Defusing Disruptive Behavior
A Workbook for Health Care Leaders
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Contents

Foreword: Disruptive Behavior and Its Impact on the Culture of Safety ...............v
Grena Porto, R.N., M.S., A.R.M., C.P.H.R.M

Introduction ..............................................................................................................1

Chapter 1: Defining Disruptive Behavior .............................................................5

Chapter 2: The Causes and Impact of Disruptive Behavior .................................17

Chapter 3: Defusing Disruptive Behavior ............................................................33

Chapter 4: Implementing a Zero-Tolerance Policy................................................57

Chapter 5: Toward a Culture of Safety: Conflict Resolution and
Other Approaches to Preventing Disruptive Behavior ........................................77

Appendix ..................................................................................................................89

Index .........................................................................................................................97
Foreword

Disruptive Behavior and Its Impact on the Culture of Safety

The importance of culture in creating a safe environment has long been recognized, as evidenced by the widespread use of the term *culture of safety*. Industries that have succeeded in vastly reducing accident rates and achieving highly reliable performance, such as aviation and nuclear power, have done so in great part because they have embraced the elements of a culture of safety. These elements include a nonpunitive approach to error, a flattened hierarchy that encourages input from all team members—regardless of rank—on areas within their expertise, and empowerment of all team members to speak up if they perceive a threat to safety. A culture of safety is characterized by a collective mindfulness that can be achieved only when there is mutual respect among team members and an absence of fear and intimidation.

Although patient safety has received much attention since the Institute of Medicine's 1999 report on medical errors, progress in achieving a culture of safety in health care organizations is less certain. According to data released by the Agency for Healthcare Research and Quality (AHRQ), only 70% of hospital workers surveyed agreed that management's actions show that patient safety is a top priority. In the same survey, only 75% of respondents agreed that staff members freely speak up if they see something that may negatively affect patient care, and only 46% reported feeling free to question the decisions or actions of those with more authority. A full 62% of respondents reported that they are afraid to ask questions when things don't seem quite right.

Clearly, authority gradient and intimidation remain powerful forces in health care organizations. Diurnically opposed as they are to the principles of a culture of safety, they stand in the way of true progress on patient safety. Perhaps one of the most disturbing signs of this lack of progress in fostering a culture of safety is the prevalence of disruptive clinician behavior, which has long been tolerated by health care organizations unwilling to confront the problem. Indeed, more than 95% of physician executives who responded to an American College of Physician Executives survey reported encountering disturbing, disruptive, and potentially dangerous behaviors on a regular basis. Likewise, in a 2002 survey of Veterans Health Administration hospitals, 96% of nurses reported witnessing or experiencing disruptive physician behavior. Physicians were not the only offenders, with nurses, pharmacists, and radiology and laboratory staff also identified as being disruptive in other survey research.

The Impact of Disruptive Behavior

The impact of disruptive behavior on patient safety has been well described in the literature. Intimidation is the goal and frequent outcome of such behavior, with those on the receiving end often acquiescing to a disrupter's unreasonable demands, even when the safety of the patient may be at risk. Employee morale and nurse turnover also suffer as a result of disruptive behavior. There are other costs as well, including those associated with rework, lost productivity, and managing staff emotional turmoil and stress that distract attention and resources from providing safe patient care.

Despite the risks and costs of disruptive behavior, health care organizations are often reluctant to confront the problem, particularly when it involves physicians. Those responsible for addressing the behavior find it to be a difficult and unpleasant task, and even when they do so, organizational mechanisms often prove inadequate to solve the problem. As a result, such behavior frequently persists over long periods of time and becomes the norm.

There is mounting evidence to suggest that this “hands-off” approach by health care leaders will no longer be tolerated, particularly by staff on the receiving end of the behavior. Consider the following accounts from the news media:
Highland Surgeon Suspended, May Be Charged: Drunken Altercation Reported in Hospital’s Operating Room  
*San Francisco Chronicle*, March 9, 2006

Doctor Must Pay in Bullying Case  
*Indianapolis Star*, March 5, 2005

In both instances, staff grew tired of dealing with bullying behavior by physicians and resorted to the legal system to redress their grievances. One case resulted in criminal charges against the offending physician, while the other resulted in a jury verdict against the physician after a civil suit was filed by a hospital staff member. In both instances, the organizations at which these incidents occurred endured protracted negative media attention and loss of reputation as a result.

There are signs that The Joint Commission, health care’s largest and most influential accrediting organization, has also tired of health care organizations’ lax treatment of this problem. Standards approved by the Board of Commissioners address the responsibility of leaders to monitor organizational culture and deal with cultural problems, including disruptive behavior. Furthermore, the Joint Commission’s Sentinel Event Advisory Group has also recognized the importance of this issue and has released a potential National Patient Safety Goal for field review, though it has not yet adopted such a goal.

There are liability exposures associated with disruptive behavior as well, although they have not been fully explored in the literature. These include potential claims of hostile work environment brought by employees and contract staff, workers’ compensation claims for workplace stress, directors’ and officers’ claims against organizations that fail to monitor the problem or take action against reported offenders by continuing to renew employment or privileges, general liability claims brought by visitors and other bystanders injured as a result of disruptive behavior, and medical malpractice claims brought by patients injured as a result of a clinician’s disruptive behavior.

Many compelling reasons can be found for organizations to confront the problem of disruptive behavior and adopt a zero-tolerance approach. Health care organizations are already suffering from staffing shortages and are challenged by employee morale issues, as demonstrated by the AHRQ survey.

Avoidance of adverse publicity and financial loss from liability and other claims is also potent a motivator because it supports the imperative of continued financial viability and organizational survival.

Although all these are compelling arguments, none are as important as the human considerations—the devastating impact that disruptive behavior has on the dignity, self-esteem, and physical safety of staff members and patients alike.

Change and the desire for it should come not because of disruptive behavior’s impact on morale, staff turnover, or liability. Rather, change should be motivated by the recognition that this behavior is simply incompatible with the core values of health care professionals and the organizations they work in, and it is at odds with that all-important phrase first uttered so long ago and more recently invoked by the Institute of Medicine—”first, do no harm.”

*Defusing Disruptive Behavior: A Workbook for Health Care Leaders* is one step toward this change and toward creating a true culture of safety in health care.


**References**

Health care in the twenty-first century is experiencing the growing pains of evolution. There have been a number of contributing factors, but when the Institute of Medicine published its seminal work *To Err Is Human* in 1999, a broad, far-reaching shift in mind-set began among health care organizations. Although the industry had already been discussing the imperative for a systems-based focus on improving the quality and safety of care, treatment, and services, the entire field was now faced with a disturbing fact: Certain unsafe and unacceptable practices that had become the norm in many health care organizations were causing medical errors resulting in serious injury and death. This broader awareness led to a sense of urgency to improve patient safety and prevent such dire outcomes.

As a result, health care organizations and national accrediting bodies have sharpened their focus on patient safety. The Joint Commission, which has been drawing attention to patient safety and quality issues since its inception, has been a leader in this effort with its standards and National Patient Safety Goals. Its revamped accreditation process—launched in 2004—uses new methodologies to help organizations see how their systems of providing safe, high-quality care, treatment, and services are functioning. This sharpened focus includes not only the call to strengthen efforts to avoid adverse events in health care but also to establish and maintain a culture of safety, thus ensuring that organizations would truly achieve their goal of being patient safety focused. (In 2007, new medical staff standards now consider “professionalism” as part of competency, which includes ethics and disruptive behavior. This is another step in the process.)

**A Culture of Safety**

In a health care organization a *culture of safety* promotes, embraces, and applies consistent patient safety principles. Organization policies and procedures that require safe practices are only part of the story—in a culture of safety, staff will demand safety and have no tolerance for unsafe practices. The Institute for Healthcare Improvement describes a culture of safety as an environment in which “people are not merely encouraged to work toward change; they take action when it is needed. Inaction in the face of safety problems is taboo, and eventually the pressure comes from all directions—from peers as well as leaders. There is no room in a culture of safety for those who uselessly point fingers or say, ‘Safety is not my responsibility, so I’ll file a report and wash my hands of it.’”

Establishing a culture of safety is akin to following the Golden Rule. “Do unto others as you would have done to you” is a principle that can and should apply in the health care work environment. Everyone wants to be respected, and all people want their contributions to make a difference. In a culture of safety, the organization fosters an environment in which all staff members are respected, empowered, and focused on the noble nature of their profession: providing for the health and well-being of the populations they serve.

But establishing a culture of safety is no simple task. There is no magic wand that will miraculously implement one in a health care organization. Organizations have found that although some elements are relatively straightforward to adopt—appointing and establishing a patient safety committee, for example—others take more time and effort. The “culture” part of the equation requires a change in mind-set, and the change has to be embraced organizationwide—from board members to support staff. Changing the organization mind-set requires examining cultural habits that have adversely affected patient safety (for example, poor communication or inadequate teamwork). Many organizations have found that one such detrimental cultural habit is the toleration of disruptive behavior.
Defusing Disruptive Behavior: A Workbook for Health Care Leaders

Disruptive Behavior
Disruptive behavior has been defined by the Joint Commission as “conduct by a health care professional that intimidates others working in the organization to the extent that quality and safety are compromised.” Research has found that disruptive behavior not only impacts the morale and staffing of an organization but can also lead to medical errors and breakdowns in the quality of care, treatment, and services delivered. Disruptive behavior—and its potentially dire outcomes—runs contrary to the concept of a culture of safety. Addressing such behavior in the health care workplace is therefore essential. The Joint Commission now expects all accredited health care organizations to adopt processes and procedures to effectively deal with disruptive behavior. This expectation is illustrated by the publication of new elements of performance under Standard LD.3.10—the standard that requires organizations to establish a culture of safety and quality.*

Navigating the Work Environment
The work environment isn’t always a straightforward place to navigate, as anyone who has spent a day on any job can attest. The complexity and variability of the work environment can be challenging and stressful. Sometimes the stress comes from the job itself, and sometimes it comes from conditions in the environment or disputes with coworkers. Each person brings different talents, competencies, and abilities to the job, and these individual skills enable each staff member to add something unique to the position. But workplace conflict can sometimes erupt. Such a complex environment has the potential for problems, and that complexity can create a perfect storm of ups and downs.

Disruptive Behavior in the Workplace
From harassment and intimidation to abuse and assault, disruptive behavior in the workplace has a devastating impact on morale and productivity. Health care is not immune to such behavior. In fact, many health care organizations seem to tolerate staff members’ rudeness, intimidation, insults, threats, passive-aggressive behavior, verbal abuse, and even physical assault (or the threat thereof). Victims are expected to “get used to it,” particularly when the perpetrator is a physician. Of course, nurses, pharmacists, technicians, administrators, and other staff are also capable of exhibiting disruptive behavior—no area of health care has been left untouched by its impact. When organization leaders tolerate disruptive behavior, the results can include lower morale, higher turnover, and reduced patient safety. In such a “toxic environment,” staff members might also begin to demonstrate additional negative behaviors, such as poor communication, hostility, resentment, stress, anxiety, avoidance, or fear—all of which impair an organization’s ability to deliver safe, high-quality patient care.

About This Publication
Defusing Disruptive Behavior: A Workbook for Health Care Leaders provides the background, information, and tools that leaders need to establish effective policies and procedures for dealing with disruptive behavior. In addition to methods of defusing disruptive behavior, proactive procedures such as conflict resolution are discussed. The publication also includes extensive scenarios, helpful case studies, sample policies from organizations around the country, discussion points, and forms and worksheets. Discussion questions have been interspersed throughout the text to give readers a chance to reflect on the content and how it relates to the unique issues in their own organizations. In addition, several sidebars feature health care leaders sharing their personal experiences and advice about disruptive behavior.

Terms Used in This Publication
Across the broad spectrum of health care organizations, different terms are sometimes used to refer to individuals who receive care, treatment, and services. For the sake of simplicity and clarity, the term patient is used in this publication to refer to those individuals. The term health care organization is used to refer to organizations that provide care, treatment, and services, except when an example refers to a specific kind of health care organization.

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* These new requirements are effective January 1, 2009.
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