Disruptive behaviour and its impact on communication efficiency and patient care

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ABSTRACT

Disruptive behaviour has been shown to have a significant negative impact on staff relationships, communication and team collaboration that can seriously affect patient and staff satisfaction, information transfer, care efficiency and ultimately, clinical outcome. Unfortunately, many healthcare organisations have been reluctant to address the issue, particularly if it involves a prominent physician. Recent events have made 'looking the other way' a non-acceptable alternative. There is a growing body of evidence linking disruptive behaviours to communication inefficiencies that compromise patient safety and quality of care. In 2009, the Joint Commission, recognising that communication gaps account for more that 70 per cent of adverse patient events, introduced a new accreditation requirement that hospitals need to implement a disruptive behaviour policy as part of their accreditation standards. Beyond disruptive behaviour is the open opportunity to improve communication efficiency. This paper presents a ten-step intervention model that promotes a positive proactive early intervention approach to addressing disruptive behaviours by raising levels of awareness, setting appropriate policies and procedures, offering multiple different levels of educational support, coaching and counselling, and addressing disruptive events when they occur.

Keywords: disruptive behaviour, communication, staff relationships, patient safety

INTRODUCTION

Today's healthcare environment is becoming more and more complex each day. Patients in the hospital are sicker, staff are stressed from cutbacks and shortages, overwork, changing priorities, disassociated

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tasks and responsibilities, and the never-ending introduction of new tools and technologies that change customary processes, procedures and practice patterns. Given this hectic pace, one has to wonder how it is possible to function effectively and provide best quality patient care. But do patients receive best-quality care? More than 10 years ago, the Institute of Medicine (IOM) published a report that highlighted significant concerns about preventable adverse events that impact on patient safety.[1] This was indeed a wake-up call for healthcare providers to reassess structure and processes and introduce new strategies to protect patients from harm. The initial response was to take a systems approach to improving safety by adding new tools, technologies and processes to more effectively monitor and assure patient safety. It has worked to a degree. The systems have definitely been improved, but preventable errors still occur at an alarming rate.[2] The Joint Commission, whose major focus is to monitor patient safety and quality as part of the hospital accreditation process, reported that nearly 70 per cent of sentinel events can be traced back to a communication error.[3] Given these facts, maybe ther is a need to shift the focus away from just system restructuring and pay more attention to the human factors issues and behaviours that influence the individual values, attitudes and reactions that affect communication, information transfer, and overall responsibility and accountability for care coordination and task completion.

METHODOLOGY

In 2002, VHA West Coast, one of 16 regional divisions of VHA Inc, a national network of not-for-profit hospitals, developed a 25-question survey tool designed to assess the relationship between physician disruptive behaviour and nurse satisfaction and retention.[4] The survey tool was distributed to physicians, nurses and administrative executives across the VHA system. Phase two of the survey increased the focus to address the extent and impact of disruptive behaviours among nurses and other healthcare disciplines, and their impact on psychological and behavioural factors affecting the process and outcomes of healthcare delivery. The results presented below include the analysis of over 7,000 surveys received between 2002 and 2009 from more than 150 hospitals across the USA.

Background

In early 2000, in the midst of the nursing shortage crisis, VHA West Coast developed a new survey tool to ascertain whether or not there was a relationship between disruptive physician behaviour and the nursing shortage. The results were surprising. These events were occurring much more frequently than suspected and the negative impact on staff morale and retention was more than anyone could have predicted. Comments received from the first survey seemed to open up a Pandora's Box. Subsequent surveys extended the research to evaluate disruptive behaviours in nursing and other healthcare disciplines and delved further into the issue to assess the impact of these behaviours on the psychological factors that influence perceptions, attitudes and actions that can adversely affect communication efficiency, information transfer, and task accountability, all of which can adversely affect patient care.[5–7]

Figure 1 shows the frequency of respondents witnessing disruptive behaviour by physicians and nurses. Some 78 per cent of survey respondents reported that they had witnessed disruptive behaviour by physicians. Of interest, is that 50 per cent of the physicians witnessed disruptive behaviour among their peers. A total of 66 per cent of the survey respon-

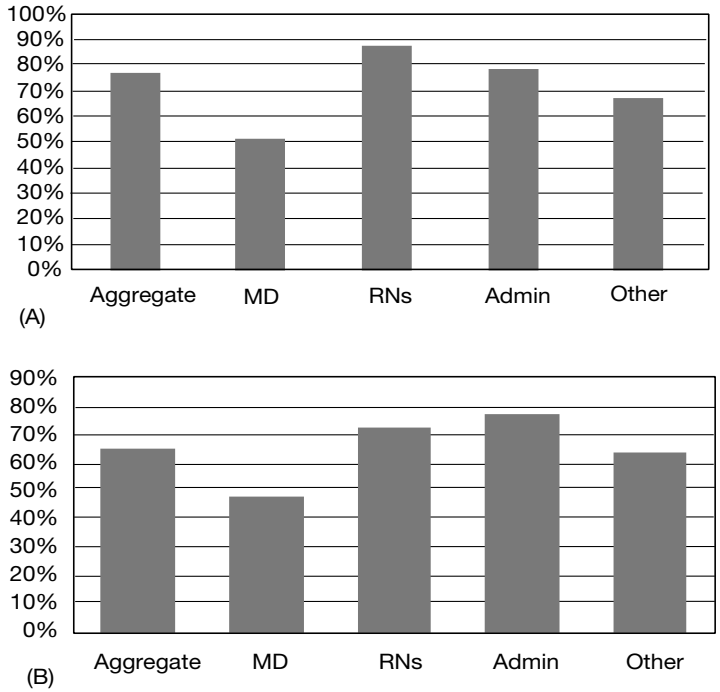


Figure 1 Disruptive behaviours in (A) physicians and (B) nurses

dents reported that they had witnessed disruptive behaviour by nurses. Of even greater interest is that 75 per cent of the nurses had witnessed disruptive behaviour among their peers. Physician disruptive behaviours are usually more overt and direct. Nursing disruptive behaviours on the other hand tend to be more subtle, passive-aggressive in nature, and have more of a back-door undermining effect. Some researchers have used the term 'horizontal hostility' to describe these behaviours.[8] Recent reports, however, have suggested that there appears to be a growing amount of female bullying in the workplace.[9]

These disruptive behaviours can have a profound effect on the recipient's willingness and capability to respond. Based on the survey results, the study looked at the impact of disruptive behaviours on psychological factors known to affect human behaviours that may affect task completion. These events can invoke a significant stress-related response that can affect focus and concentration, communication and collaboration, and the ability to effectively transfer vital information and responsibilities which could adversely affect patient care (see Figure 2). Figure 3 shows the end result of these actions which can seriously compromise patient safety and quality of care.[10]

Closer examination only serve to increase the study group's concern regarding the frequency and impact of these types of events and their downstream negative effect on patient care. What originally started out with a primary focus to address the 3–5 per cent of the physician and nursing staff that were recognised as being disruptive soon grew into an open opportunity to address the other 50 per cent of the staff who were just not effective communicators.

Strategies

It is hard to imagine that any physician or staff employee starts the day by thinking that this is their day to be disruptive and/or to be a bad communicator. Even

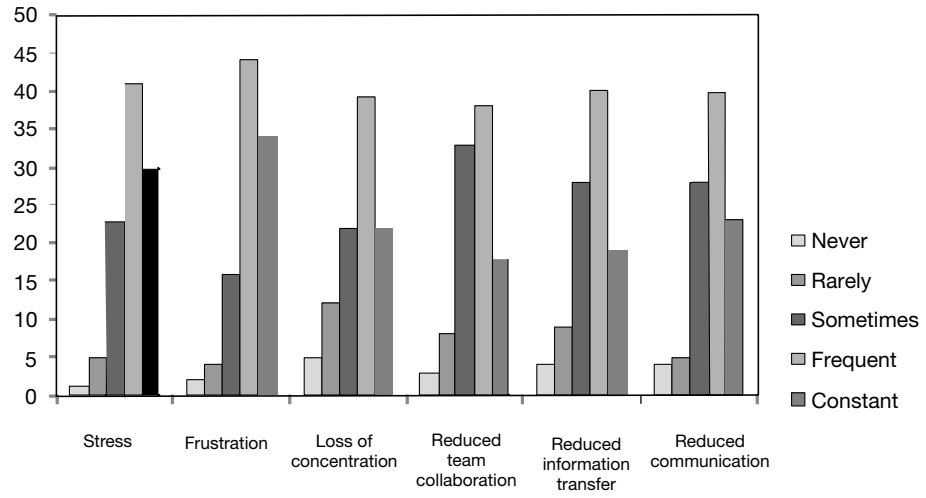


Figure 2 Impact of disruptive behaviours on psychological/ performance factors

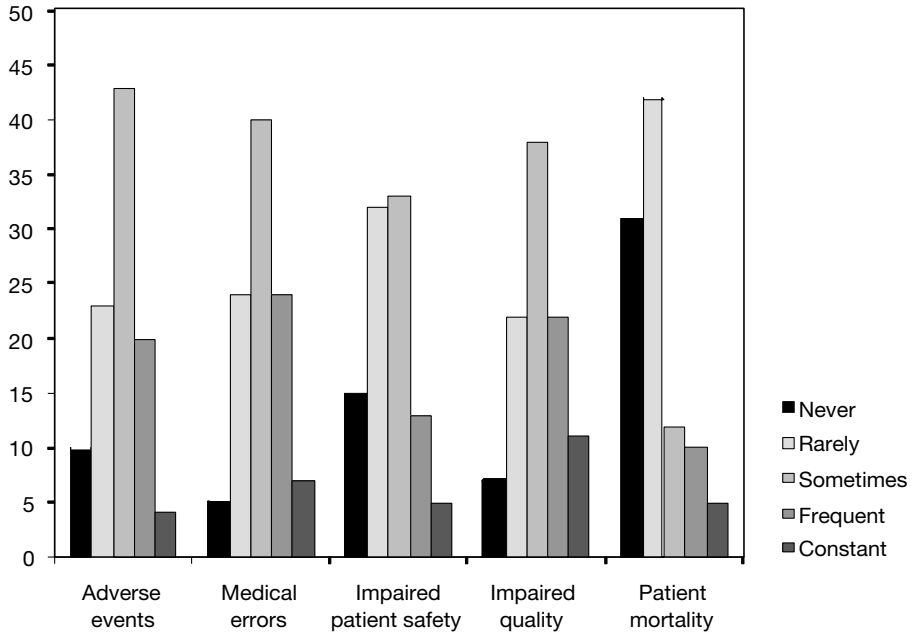


Figure 3 Linkage of disruptive behaviours to adverse effects on patient care

after the fact, most of the individuals initiating a disruptive event do not even recognise that anything was wrong. This is particularly true with physicians who are accustomed to barking out orders as the authoritative manager of patient care.

The primary focus should be on raising awareness as to the severity and consequences of disruptive behaviours in an effort to prevent the occurrence of disruptive events and address such behaviours when they do occur in an appropriate and

Table 1: Strategies for addressing disruptive behaviour

1.	Define the problem
2.	Awareness and accountability
3.	Organisational and leadership commitment
4.	Policies and procedures
5.	Staff education
6.	Communication/team collaboration skills
7.	Reporting policy and follow-through
8.	Disruptive behaviour policy
9.	Address barriers
10.	Implement intervention plan

effective manner, to minimise short-term and long-term effects. Early intervention is the key. Working with individuals early on in the cycle will help identify certain stresses and other underlying factors that may predispose an individual to elicit a disruptive reaction and in this way provide a more positive supportive resolution rather than waiting until a late cycle event has occurred where the intervention takes on the connotations of a punitive reprimand. Addressing disruptive behaviours provides an excellent opportunity to extend the focus of attention to improving everyone's skills to enhance communication efficiency and team collaboration.

Table 1 provides a step-by-step overview of suggested strategies and recommendations designed to address both disruptive behaviours and improve overall efficiencies in communication and collaboration. The programme should be developed in conjunction with other organisational efforts to improve processes and outcomes related to work efficiency, satisfaction, quality and patient safety, and should be administered with an underlying positive supportive tone of addressing and supporting opportunities for improvement to provide best patient care.

Define the problem

The first step is to define what is meant by disruptive behaviours and then engage the audience about what it really means. Many individuals, particularly physicians, do not understand what disruptive behaviour is. They will of course admit they yelled at somebody or got angry, but they accept that as part of the way they do business in their responsibilities for patient care. If they felt they have been insulting they might apologise later, perhaps send flowers or chocolates, or say they are sorry, but then walk away thinking everything was OK and no damage done. They do not see the downstream effect of their actions.

In the survey, disruptive behaviour is defined as any inappropriate behaviour, confrontation or conflict ranging from verbal abuse to physical or sexual harassment.[11] The most common behaviours include condescending attitudes, disrespectful behaviours, berating or insulting an individual in front of their peers, yelling or abusive anger, harassment, or physical abuse. The crucial first step is to make individuals aware of what disruptive behaviour is, what it can do to the individuals involved, and how it can impact on patient care.

Raise levels of awareness and accountability

Raising the level of awareness as to the seriousness and consequences of disruptive behaviours sets the stage for engagement. One of the easiest ways to raise awareness is to do an internal assessment to evaluate the current status of where things are at the organisation. Many organisations have utilised a variety of surveys, town hall meetings, or task force committees to help assess the current status of affairs and be better able to uncover targeted areas for improvement. People may have heard about the problem, but they usually think that it relates to everyone else. The data

help support the cause. The two keys to success with these initiatives are keeping results confidential and making sure that there is follow-through once the assessments are completed. Stress the importance of accountability and responsibility revolving around patient care and use the information to support appropriate action-oriented procedures. The business case for clinicians is the awareness of the potential negative downstream effect of their interactions and their overall responsibility for providing best patient care.

Develop a strong organisational culture and leadership commitment

One of the key components of any improvement programme is the underlying culture and organisational commitment to make the workplace environment a place where people want to work, like to work (satisfaction), and the customers (patients) receive good (quality and safety) service. Organisational culture is the sum of all the working parts. It is a reflection of all the standards, behaviours and expectations exhibited by all the individuals involved. In the healthcare setting, this includes front-line clinical staff, behind the scenes supportive staff, middle and senior-level management (clinical and administration), all the way up to the governing board. For the culture to succeed, all the components must take an active role in making it happen. Engaging well-respected peers to serve as project champions will help accelerate the programme's success.

Implement policies and procedures

Developing and implementing effective policies and procedures with set criteria that both set the standards for appropriate behaviour and hold individuals accountable for their actions is a vital component of the programme.[12] It is essential to hold all employees, staff and physicians working at the organisation to the same criteria and be consistent in policy application and follow-through. Starting in 2009, the Joint Commission has mandated that hospitals have a disruptive policy in place and provide supporting services around this policy as one of the new leadership standards for hospital accreditation.

Provide staff education

Staff education can be presented at a number of different levels. The first level provides a general overview of the problem and its repercussions. The sessions should strive to make the case for all individuals to take responsibility and be accountable for their actions and behaviours as it affects staff relationships, communication and process flow, and ultimately patient outcomes of care. Providing specific organisational data will increase the relevance and impact as a needed call to action.

The second level begins to focus on factors that may affect one's individual values and experiences that shape communication styles and potential tendencies for disruptive behaviour. studies have previously looked at the contributions of gender, age (generation), culture and ethnicity, personality styles, family values and life experiences that shape the way individuals deal with each other.[13] One particular uniqueness to the medical environment is the styles and attitudes that result from medical training. Physicians are measured more on their knowledge and technological skills than their ability to communicate or collaborate with their peers. They start out their training with low self-confidence and self-esteem and are quickly thrust into critical situations where they need to make life-or-death decisions. They are trained to be dominant, independent and direct with their manner and demeanour and expect everyone to respond to their demands. The

other healthcare disciplines are trained with more of a sharing and caring peer support philosophy that encourages communication and collaboration.

In an effort to work through many of these issues, some organisations have offered specific continuing medical education courses for physicians.[14] Others have offered programmes that provide diversity training, sensitivity training, assertiveness training, and/or courses on conflict, anger or stress management. Some organisations have gone a step further by providing specific training programmes on how to deal with different personality styles, gender and generational issues. In some cases, more focused education and training programmes that include individual coaching and counselling may be recommended, depending on the underlying circumstances.

Communication skills

Specific training courses on communication and team collaboration skills are now making their way into the medical marketplace.[15,16] Tools such as the SBAR (Situation/Background/Assessment/Recommendation) tool provide a framework for healthcare workers to more effectively 'present' a patient to a physician or colleague by providing them with a script that helps them organise their thoughts into a format that enables them to deliver the necessary information to the physician (or other staff member) in an efficient, cohesive manner. Team collaboration skills as utilised in the aviation and motor-racing industry provide skill training that emphasises trust, accountability, competency, anticipation, conflict avoidance, assertiveness and open discussion (or briefings) that provide an excellent forum for increasing team communication, collaboration and efficiency. Noting the growing influx of foreign-born physicians, nurses and other hospital staff members, for whom English is not the primary language, some organisations have offered programmes on linguistics training, focusing specifically on improving the efficiency of dialogue exchange in the medical environment.

Reporting policy and follow-up actions

It is crucial to make sure that the reporting process provides a consistent non-biased approach to incident evaluation and follow-up plan of action. Each event needs to be evaluated on its own merits by an individual who is trained to address the issue effectively and has no conflict of interest or peer pressure influence to sway them from making the right decision. The present research suggests that there is a tremendous amount of variability and integrity in the way incidents are evaluated, depending upon who did the reporting, what individuals were involved, and who the incident was reported to. An even greater concern is the infrequency in which hospitals actually report disciplinary actions.[17]

To prevent these potential pitfalls, it is crucial to set up a system that provides a consistent and equitable process to incident review. One way to achieve this is to set up a standard process whereby all complaints are sent to a designated committee for evaluation and recommended course of action. Having a multi-disciplinary composition offers the advantage of having a group decision with multiple different perspectives that can provide a non-biased insight and avoid any potential individual conflicts of interest. Follow-up interventions and solutions run the full gamut of severity and success.[18] The simplest alternative is to bring the event to the attention of the person involved and after an informal discussion, the individual realises what had occurred and assures that it will not happen again. More complex cases may require referral to department

chairs, directors or supervisors. In some cases, there may be recommendations that the individual must take a specific training programme, or a requirement for individualised coaching or counselling. More severe cases may require referral to the credentials committee and/or result in termination.

A second issue around event reporting is past history. Individuals are getting increasingly frustrated with the reporting process in terms of: (1) concerns about confidentiality; (2) fears of retaliation and (3) the fact they report and report again and nothing ever seems to change. It is crucial that the organisation take every step necessary to assure confidentiality and strongly address the issue of retaliation if it occurs. In regard to feedback, appropriate steps would include: (1) thanking the person for bringing this to attention; (2) letting them know that you the complaint will be tken seriously and action will be taken; and then (3) stating that 'if you do not see any change in X weeks to please let us know'.

Disruptive behaviour policy

The Joint Commission has initiated a requirement that all hospitals have a disruptive behaviour policy in place as part of its leadership standards for hospital accreditation beginning in January 2009.[19] The policy should include a statement of purpose, defined criteria, set expectations, and describe the process for evaluation of non-compliance. Many organisations already require physicians to sign a form attesting to the fact that they have read and agree to follow the contents outlined in the code of behaviour policy as part of the application process for hospital privileges or at the time or re-credentialing. Many hospitals require other employees to do the same at the time of hire. The crucial issue around the policy is not just having one, but applying it consistently and equitably across the entire organisation with the willingness to intervene and restrict or terminate privileges if necessary. This is one of the key components discussed below.

Barriers

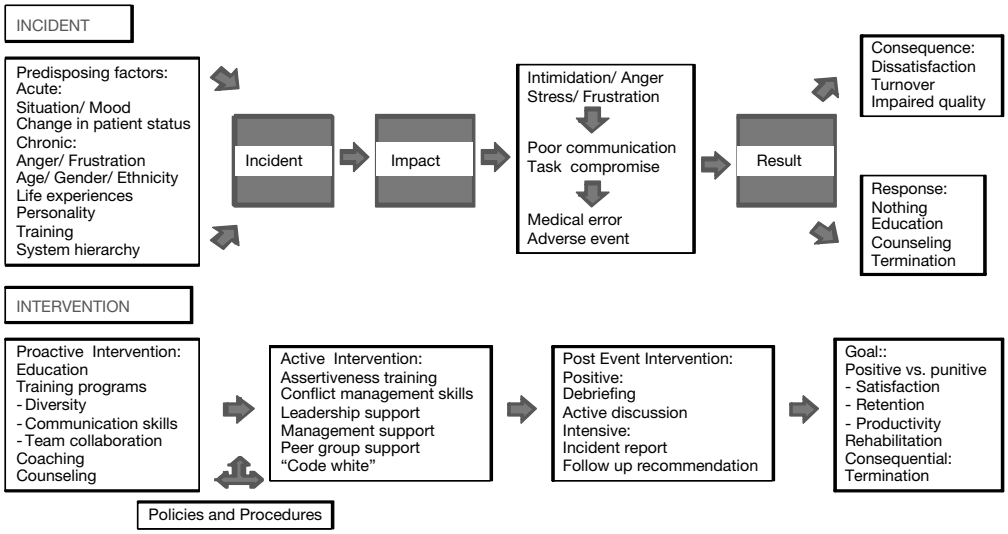
So, why has the issue taken so long to address? Is this a new occurrence brought on by the increasing stress in the medical workplace, or is it something that has been going on for years but often 'tolerated' by those in charge?

On one side is the historical reluctance of dealing with the problem. Who wants to 'interfere' with a physician who brings his or her patients to the hospital, particularly if they are a major source of patient revenue? And even if ther is a genuine desire to deal with the issue, hierarchy, peer-to-peer conflicts of interest, and/or organisational bureaucracy may get in the way. One further limitation is the lack of the necessary skill set and training experience to deal with behavioural issues. Physicians are trained in monitoring performance with regard to technical and knowledge expertise. There is no formal training on how to judge performance based on behavioural competency.[20] But now the environment has changed.

The Joint Commission accreditation requirement has brought a needed stimulus for hospitals to address the issue of disruptive behaviour more effectively. Whereas hospitals may have looked the other way in the past, or suffered from the historical reaction of not doing anything about it, the Joint Commission has now given them reason and responsibility to react.[21]

In addition to the Joint Commission requirement, concerns about hospital reputation, staff satisfaction, recruitment and retention, and a growing number of liability claims focusing on the consequences of disruptive behaviours have influenced

Figure 4
Intervention model



many organisations to take a stronger position on addressing these behaviours.[22]

The opportunity is there. At the front end is the issue of complying with the new accreditation standard. At the back end is the need to address communication gaps and accountabilities that impact patient safety. Somewhere in the middle is the opening door to approach physicians and other members of the hospital staff in proactively addressing underlying stresses or other personal issues that may affect their performance. This will be discussed in more detail in the section on the intervention model.

The risks of complacency and not reacting are huge. First is the impact on staff satisfaction and morale which affect productivity, staff retention and recruitment; particularly important now, with the growing number of physician and staff shortages. Next is the issue of liability. Most important, however, is the risk of a potentially preventable adverse event occurring, which may affect patient safety and the overall reputation of the organisation.

Developing an intervention strategy

The overall goal of the organisation should be to: (1) prevent disruptive incidents from occurring; (2) minimise the impact if they do occur; (3) address chronic issues around non-compliance and (4) improve overall staff relationships and communication efficiency. Figure 4 presents a model that addresses these issues.

The top part of the model outlines a series of events that might occur if the process was left to chance. A description of what might occur is presented below.

A series of underlying acute and chronic factors often triggered by sudden concern about the downturn in a patient's condition all line up, resulting in a disruptive event. The individual on the receiving end gets stressed, frustrated, loses focus and is afraid to speak. This results in poor communication, impaired transfer of vital information, and gaps in accountability and task follow-through, all of which may compromise care quality and/or patient safety. Chronic events such as this may lead to poor staff and patient satisfaction, sensations of a hostile workplace environ-

ment, employee turnover, liability and a tarnished reputation and image for the organisation. On the clinical side, the event may cause a downstream negative event that adversely affects patient care.

The bottom part of the model describes a comprehensive process that follows the components outlined in Table 1, which organisations may want to adopt in an effort to take a more proactive approach to addressing disruptive behaviours.

To start off with, the organisation needs to have cultural and leadership commitment to a zero tolerance policy for inappropriate behaviours. The right policies and procedures must be in place along with an equitable consistent process to evaluate and follow up on complaints with a skilled group of individuals who can make the appropriate recommendations for resolution.

Raising awareness of the problem and promoting individual and collective responsibility and accountability for adhering to acceptable behavioural standards is issue number one. Tying awareness to issues around satisfaction and patient safety provide the necessary buy-in to the process.

As mentioned previously, many organisations have extended the focus of addressing disruptive behaviours to improving overall staff collaboration and communication. Specific courses or training programmes focused on improving communication skills and team collaboration will improve overall communication efficiency. With regard to better understanding behaviours, providing programmes that enable individuals to understand the impact of their upbringing and life experiences that shape their values, attitudes and expectations will promote a better understanding of how individual styles and preferences affect how they work with others, how they communicate, and how they address task objectives. On a deeper level, courses on diversity training, assertiveness training, conflict or stress management will provide skills that may actually prevent an altercation from occurring or minimise its effect by virtue of a better understanding and appreciation of an individual's style and intent. Leadership support and the comfort that one can go to a supervisor or peer for advise is often helpful in dealing with confrontation. To provide real-time support, some organisations have implemented a 'code white' policy, where a designated group of individuals are contacted and immediately respond to the situation.[23]

Underlying stress is often a key variable that needs to be addressed. On the personal side, family issues, financial issues, and other external pressures can all affect an individual's demeanour at the workplace. Add to that workplace stresses related to job complexity and intensity, time constraints, poor staff relationships and bullying peers, supervisors or physicians, and this becomes quite a load to carry. It is at this point that the individual would benefit most from early intervention.

There are two ways to seek intervention. One is that you are told to do so by your supervisor or suggestions are made by a friend, family member, or other, that consulting someone would help deal with the stress. The second way is to recognise internally that this is an issue and voluntarily seek help. In this situation, it is the willingness to commit that is the issue. This is particularly true for physicians. Physicians are trained to be very independent and authoritative and pride themselves on their knowledge and technical competency and with that, have a high resistance to being told what to do. Yet physicians are becoming increasingly frustrated with the medical environment with regard to declining revenues and the

growing number of entities telling them what they can or cannot do. How can one reach out to the physician audience?

First is to have a basic understanding of the physician's training, thoughts, processes and priorities, and be able to discuss matters that are relevant to their interests and within their operating framework. Second is to make sure that the approach taken is positive rather than punitive. Third is to get the physician interested and engaged. Physicians are probably not aware of how the stress is affecting them, or if they are, deny any consequences or think that they are able to take care of it themselves. The focus here needs to be their recognition of the subtle impact stress can have at home and the workplace and the appreciation that things might be better. The next component is the programme itself. Physicians will ideally admit that they could benefit from coaching or counselling, but they would want to make sure that it will be worth their time, be confidential, and conducted in a manner that fits in with their current work schedule. Some physicians might seek outside referral on their own, but it usually takes a readily available stimulus from an already existing programme that is currently in place at their organisation that could accommodate their needs. For years, hospitals and other health organisations have offered employee assistance programmes (EAPs) to help employees adjust to a number of different lifestyle concerns. Not until recently have these services been offered to physicians.[24] Extending the focus of the EAP to the physician audience has several benefits. First, it is an established structure that can be made readily available for physician access. Secondly, the service can be delivered in a confidential, convenient, flexible format that meets the needs of the physician's schedule. The programme can benefit both the physician and the organisation, in that it will provide assistance in reducing the negative impact of stress on frustration, satisfaction, productivity and retention.

If an event does occur, the situation needs to be addressed. Real-time intervention is the best solution, but many individuals are still reluctant to speak up, particularly if they are in a subordinate position and facing a powerful physician. A post-procedure debriefing or a post-event discussion may help clear the air. Next best is incident reporting with appropriate investigation, evaluation and recommendation as discussed previously. When possible, focus on the positive side of improving understanding and communication, rather than approaching the issue in a direct punitive chastising manner. Not addressing the issue is even worse.

CONCLUSION

Disruptive behaviour is a serious issue with the potential for serious downstream negative effects on staff relationships, satisfaction, communication efficiency and outcomes of patient care. In the past, there has been a history of reluctance to address the issue, particularly when it comes to physicians who may threaten to take their business elsewhere. With growing concerns about the linkage of disruptive behaviours to communication inefficiencies and the occurrence of potentially preventable adverse events that affect patient quality and safety, more attention has been brought to the problem. The recent Joint Commission standard requiring hospitals to have a disruptive behaviour policy in place as part of the hospital accreditation process will do a lot to stimulate activity in this area.

To deal effectively with disruptive behaviours, organisations need to have a policy in place that describes what constitutes disruptive behaviour develop criteria for appropriate standards of behaviour, and

set the rules for those individuals who refuse to comply. To make this work, there needs to be a non-biased consistent approach to reporting and follow-up recommendations backed by staff trained in how to address disruptive individuals effectively.

The momentum should be towards prevention. Prevention calls for a better understanding of human nature and tools to help individuals react and adjust accordingly. This concept should be extended beyond just disruptive behaviours, to identify opportunities to improve overall communication efficiency.

The earlier the intervention, the greater the potential for success. Taking a proactive approach to identify individuals at risk will not only reduce the likelihood of a disruptive event, but also reduce levels of stress and frustration, improve satisfaction and enhance overall productivity and efficiency. New approaches, such as an EAP type model, can offer even reluctant physicians an opportunity for advice, coaching, or counselling in a confidential setting with a schedule that accommodates the physician's convenience. This will enhance the spectrum of success. It is worth the effort.

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