The Joint Commission’s new Leadership Standards, effective Jan 1, 2009, call for a code of conduct and a process for addressing disruptive behavior. In a Sentinel Event Alert in July, the commission made its case for why bad behavior is a safety threat and outlined 11 recommendations for addressing it. The standards and alert are at www.jointcommission.org.

The underlying theme is patient safety. The alert cites literature linking bad behavior to treatment errors, poor patient satisfaction, higher costs, and staff turnover.

A nurse and risk management expert, Grena Porto, RN, MS, ARM, CPHRM, advocated for the alert as a member of the Joint Commission’s Sentinel Event Advisory Group.

Porto says the watershed moment for her came when she was consulting at a client site and was able to trace a patient injury directly to a nurse’s disruptive behavior. “No one can tell me this is not a patient safety problem,” says Porto. “I made it my cause because I saw so much of this behavior. Plus, it has great impact on recruitment and retention.” Porto has been president of the American Society for Healthcare Risk Management and a board member of the National Patient Safety Foundation. She is a principal in QRS Healthcare Consulting, Hockessin, Delaware.

Porto talked with OR Manager about the alert and what managers can do to address bad behavior.

Q Disruptive behavior has been a problem for years. Why did the Joint Commission decide to issue an alert?

Porto: It’s not possible to have a culture of teamwork and safety when some physicians and nurses are engaging in destructive behavior, intimidation and, in some cases, even violent behavior.

In my consulting, when I’ve talked to staff about the principles of teamwork, some would look at me and say, “Yeah, well, that guy throws knives at me in the OR,” or “That one won’t talk to me when I ask her questions about a patient.” So it was pretty apparent that this issue was a major barrier to some of the changes we were trying to achieve in health care.

This alert was the result of a long-term dialog by the Sentinel Event Advisory Group. When we looked at the literature and compared notes, it was apparent the issue needed attention. Research shows the problem is widespread and not limited to 1 group, though there is some research to support what most of us have suspected—this is worse in the OR than anywhere else. There is 1 study I’m aware of that illustrates that (Rosenstein A H, O’Daniel M. J Am Coll Surg. 2006;203:96-105). Studies of disruptive behavior in nursing go back at least to 1987.

Q For a code of conduct, is there a model you think is most effective?

Porto: In my experience, these are the critical components:

• A code of conduct cannot be just aspirational. It cannot just say, “We are all going to treat each other with respect.” That does not provide guidance, particularly in a high-stress environment. You need to know what behavior is OK and what is not. Get away from aspirational language, and get into specific wording. Give examples of the behavior you want as well as what won’t be tolerated.

• The code must be universal. It must apply to everyone. You want to hold everyone
to the same standard, whether they are physicians, nurses, patients, visitors, subcontractors, or others.

• The code has to be framed in terms of the safe delivery of patient care and safe operation of the organization. The code is not just about saying “please” and “thank you.” It is about promoting an environment where patients can be safely cared for.

Here is an example: A physician is making rounds on a unit and discovers that heparin ordered 3 days ago was never started. You would expect the physician to be angry—that’s normal human behavior. The physician might say assertively, “I ordered this 3 days ago. Why wasn’t it done?” That is not disruptive behavior. Contrast with a physician who says, “You are a bunch of incompetent idiots. If it wasn’t for me coming in to check, my patients would be dead.” That is disruptive—you are undermining the confidence of people to take care of patients.

You have to look at the behavior in context and consider whether the behavior would interfere with patient care or would upset someone so much that the person would lose confidence and feel incompetent to care for a patient.

A lot of people who berate the staff tell you they are just advocating for their patients. They fail to consider that if you treat a person like that, the person won’t be able to take care of the next patient. That doesn’t mean you can’t be annoyed if something wasn’t done properly. But you have to draw the line at being so abusive that the other person is paralyzed by fear.

Does this mean managers are going to have to spend a lot of their time managing behavior?

Porto: I anticipate a lot of nurse managers, already burdened, don’t want to become the manners police. But I don’t think that’s what this is about. It’s about raising awareness that it is not OK to be rude; it is not OK to be abusive. Some people will take notice, and that will be all it takes. Others will need more action than that.

This shouldn’t always be the manager’s responsibility. If I am a staff member, and a physician speaks to me in a manner I consider offensive, I should be armed with the tools to be able to say to that physician, “I understand you were upset. But I didn’t like the way you spoke to me. You did it in front of a patient. I would appreciate it if that did not happen again.”

Not every nurse, particularly a new nurse or a nurse from a different culture, may be equipped to do that, and the manager may have to step in. I think part of this is to provide skills to a broad group of people and not to assume the nurse manager is going to be enforcing the code of conduct.

This speaks to the need for education and training.

Porto: Exactly. I think there is a need for education anyway because people don’t know how to resolve conflict. Some behavior affects patients, even if it isn’t rude. For example, a nurse says, “I don’t think this dose is correct.” The physician insists, “It is correct.” Then the nurse says, “Well, I’m not giving it—you give it.” That’s not rude per se, but it is also not safe patient care. That speaks to the need for training in conflict resolution, aside from the code of conduct.

What is needed to make sure the code of conduct applies to everyone, even the most powerful physician?

Porto: The Sentinel Event Advisory Group spent a lot of time talking about that. Just about every organization will say, “There is a surgeon who brings a ton of business to this hospital. No one wants to upset him, because he will take his business elsewhere.”

That is a failure of leadership. That is why the Joint Commission embedded this requirement in the Leadership Standards.

Will the requirement help? I don’t know. I have to think so because the surveyors are going to be asking the OR staff, “Do you have this issue? What happens if you report it?”

If they say, “Nothing happens,” and the organization can’t prove this is getting addressed, the organization is going to be considered noncompliant. The Joint Commission is not going to allow CEOs to look the other way.
The wording of the code of conduct is important. But that's not where the power of this initiative comes from—it comes from the Leadership Standard.

When a physician says, “I will take my business down the road,” consider this. First, for a physician to change hospitals is not easy, particularly if the person is high volume. Plus, if the other organization has the same standards, it is an empty threat. My response would be, “If they are accredited, they have to do this, too.”

Q Doesn’t the hospital have to worry about a lawsuit if it takes action against a physician?

Porto: Yes, but if a hospital follows its bylaws, there is no legal claim. A hospital can’t arbitrarily lift someone’s privileges. There is a process, and if the hospital follows the process, it’s fine. That is not to say a physician won’t sue, but they won’t win. When I hear the argument from executives about lawsuits, I want to say, “Here is an issue that is putting your patients in danger. And you are worried about getting sued by the doctor? You should be worried about getting sued by the patient!”

One thing I want to mention—I think nurse managers and nurse leaders own a piece of this problem. In every organization I go into where I see disruptive physician behavior, especially in the OR, I say to the staff, “What do you do about it?” They say, “We report it to the director.” When I go to the director, she or he says, “My job is to calm everyone down. Pretty soon it all blows over.” I ask, “You don’t pursue it any further?” And the director says, “No.” That to me is enabling the behavior.

I find this a lot with nurse managers—they are focusing on maintaining the status quo. They don’t want to upset anybody. That is not dealing with the problem.

Q But managers may not feel they will be supported if they report bad behavior, particularly by a powerful physician.

Porto: I know people are intimidated, and lack of leadership has been a barrier. But many times I have sat down with CEOs, and they say, “No one ever told me.” Then I go back to the chief nurse and other administrators, and I find it is true—they try to contain it and say, “Oh, no. We could never report that.” Why not?

I am amazed by how often administrators try to deny and ignore the problem and insist they can’t take it on. To me, it is no different than saying, “We don’t give antibiotics here. It’s just too expensive.”

As a nurse manager, you have to push the envelope. You have to say, “This is a safety issue. I am not putting up with this.”

References

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