Bad behavior in OR threatens patient safety, stresses teams

Surgeon speaking abusively to operating room personnel during procedure. Less attention to patient because of stress—more chance of error.

Failure of MD to listen to RN regarding patient’s condition. Patient had postoperative pulmonary embolism.

Disruptive language/action and so on from surgeons and nurses’ negative attitudes are worse. It all feeds off of each other and continues to get worse as case and day goes on.

Bad behavior like this is not un-common in the perioperative setting. It’s not only hard on morale. It’s a threat to patient safety. In a new study, 19% of respondents said they knew of a specific adverse event that happened as a direct result of disruptive behavior. Yelling, being disrespectful, using abusive language, and berating a coworker in front of others were the most frequent types of bad conduct.

Bad behavior takes a toll in stress, frustration, loss of concentration, ineffective communication, and impaired relationships.

“The most disturbing outcomes of the study were the impact on staff relationships, teamwork, and clinical outcomes of care,” say authors Alan H. Rosenstein, MD, MBA, and Michelle O’Daniel, MHA, MSG, of VHA West Coast, Pleasanton, Calif. Building on earlier research, they surveyed 244 surgical team members at a large academic medical center and compared results with their national data from more than 100 hospitals. A report appeared in the July 2006 Journal of the American College of Surgeons.

Nearly all of the respondents—94%—said disruptive behavior could potentially affect patient outcomes, and almost half—46%—were aware of such an event that could have stemmed from disruptive behavior.

Countering inappropriate behavior requires a strong commitment from the top of the organization. The study provides data that can be used to convince senior executives that confronting negative behavior is crucial to patient safety and their overall business, the researchers say.

“We don’t think you can afford to have this go on any more because bad things happen to patients,” Dr Rosenstein told OR Manager.

The problem isn’t confined to physicians. Nurses also contribute. More than one-fourth (28%) of study participants said they saw RNs display disruptive behavior at least weekly, compared to 37% who saw it weekly in attending surgeons, and 19% who saw it that often in anesthesiologists.

In discussing the findings with the medical center’s nurses and physicians in focus groups after the study was completed, Dr Rosenstein and O’Daniel say they were struck by the close tie between disruptive behavior and operational issues. Problems such as case delays, broken or missing equipment, and short staffing raised the level of tension, leading to outbursts.

“The physicians would say, ‘We keep bringing this up, and no one ever addresses it,’” Dr Rosenstein says.

Adds O’Daniel, “It’s never OK to be disruptive. But it goes back to organizational awareness and commitment. Leaders need to hear these physicians and address the issues.”

The researchers outline a program for addressing behavior in a related article on p 21.
A program for ending disruptive behavior

An 11-point program recommended by Alan H. Rosenstein, MD, MBA, and Michelle O’Daniel, MHA, MSG, authors of the new VHA study on disruptive behavior.

Gain organizational commitment

- Make a commitment to address disruptive behavior both from the top of the organization down and from the bottom up.

Trying disruptive behavior to patient safety is an effective way to get the attention and support of senior leadership, they advise.

“A lot of times, we’ve found senior executives aren’t looking at the issue from a clinical safety standpoint. They don’t see the tie between disruptive behavior and the effect on patients,” O’Daniel says. “Once they see that tie, we almost always see a shift in their mindset.”

There’s also a business case for addressing inappropriate behavior.

“If this is a problem in your organization, your reputation is at stake,” Dr Rosenstein says. Disruptive behavior can drive away staff and anesthesia providers. It influences staff satisfaction and turnover. “And it certainly influences the quality of care,” he says. There’s also the risk of a liability suit for harassment or some other issue—“that’s becoming much more prevalent,” he says.

“But it all comes down to the culture and making safety a priority.”

The study asked, “How often do you think there is a link between disruptive behaviors and the following clinical factors?” Reprinted with permission from Rosenstein A H, O’Daniel M. J Am Coll Surg. 2006;203:96-105. Copyright © 2006 American College of Surgeons.

Reference


Survey links disruptive behavior to negative patient outcomes. OR Manager. 2005;21 (3):1, 20, 22.
Raise awareness

• Conduct a self-assessment to bring the issue to the surface where it can be dealt with.

“If you do a self-assessment and put your finger on the pulse, you might find out this is much bigger and affects many more people than you might think,” he says.

Dr Rosenstein and O’Daniel conduct assessments for hospitals using their research tool, adding the data to their database. Other assessment tools that can be used are staff satisfaction surveys or the Safety Attitude Questionnaire developed at the University of Texas, which measures perceptions of health care teamwork and safety culture (http://psnet.ahrq.gov/resource.aspx?resourceID=1439).

Using the VHA assessment tool, Dr Rosenstein and O’Daniel have compiled a database from 100 hospitals, enabling them to compare one hospital’s results with others. The assessment “really goes beyond the data,” O’Daniel says. “People need to understand the data, the implications, and how to use it.” The assessment is done for both members and nonmembers of VHA.

Organize get-togethers

• Organize group meetings of physicians, nurses, and other team members to encourage discussion of behavior issues.

This can be done through a task force, committees, or town hall meetings, Dr Rosenstein suggests.

“A lot of organizations are putting together some sort of nurse-physician liaison committee where they seek input to address these issues,” he says.

Develop policies and procedures

• Set norms for behavior, such as a code of conduct.

“The policy must be for physicians, nurses, techs, housekeepers—everybody,” O’Daniel stresses. “You can’t let one person slip through the cracks for any reason, whether it’s because they bring in money or whatever.”

The policy also must be consistently applied. “You can’t have one policy for physicians, one policy for nurses, and one policy for everybody else,” she says.

For the medical staff, she and Dr Rosenstein recommend that the policy become part of the medical staff bylaws. Physicians should be required to sign the policy and agree to follow it at the time they request or renew credentials.

Set up a reporting mechanism

• Make reporting safe and easy. People shy away from reporting bad behavior because they’re afraid of retaliation or think nothing will be done about the problem.

“You need to make reporting safe, easy, with no worries about retaliation, and you need to follow up,” Dr Rosenstein says. Staff may not want to write out incident reports, so provide other ways of reporting, such as a suggestion box.

A method that can work well is to have a committee with authority to review complaints and get back to those who filed them.

Teach intervention strategies

• Help develop intervention strategies to address inappropriate behavior.

Strategies should include:

• real-time strategies to use when an incident occurs, such as assertiveness training

• approaches that address communication barriers that arise—cultural, gender, language, personality clashes, and so forth.

For example, how will the organization address barriers that may surface when a 55-year-old male physician from the Middle East is communicating with a 22-year-old female Filipino nurse?

To be effective, there needs to be a broad-based effort to improve sensitivity and communication.
“A lot of organizations know culture and ethnicity are a big issue, but they feel like it’s dicey and not politically correct. It is something that has to be acknowledged and addressed,” Dr Rosenstein says.

**Provide communication tools**

- **Give teams communication tools they can use to head off or manage communication problems.**

  “We’ve found it’s effective, especially in the OR, to use tools such as SBAR,” Dr Rosenstein says. (SBAR stands for Situation, Background, Assessment, Recommendation.)

  “We often find physicians and nurses just don’t know how to communicate with each other,” notes O’Daniel. “For instance, a nurse calls a physician in the middle of the night but doesn’t have the appropriate information from the chart. It’s never an excuse for a physician to be disruptive, but that type of situation can cause a physician to get cranky.”

  With SBAR, nurses have a communication tool they can use to get their message out in 1 minute or less. “Then physicians know exactly what’s going on, and it helps alleviate the tension,” O’Daniel says. (Suggestions for using SBAR in the OR are in the April OR Manager.)

**Address competency issues**

- **Competency issues include technical as well as communication skills.**

  “We heard physicians saying, ‘I really need to feel comfortable that the person across from me or on the other end of the phone knows what they’re doing or talking about,’” Dr Rosenstein says.

  The concern is technical as well as communication competency, he says. “You need to help people with their communication skills,” he advises. “Because when a physician is awakened in the middle of the night by a nurse who doesn’t know what’s going on with the patient, can’t speak English well, and on top of that, it isn’t even the physician’s patient, but the physician is covering for someone else—that’s a setup for disaster.”

**Identify clinical champions**

- **Recruit clinical leaders, nurses as well as physicians, to give the program credibility and set the tone for behavior.**

  “Your clinical champion doesn’t have to be the chief of staff,” Dr Rosenstein says. “But it needs to be somebody who is a respected clinician and believes in this. We’ve been finding that it’s better to have co-champions, such as a chief medical officer and a chief nursing officer. That tends to work better than a single champion.”

**Address operational issues**

- **Tackle operational issues like surgical scheduling and equipment availability.**

  A major complaint from physicians that can cause frustration to boil over is that no one addresses issues that affect them, such as equipment and the flow of cases, the researchers say. “Physicians would say, ‘I yelled at a nurse because the equipment wasn’t there.’ Then they’d say, ‘Isn’t the real issue that the equipment should have been there?’” O’Daniel says.

  In focus groups she and Dr Rosenstein conducted, “it all came to operational issues. They would say, ‘Yeah, this doctor or nurse was disruptive, but the equipment was wrong, or there were throughput issues.’ That’s what caused the tension.

  “If you make these operational adjustments, you might see a lot of this disruptive behavior alleviated,” O’Daniel says.

**Provide feedback, followup**

- **Give feedback to those who report behavior.**

  Though these incidents are sensitive and need to be handled confidentially, it’s
important for those who report the behavior to know it’s being addressed, they say.

“Some organizations have a form letter they use when they get a report of a disruptive behavior or something inappropriate,” says O’Daniel. The letter might say: “Thank you for your report. We wanted you to know we’re following up on it.”

“You need something to let them know it’s not going into a black hole.”

For more information about the VHA study and assessments, contact Alan Rosenstein at arosenst@vha.com.