What makes a behavior code effective?

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Rs have been reviewing their codes of conduct and behavior policies in view of new requirements in the Joint Commission’s Leadership Standards, which took effect Jan 1, 2009 (related article, p 17).

The University of Wisconsin (UW) Hospital & Clinics in Madison has an 8-year track record for its policy. Two factors in its success—developing the policy proactively rather than in response to a specific incident and taking time to make sure the policy was sound before implementing it.

Barbara Pankratz, RN, MSN, director of surgical services, described the policy and offered advice on developing an effective policy and process. UW has 22 inpatient ORs, 9 outpatient ORs, and 5 ORs at its pediatric hospital.

The policy, titled Guidelines for Identifying, Managing, and Preventing Disruptive Behavior by Medical Staff in Surgical Services, focuses on physicians. For nurses and technical staff, behavior issues are addressed through UW’s collective bargaining agreement, which has similar expectations.

The guidelines start with objectives and a definition of disruptive behavior (sidebar). They include a reporting mechanism and a process for managing behavior. They also protect confidentiality and prohibit retaliation. The guidelines are managed by the Surgical Services Professional Conduct Committee. Chaired by a surgeon, the committee includes 2 other surgeons, 2 anesthesiologists, and Pankratz. Several of the committee members were involved in developing the guidelines.

“The committee is really meant to be consultative and to have an educational focus,” and the vast majority of incidents can be resolved in that manner, Pankratz says.

How the process works

Persons who believe they have observed inappropriate behavior can file a Disruptive Behavior Incident Report, which is referred to the professional conduct committee. The form asks for a factual, objective description of the behavior, any circumstances that may have led to it, and the effects of the behavior. The form must be signed, either by the person filing it plus any witnesses or by a group; each person signing assumes responsibility for the report.

The report is reviewed and managed by the conduct committee according to 3 steps outlined in the guidelines.

Step 1: Identification and remediation phase

In this phase, emphasis is on education and counseling. The conduct committee or a committee member meets with the medical staff member who is the subject of the report to learn what happened and discuss the matter. They may involve the department or division chair. They may refer the person to resources such as the physician health committee or anger management.

Step 2: Focusing actions and ultimatum phase

This step is for repeat offenders, egregious behavior, or those who fail to follow through with remediation at Step 1. A formal meeting is held in which the physician meets with the conduct committee and the department or division chair, with a timeline for activities. The person may be counseled, with a deadline for potential consequences if the behavior doesn’t cease, or the matter may be discussed with senior medical staff leaders and the hospital CEO about a further process.
Step 3: Formal actions and disciplinary phase

If disruptive behavior continues or is sufficiently egregious, the conduct committee, after consulting with the department or division chair, makes an official written report to the president of the medical board, the senior vice president of medical affairs, and the hospital CEO, with request for disciplinary action under the medical staff bylaws. The bylaws require the medical staff to adhere to standards of behavior and cooperate in any review under the disruptive behavior guidelines.

Protecting confidentiality

Reports at the early stages are considered confidential. They are stamped “peer review,” and there is no paper trail.

“We try hard to protect everybody’s rights and confidentiality,” Pankratz says. “If we ask the individual to come to the committee, the reported incident is discussed in a broad way.” Even if the behavior does not rise to the definition of disruptive behavior, the committee will communicate to the physician that an incident occurred that was upsetting to those involved and was not conducive to a healthy work environment.

Retaliation is not allowed, and no conversations are permitted between the subject of the report and those who filed it.

Pankratz recalled one episode that illustrates the guidelines’ educational focus. Some of the staff had reported a physician they felt was abusive. When he met with the conduct committee, he said, “I don’t mean to be difficult. Can you give me some examples of what is troubling them?”

When examples were given, he said, “That’s very helpful. Those are things I will try to avoid.”

Staff who file reports receive feedback. After the incident is reviewed, the committee sends them a letter thanking them for documenting the behavior and telling them to let the committee know if the behavior has improved or there are continued problems.

“We let them know it was handled without disclosing confidential information,” she notes.

How effective?

What evidence is there that the guidelines are effective? One example: “We rarely have repetitive events,” Pankratz says. Also, the staff will often say they notice a difference in behavior after the committee has collaborated with a particular physician.

For the first 5 years after implementation, the staff was surveyed annually. Included in the questionnaire were questions to assess whether the staff knew how to report an issue with a manager, peer, or physician and how healthy they considered the environment to be.

“That really helped guide our education efforts and refine the policy,” Pankratz notes.

Advice on developing a policy

Pankratz offered advice for managers who are developing or fine-tuning their policies:

• Be proactive and develop the policy before you have a specific incident.
• Involve physician colleagues who have the respect of their peers.
• Take time and care in developing the policy, with review and approval from all levels of the organization. The UW guidelines took 6 months to develop.
  “I think it’s really important to get your policy right on the front end,” she says. “Otherwise, you could be in trouble when it is challenged, or you could have unintended consequences.”
• Focus on the positive. Let the emphasis be on education and remediation.

Talking through a situation

“The OR is a really stressful place,” she observes. “One of the big things we do is talk through a situation with colleagues.” For example, a surgeon who blows up in
the OR may be frustrated about a staff person who seems inexperienced or equipment that is malfunctioning.

“We can acknowledge that they were frustrated and talk through other avenues for problem solving,” she explains. Surgeons on the committee offer suggestions for alternatives, such as asking the charge nurse for assistance.

Carefully developed guidelines, involvement of key physicians, and an emphasis on consultation can help contribute to a safer environment for patients and a better environment for everyone who works in surgical services. —Pat Patterson

**Definition of disruptive behavior**

From the University of Wisconsin's guidelines for preventing disruptive behavior in the medical staff.

Disruptive behavior encompasses any action that might reasonably be construed by others as destructive or abusive to individuals, to health professional relationships in the Hospital, and/or to hospital operations, regardless of intent.

Examples of disruptive behavior include:

- Verbal and/or physically threatening behavior exhibited during interactions with colleagues, students, hospital personnel, patients, or visitors.
- Harassment in any form, including but not limited to, verbal or written slurs relating to an individual's race or ethnic background, religion, national origin, age, sex, sexual orientation, disability, or marital status. Invasion of personal space and sexual harassment in any form, explicitly or implicitly, falls within the definition of disruptive behavior.
- Demonstrations of anger and threatening acts, such as deliberately destroying property or tossing equipment about. These are clearly disruptive acts incompatible with an effective and safe work environment.
- Threatening retaliation as a result of learning of the report of acts of disruptive behavior. Such actions are incompatible with an effective, supportive, and safe work environment, even though the acts may not be directed at any individual.