month," and 33% answered "1 to 5 times per year." While 11% of the respondents said that such behavior by physicians never occurs, 8% said it's a daily occurrence. Estimates of the frequency of disruptive behavior exhibited by nurses were comparable. Of the 1,389 respondents who answered the question *How often does nurse disruptive behavior occur at your hospital?* 13% answered "weekly," 26% answered "1 to 2 times per month," and 39% answered "1 to 5 times per year" (see Figure 3, at right).

The influence of gender. In order to assess providers' perceptions of the influence of gender on disruptive behavior, respondents were asked *Do you think that gender influences the tendency to exhibit disruptive behavior?* as well as *Which gender do you think has a greater tendency to exhibit disruptive behavior?* Of the 1,503 respondents who answered the question, 47% (702) said they thought that gender does influence the tendency to exhibit disruptive behavior. Of the 950 respondents who answered the question about whether male or female physicians had a greater tendency to exhibit disruptive behavior, 57% (543) reported a greater tendency in male physicians, 2% (17) reported a greater tendency in female physicians, and 41% (390) said gender makes no difference. Asked the same question with respect to nurses, 40% (372) of the 935 respondents reported a greater tendency in female nurses, 7% (63) a greater tendency in male nurses, and 53% (500) said gender makes no difference.

Psychological and behavioral variables and clinical outcomes. Of the 962 respondents who answered the question *From your perspective, do you think that disruptive behavior could potentially have a negative effect on patient outcomes?* most answered yes (see Figure 4, page 58). To get more detailed information on how providers perceive the effects of disruptive behavior on psychological and behavioral variables among their colleagues (see Figure 5, page 59), respondents were asked, *How often does disruptive behavior result in the following* [psychological and behavioral effects]*?* A list of seven variables followed: stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, and impaired nurse–physician relationships. For each variable, respondents checked one box on a 5-point scale that ranged from "never" to "constantly." To assess providers' perceptions of the link between disruptive behavior and clinical outcomes (see Figure 6, page 60), respondents were asked, *How often do you think there is a link between disruptive behavior and the following* [clinical outcomes]*?* A list of six outcomes followed: adverse events, errors, patient safety, the quality of care, patient mortality, and patient satisfaction. Responses were made according to the same 5-point scale. Subtotals of the "sometimes," "frequently," and "constantly" responses to these questions were also combined to determine the percentage of respondents who perceived such disturbances as common occurrences. Depending on the variable being measured, between 83% and 94% of respondents indicated that disruptive behavior does have a significant effect on psychological and behavioral variables, and between 53% and 75% of respondents said they saw a strong link between disruptive behavior and negative clinical outcomes (except for patient mortality; only a quarter of respondents saw such a link). (How the three

Figure 2 Respondents' Estimates of the Percentage of Physicians and Nurses Who Exhibit Disruptive Behavior

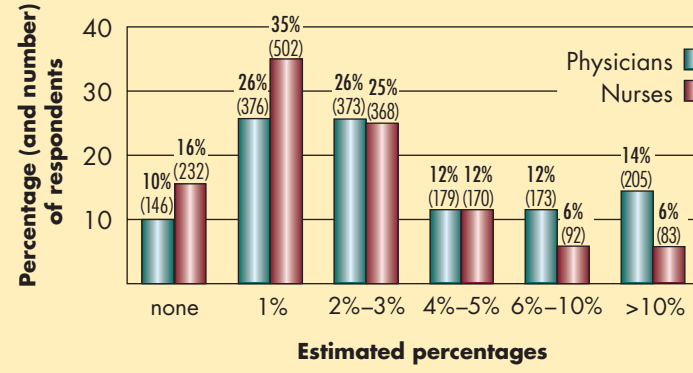


Figure 3 Respondents' Estimates of the Frequency of Occurrence of Disruptive Behavior Exhibited by Physicians and Nurses

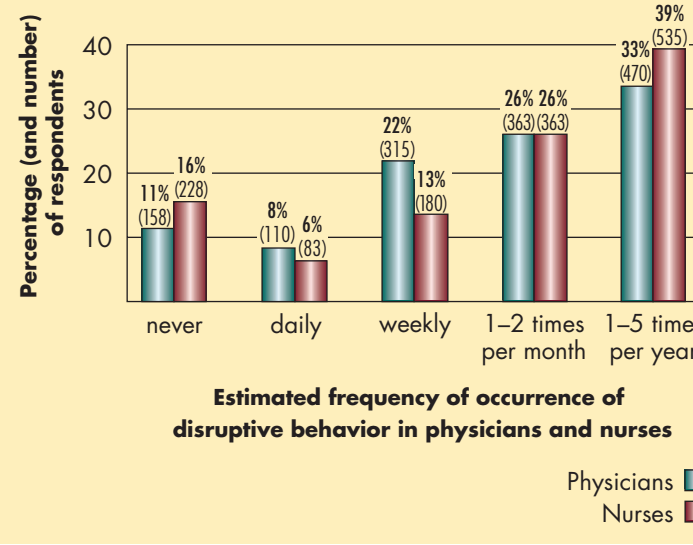
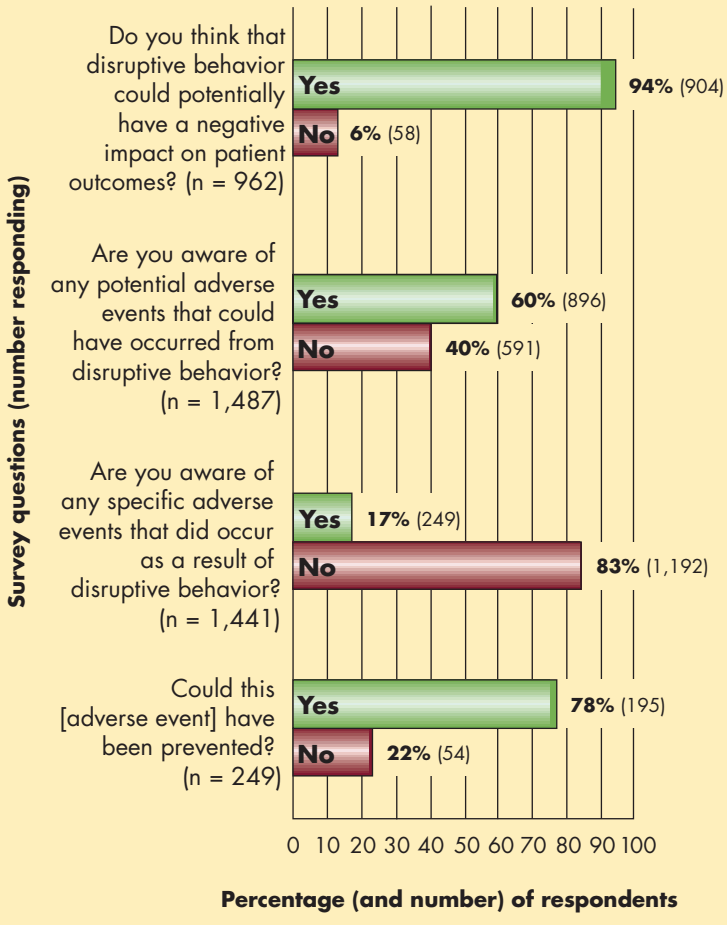


Figure 4 Respondents' Answers to Selected Survey Questions



groups responded individually is also shown in Figures 5 and 6.)

Further analysis revealed statistically significant differences between the nurses' and physicians' responses ($P < 0.01$) to five of the seven questions about psychological and behavioral variables. Because of the small size of the executive group, significant differences from the nurse and physician groups couldn't be determined.

Of the 1,487 respondents who answered the question *Are you aware of any potential adverse events that could have occurred from disruptive behavior?* 60% answered yes (see Figure 4, above). Of the 730 respondents who answered the follow-up question, *If yes, how serious an impact do you think this could have had on patient outcomes?* almost three-quarters thought that these events could have a serious, very serious, or extremely serious impact on patient outcomes. Of the 1,441 respondents who answered the question *Are you aware of any specific adverse events that did occur as a result of disruptive behavior?* 17% answered affirmatively (see Figure 4, above). All who answered yes also answered the follow-up question, *Could this [adverse event] have been prevented?* Seventy-eight percent thought that the adverse event could have been prevented (see Figure 4, at left).

Of the 1,395 respondents who answered the question *Did you participate in the previous VHA survey measuring the influence of physician behavior on nurse satisfaction and retention?* 13% (120) said yes. Those 120 respondents also answered the question *Has your organization done anything different to address the issue as a result of participating in the first survey?* and 37% (43) said yes. And of 118 respondents who answered the question *Since the previous survey, what is the status of nurse–physician relationships?* 24% (28) reported improvement.

Respondents' comments. Several questions in the survey invited respondents to describe their experiences and concerns. Representative responses to these open-ended questions are included in the discussion section, below.

DISCUSSION

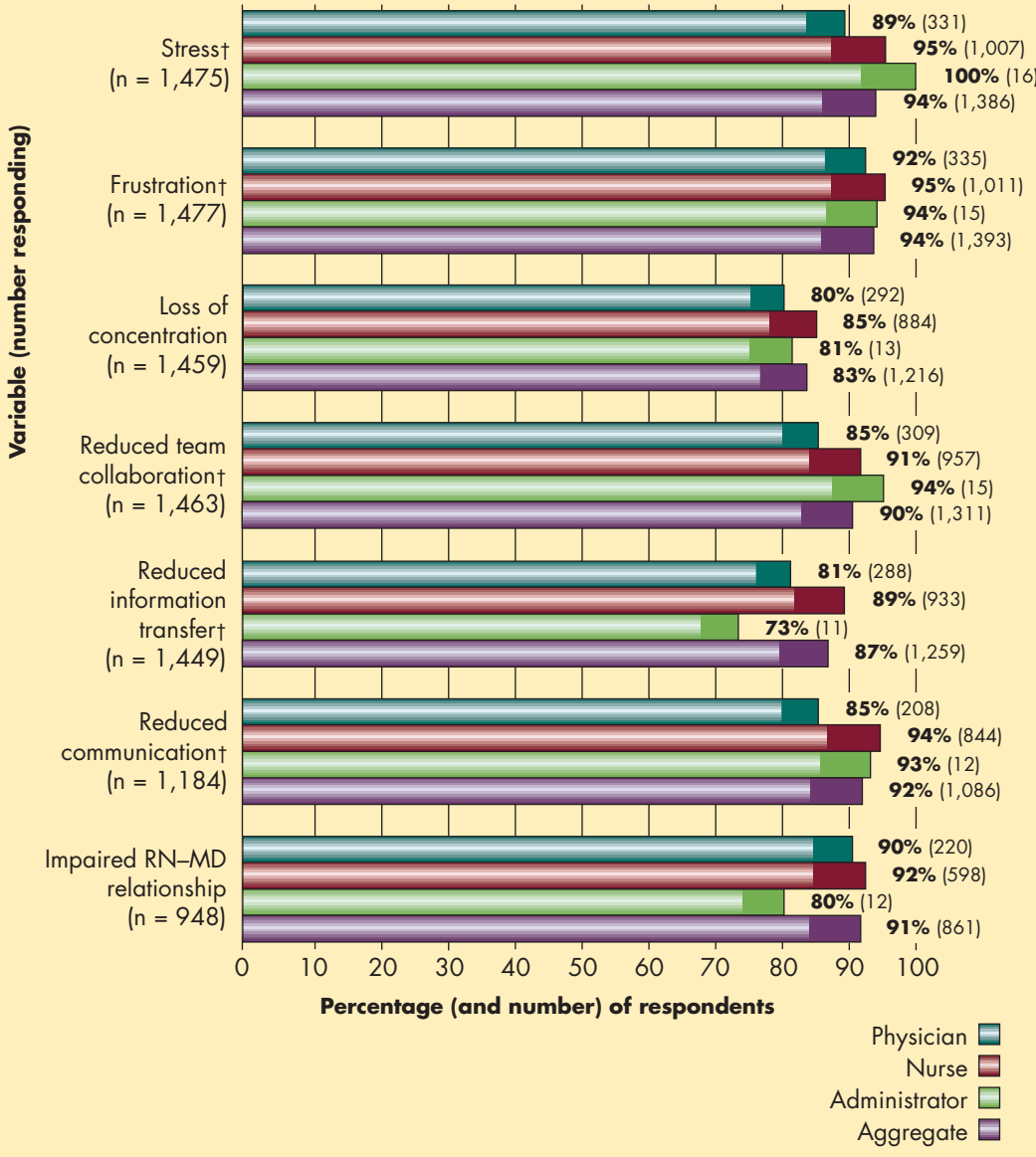
Staff relationships are an important element in health care delivery. Having the right number of staff members, the optimal staff mix, and strong communication and collaboration can have enormous effects on health care delivery and its outcomes. Disruptive behavior is one of the most important influences on the quality of staff relationships. The current survey was designed to evaluate perceptions of the prevalence and significance of disruptive nurse–physician working relationships and assess perceptions of their impact on clinical outcomes.

A problem within and across disciplines. Disruptive behavior is not unique to physicians. The current survey revealed a high prevalence of disruptive behavior among nurses as well as physicians. And disruptive behavior affected not only nurse–physician relationships but also relationships between physicians and between nurses. Of particular significance are the findings that nearly half of the physicians witnessed disruptive behavior in other physicians and nearly three-quarters of the nurses witnessed disruptive behavior in other nurses. This suggests a serious problem within and across disciplines.

While it wasn't within the scope of this study to examine how providers' disruptive behavior affected their relationships to patients or family members, several responses to open-ended questions touched on this concern. For example, one nurse wrote, "When patient [was] brought to unit for GI bleeding, patient saw MD yelling at nurses. Patient asked if that was his doctor. [Patient was told] 'Yes.' Patient refused treatment and was transferred to another hospital." (This respondent added, "I am retiring early and never recommend someone becoming a nurse.") Another wrote: "MD became angry when RN reported decline in patient's condition and did

Figure 5

Percentage of Respondents Answering 'Sometimes,' 'Frequently,' or 'Constantly' to the Question *How often does disruptive behavior result in the following [psychological or behavioral effects]?**



*Respondents who did not identify themselves by job title are included only in the aggregate group; therefore, the aggregate subtotals are larger than the sums of nurse, physician, and administrator subtotals.

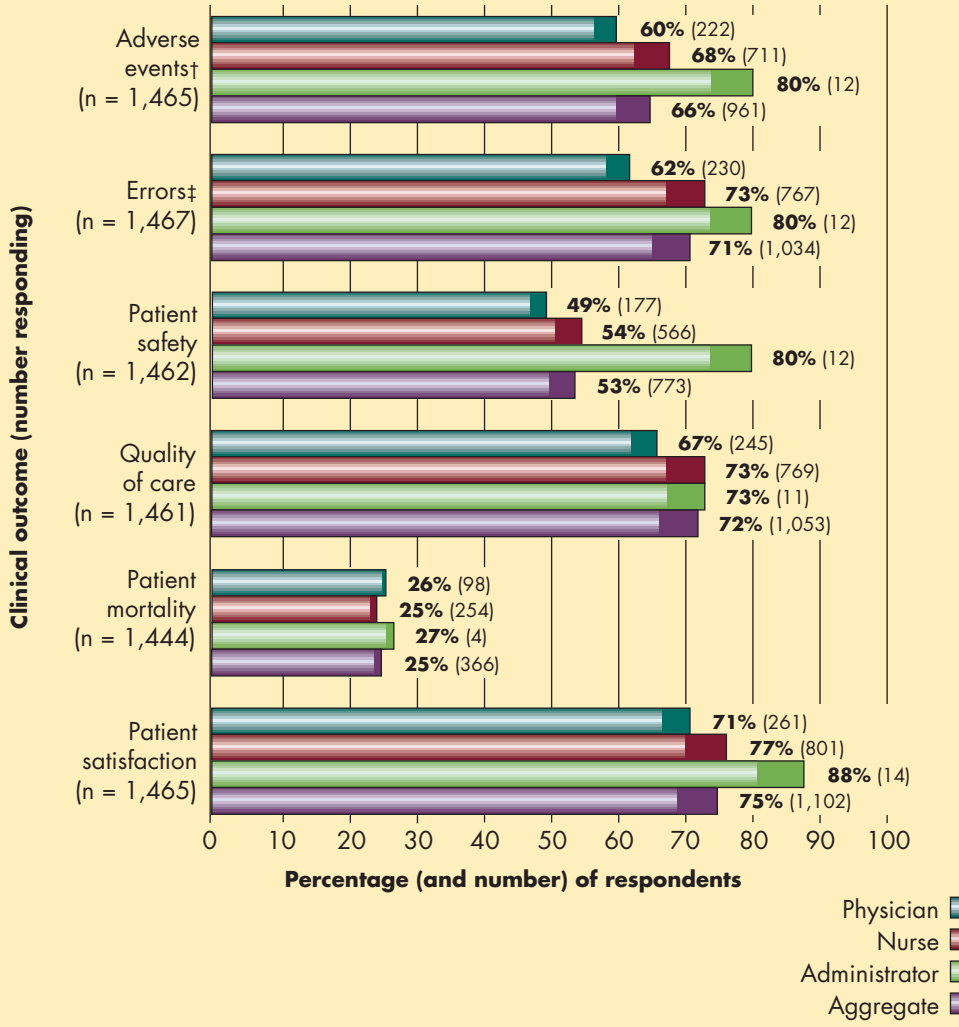
†The difference between nurses' and physicians' responses was statistically significant ($P < 0.01$).

not act on information. Patient required emergency intubation and [was] transferred to ICU. This caused family much unnecessary heartache and disruption in family grieving process."

In a recently completed, unpublished survey conducted in the VHA Mountain States region, disruptive behavior was noted in other departments as well, such as pharmacies, radiology departments, and laboratories.

Gender. Responses to the questions on gender were mixed. Nearly half of the respondents thought that gender played a role in disruptive behavior, and

Figure 6 Percentage of Respondents Answering 'Sometimes,' 'Frequently,' or 'Constantly' to the Question *How often do you think there is a link between disruptive behavior and the following* [clinical outcomes]?*



*Respondents who did not identify themselves by job title are included only in the aggregate group; therefore, the aggregate subtotals are larger than the sums of nurse, physician, and administrator subtotals.

†The difference between the nurses' and physicians' responses was statistically significant ($P < 0.05$).

‡The difference between nurses' and physicians' responses was statistically significant ($P < 0.01$).

slightly more than half thought it didn't. A majority (57%) of respondents thought that male physicians had a greater tendency to exhibit disruptive behavior, and 40% thought female nurses also had this tendency. These findings may reflect the disproportionate numbers of men and women in medicine and nursing, respectively, although responses to the open-ended questions mentioned specific concerns about female physicians and male nurses. For example, one respondent wrote, "A male nurse has a particularly difficult time dealing with male physicians." Another respondent said, "Physician was told twice that sponge count was off. She said, 'They will find it later.' Patient had to be reopened."

Another wrote:

> In the past year, Dr. X (a female physician) has chosen to be argumentative, demeaning, and rude, not just to nurses but to [physician] col-

leagues. We are all a team but, unfortunately, patient care and morale have suffered. Nurses are afraid [and] intimidated to talk to Dr. X and delay that for as long as possible, sometimes avoiding Dr. X all together. I want to work in an environment where we, as a team, set patient goals and achieve them together.

Psychological and behavioral variables and clinical outcomes. The main focus of the survey was to assess the impact of disruptive behavior on psychological and behavioral variables and clinical outcomes, according to what physicians, nurses, and hospital administrators perceived. The respondents reported that disruptive behavior had a significant negative impact on levels of stress, frustration, and concentration and on team collaboration, information transfer, communication, and nurse–physician relationships. Written comments included the following.

- "There are several MDs on the staff who have rude and intimidating personalities. These physicians do not respect the nurses and make for a very stressful environment."
- "Disruptive behavior is not unique to physicians. Some nurses exhibit an air of superiority which makes communication difficult."
- "Physicians who are disruptive are usually chronic disrupters and have run-ins with several nurses. There are also nurses who are chronic disrupters. These people are often avoided by other staff which leads to lowered communication. I am sure that a serious incident is just around the corner."

The results also showed a strong perception of an association between disruptive behavior and the occurrence of adverse events and errors, as well as the negative effects of disruptive behavior on patient safety, the quality of care, patient mortality, and patient satisfaction. Responses to several survey questions highlighted the seriousness of this issue. In response to the question about the potential of adverse events to result from disruptive behavior, more than one-third of the respondents thought that such a potential existed. The following are representative responses to the open-ended questions.

- "The environment of hostility and disrespect is very distracting and causes minor errors. I have caught myself in the middle of mislabeling specimens after confrontations that have been upsetting."
- "Disruptive behavior resulting in negative patient outcomes is not just a potential problem, I think about it 80%–90% of the time. It creates problems."
- "Employee stress as a result of a physician yelling resulted in decreased patient safety."
- "Intimidation of RN led to lack of communication and patient intervention."
- "Delay in patient receiving meds because RN was afraid to call MD."
- "Most nurses are afraid to call Dr. X when they need to, and frequently won't call. Their patient's medical safety is always in jeopardy because of this."

Even more striking were the responses to questions about the respondents' awareness of specific adverse events that did occur as a result of disruptive behavior and whether those events were preventable. Seventeen percent of respondents reported that they knew of an adverse event that occurred as a result of disruptive behavior, and nearly 78% of them thought that the event in question could have been prevented.

Of survey respondents, 17% knew of an adverse event that occurred as a result of disruptive behavior; 78% of them thought the event could have been prevented.

While any adverse event is an unwelcome occurrence, a few are to be expected. For example, according to a 2000 report conducted by Brigham and Women's Hospital and the Harvard School of Public Health that examined 15,000 medical records from 28 hospitals, "adverse events occurred in 2.9% of hospitalizations."[17] These results raise a very strong concern about the influence of human factors on clinical outcomes.

The following are some respondent comments.

- "Adverse event related to med error because MD would not listen to the RN."
- "RN did not call MD about change in patient condition because he had a history of being abusive when called. Patient suffered because of this."
- "Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended."
- "Difficult endoscopy. Physician angry, frustrated, abusive to patient and technician. Patient safety compromised."
- "Communication between OB and delivery RN was hampered because of MD behavior. Resulted in poor outcome in newborn."
- "MD yelled at RN for calling at night, patient condition not addressed, resulting in a negative patient outcome."

- "RN called MD multiple times re: deteriorating patient condition. MD upset with RN calling. Patient eventually had to be intubated."
- "Failure of MD to listen to RN regarding patient's condition. Patient had postop pulmonary embolism."
- "RNs did not want to call MD after IV ran out. No antibiotic therapy for four days. RN afraid to call MD. Patient expired."
- "Poor communication postop because of disruptive reputation resulted in delayed treatment, aspiration, and eventual demise."

Support in the literature. There are very few published studies documenting the ill effects of disruptive behavior on psychological and behavioral variables and the resulting impact on patient care. As mentioned above, research conducted by the IOM, JCAHO, and other organizations that promote patient safety have shown a strong correlation between human factors and medical errors and adverse events.[7, 18-20] Bates and Gawande, in their excellent article, "Improving Safety with Information Technology," cite several studies that focus on "failures of communication, particularly those that result from inadequate 'handoff' between clinicians" as being among "the most common factors contributing to the occurrence of adverse events."[21]

Another study that reviewed 26,212 error records listed "distractions" as the number-one factor contributing to medication errors.[22] Blendon and colleagues assessed physicians' views on medical errors and reported that 53% believed nurse understaffing to be a "very important" factor in errors; 50% believed overwork, stress, or fatigue on the part of health care professionals to be very important factors; and 39% believed that another factor was the failure to work as a communicative team. According to the same study, 67% of 1,207 randomly selected members of the general public rated the failure of health care professionals to work as a team as a very important cause of medical errors.[23]

Cassirer and colleagues, in their study of workplace abuse, outlined a model that linked abusive behavior to stress and "human system failure," which, in turn, contribute to risks to patients, including errors and injuries.[24] A *Hospitals and Health Networks* article on the ill effects of abusive behavior linked it to stress, burnout, and errors in patient care that resulted from miscommunication.[25] The March 2004 issue of the *ISMP* [Institute for Safe Medication Practices] *Medication Safety Alert* reported that 7% of medication errors could be attributed to the intimidation of nurses by physicians.[26] Until our study, there had been no research-based report linking disruptive behavior to detrimental effects on providers' psychological well-being or on outcomes.

Impact of the previous nurse–physician relationships survey. About a third of the respondents who participated in the first survey reported that their hospital had done something different to address the issue of disruptive behavior as a result of that participation. Also among those who had participated in both surveys, 24% (28 respondents) reported a resulting improvement in nurse–physician relationships (two respondents didn't answer this question).

Strategies employed by these organizations had two main themes: education and leadership support. Raising physicians' and nurses' awareness and offering specific educational programs on such topics as mutual respect, sexual harassment, diversity, team collaboration, and anger management played important roles in improving nurse–physician relationships. Other studies support the notion that strong leadership and commitment to changing an organization's culture, as well as the development of well-defined code-of-conduct and disciplinary policies and special committees charged with intervening when disruptive behavior arises, are critical to reinforcing appropriate standards.[27-32]

Wider implications. The impact of disruptive behavior on the job satisfaction and retention of nurses is especially important in light of the nursing shortage. Respondents to our survey believed that disruptive behavior contributes to this trend. According to a JCAHO white paper, *Healthcare at the Crossroads,* the American Hospital Association estimated that there were more than 126,000 unfilled RN positions across the country in 2001.[3] An article in the *Chicago Tribune* stated that "some 490,000 licensed nurses no longer work in the profession" and that "by 2005, experts predict, more nurses will be leaving the profession than entering it."[33] Consequences of the shortage include unit closures, canceled procedures, ED and hospital admission diversions, and service delays. For these reasons, it's all the more imperative that hospitals and other health care institutions take the lead in addressing the problem of disruptive behavior among health care workers.

Limitations. One limitation of using a convenience sample is that responses are voluntary; therefore, there's a potential for the results to be biased by self-selection—that is, those nurses, physicians, and administrators who are most interested in the issue, or who have had personal experiences related to it, may be most inclined to complete the survey. However, returned surveys from a variety of hospital settings presented mixed responses concerning the prevalence of disruptive behavior, including perceptions of both very poor and very good staff relations, suggesting that selection bias was not a significant factor.

STRATEGIES FOR IMPROVEMENT

While the incidence of disruptive behavior in the workplace may be low, such behavior can be an extremely destructive force that undermines employee morale, increases stress and frustration, stimulates staff turnover, and leads to adverse patient outcomes. Disruptive behavior is not unique to any one discipline. Given the potential of disruptive behavior to result in adverse events, health care organizations must recognize the importance of addressing this issue practically, developing strategies that support appropriate behavior, and implementing policies that deal effectively with disruptive incidents when they occur.

Initial strategies for improvement include the following.

- *Conduct an organizational self-assessment.*
- *Increase staff awareness* of the nature and severity of the issue.
- *Open up lines of communication* between affected parties in order to create a nonantagonistic environment in which important issues can be discussed.

The next step in the process is to promote opportunities for collaboration. This can be accomplished either in informal meetings or discussion groups or in more structured committees or task forces where these issues are addressed.

Provide appropriate classes to support mutual respect among coworkers and the benefits of team collaboration. Once the major topics are identified, structured staff education programs may be necessary to reinforce appropriate modes of conduct and communication. Courses focusing on communication skills, conflict management, and team building provide a forum for improving "people skills." For example, phone etiquette classes have been particularly effective because many disruptive events are precipitated by telephone calls to physicians. As one physician respondent said, "Nurses should receive better clinical training. When calling a physician, they should know what the doctor expects her to know, which includes a basic amount of information, such as the patient's name, vital signs, the diagnosis, and the type of surgery the patient has had or is scheduled for. She should also identify herself by name and position."

Improving physicians' receptiveness and responsiveness to calls and improving nurses' competency in presenting information to physicians will help improve communication and information transfer. (See "Communicating for Better Care," December 2004.)

Implement policies and procedures that reinforce acceptable codes of behavior. The organization must also be committed to improving staff relations. This commitment must include creating a culture in which respect and integrity are valued, unacceptable behavior isn't tolerated, and the reporting environment is nonpunitive. The organization must develop a fair process for evaluating and acting on staff complaints. It must have a well-defined code of behavior that's applied consistently to all members of the organization. The organization must also develop an effective disruptive behavior policy to deal with those members of the organization who are constant abusers of the system and do not improve after education and counseling.

Another suggestion for improvement: having a well-placed "clinical champion," such as the chief of staff, vice president of medical affairs, or chief medical officer, who supports and takes responsibility for the process of transforming the institution's culture, is an extremely valuable asset. A clinical champion who takes a leadership role and who is passionate about both improving staff relations and clinical outcomes could mean the difference between the program's success and failure.

Promote better patient care and clinical outcomes. Improving relationships among clinicians is the most important factor in reducing the unwanted effects of disruptive behavior on clinical outcomes. The first step in implementing a successful improvement strategy involves increasing awareness of the seriousness of the problem. The best way to accomplish this is to perform an organizational self-assessment to determine the extent of the problem and identify areas of need. Results of the assessment should be discussed with the clinical and administrative teams. A concerted effort should be made to increase the understanding of individual values, roles, and responsibilities and address any underlying barriers or resistance before moving forward. ▼

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CE 3 HOURS
Continuing Education

GENERAL PURPOSE: To provide registered professional nurses with information on the impact of disruptive behavior on communication and collaboration among clinicians and the adverse impact it may have on patient care.

LEARNING OBJECTIVES: After reading this article and taking the test on the next page, you will be able to

- discuss the incidence and reporting of disruptive behavior among physicians and nurses.
- describe what physicians, nurses, and hospital administrators believe are the effects of such behavior on patient care.
- describe research findings on and strategies for improving clinical outcomes and relationships among clinicians.

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