

Putting the Brakes on Health Care “Road Rage”

Recognizing and Opposing Disruptive Behavior to Help Maintain Safety and Security

The synonyms for *disruptive behavior* and *intimidation* are as varied as the individuals who engage in it—and those who are targeted. Among those names are bullying, emotional abuse, harassment, organizational road rage, psychological violence, relational aggression, lateral violence, and mobbing. Whatever you call it, intimidation seems to be everywhere, even in health care organizations.

Joint Commission Standard EC.01.01.01 urges hospitals to manage safety and security and to protect individuals against risks such as workplace violence. On July 9, 2008, to alert health care organizations to this widespread practice, the Joint Commission issued the *Sentinel Event Alert* “Behaviors That Undermine a Culture of Safety.”¹ According to the *Alert*, intimidating behaviors can “foster medical errors, contribute to poor

patient satisfaction and preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments.”

This was followed by a new “Leadership” (LS) chapter standard, LD.03.01.01, which took effect on January 1, 2009, and addresses disruptive and inappropriate behavior in two of its Elements of Performance (EPs):

- EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
- EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

These standards require health care organizations to create new training, post a code of conduct for staff members, and set up a mechanism for

health care workers to report inappropriate behavior.

Defining Disruptive Behavior

What is intimidating behavior? How does it threaten safety and security? How is it different from bad manners or incivility? For many people, the answer to the last question is: I know it when I see it. Following are several examples of the kinds of disruptive behavior that can threaten safety and security and limit or destroy the effectiveness of health care teams in caring for patients:

- Targeting individuals for mistreatment
- Belittling or denigrating someone’s opinion
- Using condescending language and attitude
- Engaging in patronizing nonverbal communication, such as eye rolling, raised eyebrows, smirking, and so on
- Refusing to answer legitimate questions
- Incessantly criticizing, finding fault, and scapegoating
- Displaying an attitude of superiority regarding another’s knowledge, experience, and/or skills
- Undermining the effectiveness of a person or a team
- Spreading rumors and making false accusations
- Putting staff members in conflict with each other
- Engaging in tantrums and angry outbursts
- Engaging in any unnecessary disruption



Experiencing intimidation in the health care environment disrupts a culture of safety.

Root Causes, Contributing Factors, and Results

The next question is, why health care? Is there anything about this field that makes it susceptible to bullying and intimidation? “Health care is by nature hierarchical and authoritarian,” says Gary Namie, Ph.D., co-founder and director of the Workplace Bullying Institute (<http://workplacebullying.org>). “Hospitals are where people live and die and have their lives saved by wonderful skilled people, who at the same time can be thoroughly dehumanizing to one another. Add to that the rush, or ‘stat,’ nature of acute care hospitals. Between cases, some people can be brutal to each other.” Namie also points to the many caring, compassionate people in the field who can be targets for intimidation. “They’d rather help people and keep a low profile than fight back.”

Another experienced and knowledgeable observer in the field of organizational intimidation is David C. Yamada, J.D., a professor at the Suffolk University Law School in Boston. “I hear stories from lower-level employees at some hospitals about loud, angry behavior from people who show a lack of respect for their work,” he says. “It could just be having a tough boss. But regardless of the label, we have to draw a line between behaviors that are targeted and malicious and those that aren’t. When it becomes malicious and they feel someone is out to get them, that’s a big distinction compared to what might be characterized as incivility or discord.”

Yamada points to three reasons that health care is susceptible to disruptive behavior. “First, it’s an area of work that’s inherently stressful,” he says, “and when people feel under the gun, they may not be able to control their emotions. Second is the current

Some Statistics on Intimidation

The Institute for Safe Medication Practices (ISMP) was concerned about workplace intimidation and its effect on patient safety and security, so it surveyed³ health care professionals, including nurses, pharmacists and other providers.

Of the more than 2,000 who responded, nearly one-quarter had encountered disruptive behavior by physicians and medication providers. That behavior ranged from subtle questioning of judgment to more explicit threatening behavior. Nearly one-quarter of respondents said that they often encountered condescending language or tone of voice (21%) or impatience with questions (19%). Almost half (48%) of respondents reported being the recipients of strong verbal abuse or threatening body language (43%) at least once during the previous year.

According to the study, 38% of nurses experienced strong verbal abuse and 69% encountered reluctance from prescribers to answer questions or return phone calls.

economic downturn, which is worsening tensions on the clinic or hospital floor. Third is the hierarchical nature of health care organizations, with ranks of physicians, nurses, and other health care professionals. All this encourages intimidating behavior.”

Edward Stern, senior program analyst in Expert Systems at the Occupational Safety and Health Administration (OSHA), points out the effects of intimidation among staff members who witness these episodes. “When coworkers see one of their own being bullied, they wonder whether they might be next,” Stern says. “The negative effects of this kind of treatment on the workplace are hard to measure.”

The Joint Commission’s *Sentinel Event Alert* points out that, although most formal research focuses on intimidating and disruptive behavior among physicians and nurses, evidence shows that it occurs among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. Furthermore, says the *Alert*, this behavior creates “an unhealthy or even hostile work environment—one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors

also expose themselves to litigation from both employees and patients.”

Zero Tolerance for Bullying

Disruptive behavior often goes unreported because victims and witnesses alike fear retaliation and the stigma associated with being labeled a whistle-blower. Not many people have the courage to confront the bully. And, says the Joint Commission *Sentinel Event Alert*, “staff within institutions often perceive that powerful, revenue-generating physicians are let off the hook for inappropriate behavior due to the perceived consequences of confronting them.” The *Alert* cites a physician behavior survey by The American College of Physician Executives which found that 38.9% of the respondents agreed that “physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue.”²

Namie considers intimidation a form of workplace violence that’s primarily psychological. “If a health care organization tolerates bullying, it tolerates violence,” Namie says. “Bullies often come across as hard-driving and ambitious. The people who pick up a gun

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and use it at work—were they at one time the target of bullies? Statistics show that 40% of people who are intimidated simply quit, while 24% are fired and 13% transfer. In other words, the targets pay the price by losing the job they love.”

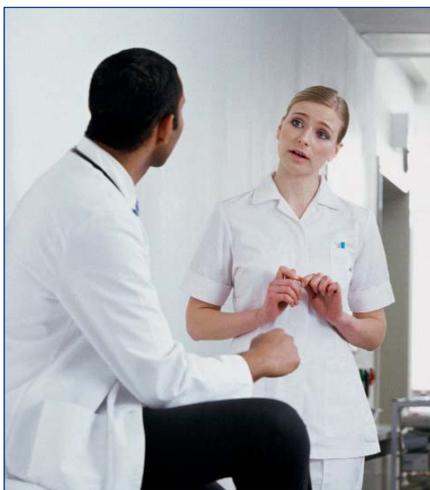
Says Yamada, “Organizations that are highly dysfunctional may exhibit different forms of aggression. And dysfunction can cut in different directions, because people who have been bullied may become violent.”

Edward Stern, senior program analyst, Directorate of Evaluation and Analysis, OSHA, believes that an exception should be made for occasional lapses. “Sometimes a person just comes to work on a bad day and may lash out at a coworker for a perceived mistake,” he says. “In that case, the team may cut that person some slack. But it’s a far cry from there to a serial intimidator.”

Suggested Action

The Joint Commission’s *Sentinel Event Alert* spells out a comprehensive program of remedies for disruptive behavior. Among them are the following:

- Educate physicians and nonphysician staff about appropriate professional behavior laid out in the organization’s code of conduct, with particular emphasis on respect.



Ask staff if they’ve experienced bullying.

- Hold all team members accountable for modeling appropriate behavior. Enforce the code of conduct equitably among all staff, regardless of their seniority.
- Mandate zero tolerance for intimidating and disruptive behavior, especially assault and other criminal acts. Incorporate the zero-tolerance policy into medical staff bylaws and employment agreements.
- Reduce fear of intimidation or retribution and protect those who report or cooperate in investigating unprofessional behavior.
- Respond to patients and families who are involved in or witness intimidating behavior. Listen to and empathize with their concerns, thank them for sharing those concerns, and apologize.
- Decide how and when to begin disciplinary action, such as suspension, termination, loss of clinical privileges, and submission of reports to professional licensure organizations.
- Solicit and integrate input from inter-professional team members, including medical and nursing staff members, administrators, and others.
- Offer training and coaching for leaders and managers in relationship-building and collaborative practice, including conflict resolution and how to give feedback on unprofessional behavior. Use cultural assessment tools to measure whether attitudes change over time
- Develop a surveillance system (possibly anonymous) for detecting unprofessional behavior. Use periodic surveys, focus groups, and evaluations by peers and team members to monitor the effectiveness of this system.
- Design strategies to learn whether intimidating and disruptive behavior exists or recurs, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
- Supplement surveillance with tiered, nonconfrontational intervention, starting with informal coffee conversa-

tions to address the problem. If the behavior persists, move toward action and progressive discipline.

- Use mediators and conflict coaches, as needed, to resolve professional disputes.
- Document all attempts to address intimidating and disruptive behavior.

(For more information, see the full text of the *Sentinel Event Alert* at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm.)

Pending Legislation

At this time, legislation to prohibit intimidating behavior in the workplace is pending in nearly a dozen states. “When you have a staff member who is providing direct patient care while being hounded and sabotaged by other team members, it can create an angry, hostile workforce and thus impair patient care,” says Namie. And Yamada asserts, “Bullying is the most significant form of employee mistreatment that remains largely unaddressed by the law.” At this rate, outlawing intimidation and disruptive behavior and maintaining safety and security may be a measure whose time has come. 

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References

1. The Joint Commission: Behaviors that undermine a culture of safety. *Sentinel Event Alert* 40, Jul. 9, 2008. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm (accessed Nov. 22, 2009).
2. Keogh T., Martin W.: Managing unmanageable physicians: Leadership, stewardship and disruptive behavior. *Physician Exec* Sep./Oct. 2004, pp. 18–22.
3. Institute for Safe Medical Practices: Intimidation: Practitioners speak up about this unresolved problem (Part I). *Medication Safety Alert*, Mar. 11, 2004. https://www.ismp.org/Newsletters/acutecare/articles/20040311_2.asp (accessed 11/30/09).