

Bad Blood: Doctor-Nurse Behavior Problems Impact Patient Care

By Carrie Johnson

In this article...

Examine the results of the 2009 Doctor-Nurse Behavior Survey and discover some of the reasons why the bad behaviors persist.

One physician hurled a surgical instrument at his co-workers in a fit of anger. Another tried to stuff a nurse head-first into a trash can. A group of nurses banded together to blackball a doctor and get his privileges revoked.

Bad behavior among doctors and nurses has always been health care's dirty little secret. Almost everyone in the industry has a story to tell about harassment, insults traded back and forth or a screaming match in the operating room.

But a new survey conducted by the American College of Physician Executives illustrates just how pervasive the problem has become. And ACEP is working to find ways to curb the bad behaviors.

According to the survey results, outrageous behavior is still common in this country's health care organizations. More than 2,100 physicians and nurses participated in the survey, and some of the tales they related were surprising:

- Physicians groping nurses and technicians as they tried to perform their jobs.
- Tools and other objects being flung across the OR.
- Personal grudges interfering with patient care.
- Accusations of incompetence or negligence in front of patients and their families.

According to the respondents, the fundamental lack of respect between doctors and nurses is a huge problem that affects every aspect of their jobs. Staff morale, patient safety and public perception of the industry all suffer as a result.

The electronic survey was emailed to about 13,000 doctors and nurses. Of those who participated, about 67 percent were nurses and 33 percent were physicians.

Behavior problems are obviously pervasive: nearly 98 percent of the survey respondents reported witnessing behavior problems between doctors and nurses in the past year. Responses were divided over how frequently problems arose.

About 30 percent of participants said bad behavior occurred several times a year, while another 30 percent said it happened weekly, and about 25 percent said monthly. A surprising 10 percent said they witnessed problems between doctors and nurses every single day.

What was the most common complaint? Degrading comments and insults that nearly 85 percent of participants reported experiencing at their organizations. Yelling was second, with 73 percent. Other typical problems included cursing, inappropriate joking and refusing to work with one another.

Some of described behavior is criminal, and would appear to meet the criteria for an assault charge, such as throwing scalpels or squirting a used syringe in a co-worker's face. But according to some survey participants, it's the day-to-day putdowns and slights that can be the most harmful.

"The worst behavior problem is not the most egregious," wrote one participant. "It's the everyday lack of respect and communication that most adversely affects patient care and staff morale."

Physician, heal thyself

While there were complaints about nurse behaviors, both doctors and nurses who filled out the survey said physicians were to blame for a large part of disruptive behaviors. Many of the participants accused physicians of patronizing and belittling nurses, a pattern some surmise may have been instilled in medical school.

"Some ED physicians do not respect the nurses' opinions or suggestions," one wrote. "They will then appear to delay patient care 'just to show' the nurse."

Over and over again, survey participants reported instances of physicians questioning the intelligence of nurses or calling them stupid.

“A surgeon who was frustrated by a staffing issue in the OR stated loudly and publicly that monkeys could be trained to do what scrub nurses do,” wrote one participant.

Another shared this example: “A physician demanded a nurse be drug tested because she questioned an order. The order would have placed the patient at risk. He then demanded she be fired because she ‘evidently wasn’t competent to care for a slug.’ He also called her names and cursed at her in front of staff and family members.”

Many of the survey participants said they witnessed doctors acting as though they should receive special treatment because of their positions. They described childish temper tantrums, including one surgeon who threw himself on the OR floor while a patient was still open and under anesthesia because an instrument was not working properly.

Throwing objects to express frustration is apparently quite common. According to the survey respondents, nurses have ducked bloody chest tubes, scalpels, power tools, telephones, surgical instruments, clipboards, floor mats and more.

Sexual harassment

Sexual harassment was also a common theme in the survey. Thirteen percent of respondents reported witnessing acts of sexual harassment in the past year. The harassment takes many guises.



“A surgeon, during surgery, needed to step behind a shield while an X-ray was taken,” one participant wrote. “A young female radiology tech was shooting the film, and the doctor stood behind her and fondled her breasts.”

Some of the stories involved physicians and nurses spreading rumors, such as the doctor who told a nurse’s boss she was a poor practitioner after she refused to date him.


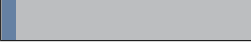
There were also examples of doctors and nurses engaging in inappropriate behavior together, which contributed to an uncomfortable working environment.

“A married hospitalist started dating an ICU RN,” wrote a participant. “The ICU RN had some behavior




1. Are you a nurse or physician executive

	Response	%	Count
Nurse Executive		67.2%	1,428
Physician Executive		32.8%	696
answered question			2,124
skipped question			33

2. Does your health care organization ever experience behavior problems with doctors and nurses?

	Response	%	Count
Yes		97.4%	2,088
No		2.6%	55
answered question			2,143
skipped question			14

3. Over the last 3 years, how would you characterize the number of behavior problems between doctors and nurses at your health care organization?

	Response	%	Count
More behavior problems between doctors and nurses		12.0%	213
About the same number of behavior problems between doctors and nurses		52.3%	927
Less behavior problems between doctors and nurses		35.7%	633
answered question			1,773
skipped question			384

issues. If the ICU RN did not like a RN, the hospitalist would not respond to that RN's pages or would question the info shared by the RN."

Nasty nurse

The nurses weren't above reproach. Most of the complaints

about nurses revolved around backbiting, spreading rumors and attempting to blackball doctors or other members of the staff.

"We've had more difficulty with nurses fighting with nurses than doctor-nurse relationships," one person wrote. "We did have one nurse who kept


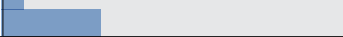
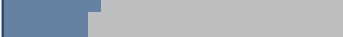
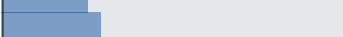
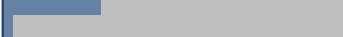
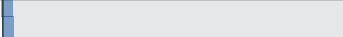
detailed records (to the point of stalking) on several nurses and doctors in the hope of getting them fired. She filed a restraining order on one male nurse but never showed up at the court hearing."

Another survey participant reported having trouble with the director of nursing and the nursing supervisor. "(They) screamed at their own staff and tried to get the doctors in trouble. They constantly complained to me about the doctors and encouraged the nurses not to follow doctors' orders. Finally, the nurses signed a petition to HR that they were in fear for their physical safety from the nursing supervisor, and she was put on administrative leave while it was investigated."





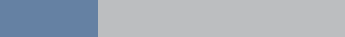
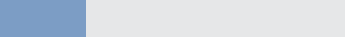
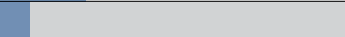


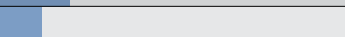
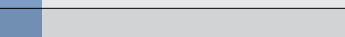
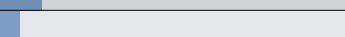
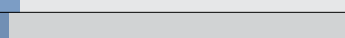
Several people complained about nurses overreacting to normal workplace interactions.

"False accusations based on erroneous interpretations between being 'yelled' at and being held accountable," one person wrote. "The political correct-

4. Generally speaking, how often do behavior problems arise between doctors and nurses at your health care organization?

	Response	%	Count
Daily		9.5%	168
Weekly		30.0%	530
Monthly		25.6%	452
Several times a year		30.9%	547
Once a year		2.9%	51
Less than once a year		1.2%	21
answered question			1,769
skipped question			388

5. In the last year, what types of behavior problems have you experienced at your health care organization between doctors and nurses? (Check all that apply.)

	Response	%	Count
Yelling		73.3%	1,294
Cursing		49.4%	873
Degrading comments and insults		84.5%	1,493
Refusing to work together		38.4%	679
Refusing to speak to each other		34.3%	606
Spreading malicious rumors		17.1%	302
Inappropriate joking		45.5%	804
Trying to get someone disciplined unjustly		32.3%	570
Trying to get someone fired unjustly		18.6%	328
Throwing objects		18.9%	334
Sexual harrasment		13.4%	237
Physical assault		2.8%	50
Other		10.0%	177
answered question			1,766
skipped question			391

ness and physician discipline movement has gotten to the point that holding people responsible for their actions and accountable for their portion of patient care is now considered by those confronted as being victims of disruptive behavior. This is affecting patient care, morale and employee retention.”

One participant wrote in to complain about what he called “chart Nazis,” nurses who spend more time making sure charts have been properly updated than worrying about patient care. “The nurses spend more time sitting around talking, drinking coffee and ‘charting’ than taking care of patients. The recent influx of nurses into the market (because of a supposed shortage of nurses) has resulted in a huge increase of new, untrained grads who have no knowledge.”

Patients in the middle

While disruptive behavior is terrible, no matter whom the target, the problem becomes especially worrisome when it affects innocent third parties—patients and their families.

From making mean and insensitive comments within earshot to behavior that actually puts lives at risk, both physicians and nurses are guilty of putting patients in uncomfortable and downright dangerous situations, survey respondents said.

One person wrote in with a story about a baby who needed immediate attention from a physician. With the mother looking on, the doctor berated the nurse by saying, “What did you do to kill this baby?” The infant later died.

Some participants wrote stories of nurses who hesitated to offer their opinions for fear of being berated by physicians.

For example, one person related a story about a patient in the ICU who began experiencing problems after his surgery. “The nurse contacted the doctor and the doctor yelled at the nurse and refused to come and see the patient.... The nurse contacted the doctor again when the patient’s symptoms did not improve. The doctor became even more verbally upset. The nurse refused to call the doctor again, and when she finally did, the patient was hemorrhaging internally, rushed back to the operating room and expired. The nurse did not follow the escalation process and the doctor never came to see the patient.”

In yet another instance, a doctor told a nurse he would not see a critically ill patient because he had “live patients” to care for.

6. From the list, choose the 3 behavior problems between doctors and nurses that occur most often at your organization.

	Most frequent behavior problem	2nd most frequent behavior problem	3rd most frequent behavior problem	Rating Average	Response Count
Yelling	58.1% (702)	27.4% (331)	14.6% (176)	1.56	1,209
Cursing	9.9% (61)	47.6% (294)	42.6% (263)	2.33	617
Degrading comments and insults	46.8% (619)	34.4% (455)	18.9% (250)	1.72	1,324
Refusing to work together	24.4% (103)	34.4% (145)	41.2% (174)	2.17	422
Refusing to speak to each other	16.3% (50)	41.4% (127)	42.3% (130)	2.26	307
Spreading malicious rumors	22.6% (28)	29.0% (36)	48.4% (60)	2.26	124
Inappropriate joking	20.5% (77)	35.1% (132)	44.4% (167)	2.24	376
Trying to get someone disciplined unjustly	13.3% (39)	33.0% (97)	53.7% (158)	2.40	294
Trying to get someone fired unjustly	5.0% (4)	22.5% (18)	72.5% (58)	2.68	80
Throwing objects	4.9% (4)	13.4% (11)	81.7% (67)	2.77	82
Sexual harrassment	5.5% (3)	12.7% (7)	81.8% (45)	2.76	55
Physical assault	33.3% (5)	20.0% (3)	46.7% (7)	2.13	15
				answered question	1,738
				skipped question	419

7. At your health care organization, who most often exhibits behavior problems?"

	Response	%	Count
Doctors		45.4%	691
Nurses		6.8%	103
A pretty even mix of both doctors and nurses		47.9%	729
answered question			1,523
skipped question			634

8. In the last year at your health care organization, have there been any NURSES terminated due to behavior problems?"

	Response	%	Count
Yes		61.2%	897
No		38.8%	569
answered question			1,466
skipped question			691

9. In the last year at your health care organization, have there been any DOCTORS terminated due to behavior problems?"

	Response	%	Count
Yes		22.2%	326
No		77.8%	1,145
answered question			1,471
skipped question			686

10. In the last year, has your health care organization held any staff training programs to try to reduce behavior problems between doctors and nurses?"

	Response	%	Count
Yes		55.8%	839
No		44.2%	664
answered question			1,503
skipped question			654

There are some solutions

Obviously, these are not problems that can continue unabated. But several participants said their attempts to rectify the situation were thwarted because of what they perceived as a double standard for physicians and nurses.

"In each case, the physicians investigating the report (all different doctors) found that 'there is no reason to sanction the doctor; this was probably just vindictive nurses,'" one person wrote. "Then the reporting nurses were treated coldly by the doctor and associates and branded as troublemakers."

Another participant echoed those thoughts:

"If nurses display disruptive behavior, they are soon terminated after going through the disciplinary process. Or if the action was severe, they are terminated immediately. Physicians seem to have more leniencies when it comes to disciplinary actions related to disruptive behavior. Therefore, it might appear that the organization is more willing to tolerate their negative behavior, which sends a message not only to the physicians but to the nurses and staff that are dealing with it on a frequent basis."

On the flip side, some survey participants said nurses are too quick to blow the whistle on doctors. They accuse nurses of launching unfair personal vendettas against physicians, which sometimes result in unfair punishment or stigma.

Still, many offered suggestions for ways to improve relations between doctors and nurses. The most frequently suggested solution: education. In fact, many participants wrote to say they believed instruction was needed as early as medical school or nursing training.

"Reduction of behavioral problems can only be corrected through early education for both physicians and nurses," one person wrote. "This needs to be thoroughly ingrained during medical school and nursing school. Bad behavior needs early intervention."

11. Please indicate what type of health care organization you are working for:

	Response	%	Count
Hospital		68.9%	1,091
Group practice		5.0%	79
Academic medical center		9.3%	147
Military/government facility		3.0%	48
Managed care organization		1.6%	25
Integrated health system		7.3%	115
Other		5.0%	79
answered question			1,584
skipped question			573

One participant described a program where medical students shadow nurses as part of their training. “We are amazed at the feedback we receive from both the nurse and the medical student. The medical student doesn’t have a good picture of the many facets of the nursing role.”

But what about those who have already progressed beyond medical or nursing school? Learning to work together—whether through organization-sponsored training programs or simple reminders of common courtesy—was a popular response. Many called upon hospital leaders to emphasize teamwork and collaboration.

Wrote one person: “Training, increased awareness and positive reinforcement helps tremendously. Removing the very real sources of physician or nurse frustrations that create barriers to their performance is key. Both disciplines want the same thing: the very best outcomes for their patients.”

Other vital ingredients include follow-through on complaints and clear consequences for bad behavior, survey participants said. Suggestions include a zero-tolerance policy, a clearly-enforced code of conduct and a process for promptly dealing with complaints.

“Address problems swiftly and seriously,” one person wrote. “Repeated behavioral problems by any individual

require progressive discipline, up to and including termination. Individuals need to know that inappropriate behavior will not be tolerated by anyone.”

Additional successful strategies included creating physician and nurse liaison groups that meet regularly to discuss problems, and allow the medical staff to create a physician conduct policy, with the hope of inspiring everyone involved with enforcing it.

One resourceful organization implemented a special code where the rest of the staff will step in to help contain the situation if bad behavior is witnessed. Another created a Web-based program to collect reports of bad behavior, including those submitted anonymously. The reports are sent directly to the appropriate channels.

Nearly all agreed: Change needs to come from the top.

“Have excellent relationship between the chief medical officer and the chief nursing officer,” one person wrote. “Prioritize and emphasize corporate citizenship. Have policies and bylaws that support the efforts. And, most importantly, early intervention and timely feedback.”

Hope for the future

While the results of this survey may seem disheartening, not every organization reported difficulty between physicians and nurses. Several

participants said the problem was much less prevalent than it once was.

“In my 32 years as a nurse, things have gotten better,” one person wrote. “I remember as a young nurse hearing degrading comments and yelling from attendings, which has improved. I think we are learning to communicate better.”

“Sorry, but we have an excellent team that tries to work together as much as possible,” another wrote. “We have occasional episodes of personality clashes, but have never had malicious rumors, throwing objects, etc.”

For all the stories of physicians who threw temper tantrums, physically assaulted co-workers and verbally abused colleagues, there was this example of a once-incorrigible doctor who was taught the error of his ways.

“One physician got into a verbal dispute with nurses each time he was on call. But after extensive mentoring, he is now the ‘poster child’ for good behavior.”

In fact, that physician is now the head of the organization’s doctor-nurse collaborative counsel.



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'Disheartening' Developments for Disruptive Behavior

By Carrie Johnson

In this article...

Experts say the longstanding problem of disruptive behavior is finally getting some attention from The Joint Commission, but it will be up to health care organizations to enforce the codes of conduct.

For more than a decade, William "Marty" Martin, MPH, PsyD, has been writing about, lecturing and studying bad behavior in the workplace with the hope of eliminating it, once and for all.

So he had just one word to describe the results of the survey on disruptive behavior in the health care field conducted by ACPE: "Disheartening."

"Seemingly, there has not been a lot of forward movement," said Martin, associate professor of leadership studies at DePaul University in Chicago, Ill., and an ACPE faculty member.



Martin, like other experts in this area, is concerned about the apparent lack of civility in the health care field. While workplace bullying is always hard on morale, it's particularly troubling when there's the possibility of injury to an innocent third party, such as a patient.

"This isn't simply an issue of physician engagement," Martin said. "It really does have an impact on patient safety

and quality."

The good news: The issue is now getting attention from those at the highest level of the medical field, as well as Congress and the U.S. court system. Perhaps the most noteworthy development was the decision by The Joint Commission in 2008 to require health care organizations to create a code of conduct defining acceptable and unacceptable behaviors and to establish a process for managing unacceptable behavior.

But Martin said The Joint Commission's requirement will only work if health care organizations have the fortitude to enforce the code of conduct. In many cases, the best of intentions are easily derailed when a company's finances are on the line, Martin said.

Slap on wrist

For example, if he was a cardiovascular surgeon who brought in more than \$5 million per year and engaged in bad behavior, "most organizations, they're going to come to me and slap me a little on the wrist," he said.

Martin said he finds this attitude particularly hypocritical in the medical field, where physicians are sworn to protect the health of others. Meanwhile, workplace bullying not only puts patients at risk, it can also severely affect the mental and physical health of other employees. However, if money is the most important priority, organizations need to be transparent about this so employees can make their choices wisely, Martin added.

So how should an organization address this?



Steven Tremain, chief medical officer and chief medical information officer at Contra Costa Regional Medical Center in Martinez, Calif., said courage is an essential ingredient. It takes courage to set strict boundaries and even more to enforce them, he said.

"We have to recognize that medicine is a team sport," he said. "And the ultimate challenge at the end of the day

is winning the game, together.... If the nurses aren't on your team, your patient isn't going to do very well. And to do that, you've got to get your ego out of the way."

One thing most experts agree upon is that change must come from the top. That includes the entire leadership — from the board of directors down — so that all employees feel empowered to report bad behavior.

It's also important to set a good example. If the chief medical officer and the chief nursing officer don't get along, the rancor is likely to trickle down throughout the ranks, Tremain said. He's worked hard to build good relationships with the nurse executives at his hospital.

"It's all about breaking down walls and building teams," he said. "And that starts at the top."

Studying best practices can be helpful, but the most effective policies will be tailored specifically to meet the needs of your organization, Tremain said. One strategy that worked well in his hospital was to build multi-disciplinary units so that all employees are forced to work with people outside of their areas of specialty.

Physician leaders also need to do a better job of handling complaints of disruptive behavior and dealing with it immediately. Too often, executives tend to dismiss complaints until the problem becomes too large to ignore. By then, it's too late, Tremain said.

The good news: Once you put systems in place and leaders begin expecting good behavior, self-policing takes over, Tremain said. He witnessed a surge of momentum in his hospital. Now peer pressure helps keep everyone in line, he said.

Don't overlook the pariah factor, he added. It used to be an employee who was scolded for disruptive behavior at one hospital could easily find work someplace else. But as awareness grows about the harmful effects of workplace bullying, disruptive doctors are finding it harder and harder to shake their reputations. This creates extra incentive for physicians to practice civility.

But Martin said he doesn't see widespread change occurring until there's a highly publicized event, such as discipline by The Joint Commission or a landmark court case.

"As long as some organizations value money over anything else, they will allow the revenue producers to do whatever... they want to do until they become a financial risk," Martin said.

Education is key



David R. Marshall, the interim chief operating officer of the University of Texas Medical Branch Hospitals and

Clinics and a registered nurse, said his organization took a cue from the aviation industry and implemented "crew resource management" in all of its operating rooms. Under this process, the medical team holds a quick meeting before every operation and the lead surgeon encourages them to speak up if they see anything that needs attention. The crew also holds a short debriefing afterward.

Marshall said this empowers all members of the staff and encourages everyone to work together. "We really make that expectation live within our organization," he said.



Maureen Swick, vice president of patient care services at Saint Peter's University Hospital in New Brunswick, NJ, said relations

are better now than they have ever been during her 26 years in nursing. She said that's largely because health care has become far more transparent than it was in the past.

"I think most health care institutions really don't have a choice anymore," she said.

Still, there is room for improvement, as the survey results show. Swick's solution: "Education, education, education."



Pam Rudisill, vice president of nursing and patient safety at Health Management Associates, Inc., said shared governance on

hospital boards is an important first step toward creating better relations between doctors and nurses. Like Swick, she sees hope for the future. "I would hope the survey results would be very different a year from now," Rudisill said. "We're just in that time-frame where we're going to see a shift in the culture."



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Early Intervention Can Help Prevent Disruptive Behavior

By Alan H. Rosenstein, MD, MBA

In this article...

Identifying people who may exhibit disruptive behavior and counseling them can help reduce future incidents.

It's not like a doctor or nurse starts the day out planning to be disruptive. There are a series of deep-seated, sub-acute, and acute events that may trigger a disruptive response (see Table 1).

Unfortunately, most of the interventions start in the post-event stage after a disruptive event has already occurred. Interventions at this stage of the process often take on a confrontational, punitive approach, that have varying degrees of success.

For some individuals simply discussing the event and raising the level of awareness about how the event was perceived at the receiving end impacting the individual's perception and reaction is enough to raise their level of awareness and sensitivities to the point that another disruptive event would be unlikely to occur.

In others there are more deep-seated issues that may benefit from participation in educational programs or training workshops. Some individuals may require more intensive counseling. For the small number who refuse to comply, disciplinary action such as temporary suspension or termination may be required.

But a greater opportunity for success would be to intervene earlier on in the process. Identifying individuals who are "at risk" for a disruptive event and proactively providing coaching or emotional support is a more positive and successful approach than the post-event intervention process.

Values

There are several forces at work here. Values are set early in life. Some of these values are formed by genetics, family upbringing

and life experiences. There are different sets of assumptions, perceptions and "ways of doing business" based on an individual's age, gender, cultural beliefs, and personality.

For physicians, we know that certain personality types are linked to choice of specialty. Life experiences and training are other contributing factors. Think of the medical school and residency model. When you start out it's made very clear that you know nothing and are at the very bottom of the food chain that promotes low self-esteem and confidence.

You learn to work independently, building fortitude and competency based on knowledge and technical expertise. You have ultimate responsibility for making critical decisions that are often carried out with an autocratic domineering tone that in some cases may be perceived as being "disruptive."

Unfortunately, what's lacking are the people skills, communication skills, and team collaboration skills so important in today's complex medical environment.

Below the surface are issues related to "emotional intelligence," which simply stated is your perception, awareness and sensitivity to what's going on around you. Other contributing factors include the growing stress and frustration with the health care environment that may lead to anger and resentment, fatigue, burnout, and depression. In some cases, there is also a history of underlying substance abuse.

A variety of external factors may influence one's mood and demeanor and subsequent interactions with others. These may include a recent serious event (family illness, other), operational inconvenience (wrong equipment/scheduling inefficiencies/inadequate staff support) or being provoked by another individual or stressful event.

Recommendations

Having the right policies and procedures in place, supporting the program with appropriate education and leadership, and addressing disruptive events from a perspective of prevention, real-time intervention and follow-up action are all the right things to do.

Most of the prevention efforts have focused on raising awareness and providing courses on communication and collaboration. Real-time interventions have been supported by courses on assertiveness training and team building skills.

Some organizations have also introduced a “code white” call where, similar to a code blue, someone pages the team to intervene real-time during a disruptive event. Follow up interventions have included a post-event “debriefing” or individual follow-up actions as described previously.

But what if we took a different approach? If we could identify individuals or potential sites of risk, could we not intervene at an earlier stage in the process?

We know that disruptive events are more likely to occur in high-intensity/high-stress areas and involve high-intensity/ high stress specialties. More subtle risks may be evident from observing sudden changes in attitude or demeanor, notable lapses in attention to detail, or obvious changes in physical appearance. The trick is to get the individual to recognize that they may have a potential problem. This is particularly true for physicians.

How do you approach a physician? It’s one thing if somebody mandates that they seek help, but it’s another thing to get a physician to voluntarily open up and look for outside assistance. For the most part physicians may either be unaware that they are working under stressful situations that are impacting relationships with their peers or, if they do, are reluctant to ask for help under the impression that they have lived with stress all their lives and traditionally have gotten through it on their own.

Approaching the physician on this issue may be tricky. First is to assure them that services being offered are confidential, will be delivered in a convenient format, and will emphasize the context of coaching support. The physician also needs to be convinced

that you truly understand the physician’s world and can relate to their unique pressures and needs.

Coaching and counseling of this type will lead to improved satisfaction, improved relationships at work and at home, improved productivity, and improved communication efficiency, with a lower likelihood of disruptive behavior.

Given today’s environment with the growing threat of physician shortages, making a special effort to retain key physicians is more important than ever.



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Table 1

**Driving Forces:
What Causes People
to act and react
the way they do?**



Deep seated:

- Age (generation)
- Gender
- Culture and ethnicity
- Personality
- Family/ life values and experiences
- Training

Sub acute:

- Emotional intelligence
- Stress and frustration
- Fatigue/ Burnout
- Depression
- Substance abuse

Situational:

- Environmental
- Operational
- Provoked response

Strengthening Physician-Nurse Partnerships to Improve Quality and Patient Safety

By Michael Buckley, MD, John Laursen, and Victoria Otarola

In this article...

Discover how a teamwork pilot project at a large hospital improved doctor-nurse relationships and is expanding rapidly throughout the system.

Support for improving patient care quality and safety was never an issue at Pennsylvania Hospital. Like many others, the Philadelphia hospital developed ideas for a variety of quality and safety initiatives that had significant buy-in from physicians and nurses.

Yet, despite lots of good ideas and backing from physicians and nurses, implementation of improvement initiatives at the bedside was inconsistent or lacking. The obstacles, it turned out, were not about lack of interest or resources to get the job done.

Rather, the barriers to achieving breakthrough performance in improving quality and patient safety had more to do with the need for better communication, collaboration and shared ownership and responsibility for patient care—key ingredients of teamwork.

That's why, in 2007, the hospital's physician and nursing leadership embarked on a new approach to emphasize that care delivery is really a team effort by introducing the Unit Based Clinical Leadership Program (UBCL).

Pennsylvania Hospital is a 500-bed teaching institution that is part of the University of Pennsylvania Health System (UPHS). Consistently running at high rates of occupancy while at the same time training new medical residents means that hospital clinicians and staff work at a brisk pace, focusing primarily on their individual role and contributions to care delivery.

Physicians might say, "I did my job by ordering an injection."

Nurses would say, "I did my job by giving the patient the injection that was ordered."

However, physicians and nurses were not viewing these actions together and saying, "Did we do what was right for the patient by ordering and giving the injection in a timely, correct manner?"

The result was less emphasis on the overall patient experience as nurses and physicians worked to care for an increasing number of patients. High patient volume also meant that beds were in short supply. Patients who needed the same type of care were often geographically dispersed among several units, depending on where beds were available, creating further challenges for physicians and staff to function smoothly and efficiently as caregiving teams.

To help address these issues, the hospital piloted the UBCL in July 2007. The other health system hospitals, The Hospital of the University of Pennsylvania and Penn Presbyterian Medical Center, also instituted these pilots, although initially on a smaller scale.

The goal of the program was to build physician-nurse leadership partnerships based on shared responsibility and accountability for increasing quality and patient safety to improve the patient's care experience and outcomes.

Leadership teams

The Pennsylvania Hospital pilot established leadership teams on seven of the hospital's clinical care units. Each team consisted of four members:

1. Physician unit clinical leader
2. Nurse manager, who shared responsibility for unit clinical leadership
3. Nurse educator or nurse specialist, depending on the unit
4. Quality coordinator responsible for collecting and analyzing data and providing project management support

In most hospitals, nurse managers are used to being responsible and accountable for their units; however, physicians typically are not. Selecting the right physician to be part

of each leadership team was therefore critical to success.

At Pennsylvania Hospital physician participants were chosen based on three criteria.

1. First, we asked nurse managers to identify the physicians they'd most like to work with, based on those who spent significant time on their units.
2. Next, we identified physicians who had the time to devote to the pilot.
3. Then, we looked for physicians who were interested in the initiative.

At Pennsylvania Hospital we asked each physician team leader to commit two hours a week to the UBCL pilot. One hour was devoted to multi-disciplinary rounding to observe care activities on the unit, identify issues and problems and determine which ones the team wanted to address.

The second hour was focused on meeting with the nurse manager and other team members to review progress and results related to specific improvement projects the team was working on.

Once a month each team also met with the chief medical officer, director of quality, director of patient safety and either the clinical director of nursing responsible for the team's nurse manager or the hospital's chief nursing officer.

This meeting focused on:

- The status of the team's work
- Removing obstacles and solving problems
- Ensuring that improvement projects kept moving forward

As is the case with most other administrative duties that physicians perform at the hospital, UBCL physicians were compensated for participating on the teams. The

Exhibit 1

The Pennsylvania Hospital Quality and Patient Safety Unit Based Physician Leader Job Description



The barriers to achieving breakthrough performance in improving quality and patient safety at Pennsylvania Hospital had more to do with the need for better communication, collaboration and shared ownership and responsibility for patient care—key ingredients of teamwork.

Job Summary: The Quality and Patient Safety Unit Based Physician Leader for this Unit of the Hospital will partner with the Quality and Patient Safety Coordinator and Unit Nursing Leadership on quality and patient safety processes to improve outcomes.

Job Responsibilities:

1. Partners with Nurse Manager to ensure quality care and implement clinical strategy within the unit by meeting at least weekly on the patient care area.
2. Partners in the management of clinical care with other clinicians. Provides medical leadership and communication to medical staff and house staff as indicated.
3. Collaborates with clinicians, allied health, nurses and all staff to improve and sustain quality and patient safety goals through rounding and presence at least weekly on assigned clinical area.
4. Reviews and assists with interpretation of data on selected quality and patient safety indicators for assigned area, such as The Joint Commission National Patient Safety Goals, incident reports, Rapid Response Team reports, patient complaints, quality outcomes, hospital-acquired infections, and Core Measures.
5. Takes action and responsibility with team for improving and sustaining quality and patient safety indicators on assigned clinical area.

Exhibit 1 continued

6. Participates in unit based interdisciplinary rounds and other meetings as required including hospital quality and patient safety.
7. Participates with Nurse Manager in annual review and goal-setting for unit quality and patient safety indicators with Chief Medical Officer and hospital leadership.
8. Partners with Nurse Manager in reporting progress of unit quality and patient safety indicators to selected committees, groups, and Hospital leadership.
9. Utilizes clinical skills to assist in the design, implementation and monitoring of initiatives related to clinical processes and patient outcomes.
10. Utilize interpersonal skills/strategies with individuals and/or groups to achieve desired/satisfactory and/or acceptable outcomes.

hospital developed a job description for the physician unit clinical leader role. Physicians were asked to document their hours monthly and show how their work related to the job description (see Exhibit 1). The chief medical officer then signed off on the documentation.

All teams received training for participation in the pilot. The system partnered with consultants from the University of Pennsylvania's Wharton School of Business to help team members build skills in goal-setting, managing staff, promoting positive changes in work culture, and negotiating and resolving conflicts.

Team members also learned how to structure projects, collect and analyze data and develop action plans for performance improvement. To the extent possible, physician and nurse team leaders went through training together.

Each team initially focused on two major projects. Sample projects and results are included in Exhibit 2.

As projects progressed, UBCL teams also received significant support from Stockamp, a Huron Consulting Group Practice. Pennsylvania Hospital had hired

Stockamp to conduct a patient flow improvement engagement in 2007. That project brought together multidisciplinary care coordination teams that conducted daily rounds to focus on each patient's plan of care.

Stockamp's care coordination rounds helped to structure and facilitate the work of UBCL teams and to overcome some of the geographical barriers to caring for patients on different units.

Physician unit clinical leaders also helped promote involvement of residents and other clinicians in the care coordination rounds, orienting them to the process and helping them understand the importance of consistent participation.

Stockamp's care coordination rounds helped the hospital significantly improve care delivery. Stockamp's focus on reducing patient waiting time for admission, placing patients on the optimal unit for care and treatment, ensuring quicker bed turnaround and more efficient patient transport and implementing an efficient, effective discharge process all contributed to greater patient satisfaction (see Exhibit 3 for Stockamp project results).

The care coordination rounding process also created a more patient-centered care experience by helping patients understand that everyone involved in their care met regularly to discuss their progress and to plan for next steps.

Before care coordination rounds, nurses talk with each patient, letting them know that their doctors and other members of the care team will be meeting, and asking if the patient has any questions or concerns for the team to address.

After rounds, the nurse reports back to the patient and describes the plans for the patient's care. This process has led to improved communication, and has been a significant "satisfier" for patients, allowing them to participate in their treatment and see that their care team is working together and speaking with one voice.

Physicians and nurses who initially objected to taking the time to participate in the rounds soon learned they were actually a time saver. Rather than spending all morning on the phone trying to address a particular patient's needs, during the rounds staff got all their questions answered in a few minutes.

Pilot results

The UBCL pilot not only resulted in breakthrough improvements in quality and patient safety, but also forged better physician-nurse collaboration and job satisfaction as well.

The greatest success was bringing together physicians and nurses to lead in ways that reinforced that patient care is truly about partnership. Although the pilot only involved some 10 physicians in a staff of hundreds, its success is convincing more and more department chairs and other clinical leaders that the nurse-physician partnership is important—the beginning of a change in culture.

Because Pennsylvania Hospital is a teaching facility, the program

also exposed residents to this team approach to patient care, preparing them to function in similar ways throughout their careers.

Both physicians and nurses also came to better appreciate each other's pressures and challenges. For example, the physician leaders didn't realize the myriad issues nurse managers deal with daily to ensure delivery of timely, effective care. Nurses likewise didn't understand, for example, that one of the reasons residents sometimes didn't appear on their floor was because they had to see patients on five other floors as well.

The UBCL pilot also enabled physicians and nurses to view problems and challenges differently. For example, at the start of the stat antibiotic project, the team assumed that the pharmacy was responsible for delays in patients receiving their antibiotics. Investigation of the problem revealed that the pharmacy was getting the antibiotic to the unit quickly when it was ordered. The real problem was communication.

Physicians were not consistently telling nurses that they had ordered the antibiotic stat, and therefore the nurses did not always know to look for it immediately. The other problem was that nurses on some units didn't understand the importance of getting the antibiotic into the patient quickly and also needed to learn how to better document antibiotic administration in the hospital's computer system. Once these issues surfaced, they were easily resolved.

Next steps

The University of Pennsylvania Health System's chief medical and nursing officers believe that the Unit Based Clinical Leadership Program is the care model of the future for UPHS and are working with administrative leaders to invest in expanding the program in all system hospitals. Pennsylvania Hospital currently has 12 teams and 18 additional teams are now coming online systemwide.

Exhibit 2

Sample Unit Leadership Team Projects and Results



1. Administration and documentation of deep venous thrombosis prophylaxis on an orthopedic unit: Documentation of compliance reached 100% over a 6-month period.
2. Medication reconciliation at admission and discharge: units with teams have achieved at least a 95% compliance rate, and most are approaching 100%.
3. Length of stay for sickle cell patients: LOS was reduced by 10% due to better pain management and improvements in the initial care provided in the Emergency Department for these patients, and the readmission rate was reduced by 80% by coordinating the discharge plans with their outpatient providers and by new pain management protocols upon return visits to the Emergency Department.

Exhibit 3

Patient Flow Improvement Project Results



Stockamp worked with Pennsylvania Hospital over 10 months to improve patient flow processes with the following results:

- A 40% improvement in the care team's ability to predict discharges one day in advance of the patient's departure
- A 60% increase in the number of patients case management staff assessed for discharge planning upon admission
- A 33% decrease in housekeeping bed turnaround time
- An increase of 8 virtual beds without adding capacity, enabling Pennsylvania Hospital to serve 600 more patients annually
- An increase in Press Ganey patient satisfaction scores on 22 of the 25 questions related to improving patient flow

During 2008, each team was asked to take on four to five projects related to the Blueprint for Quality, a systemwide initiative that established 21 goals for improving quality and patient safety. Teams across the system now meet together at least twice a year to identify best practices and to learn from each other.

While learning continues as the program expands, it is clear that the ongoing success of the UBCL depends on:

- Carefully identifying physician unit leaders with input from unit nurse managers.
- Ensuring that the right support structure is in place, including training team members in data col-

lection, analysis and project management, as well as involving senior clinical leaders to remove barriers and keep team projects moving.

- Buy-in at the top—the organization's chief executive must believe that this is the right thing to do.



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Crucial Conversations: The Most Potent Force for Eliminating Disruptive Behavior

By Joseph Grenny

In this article...

Examine techniques to encourage health care workers to speak up and address a problem with patient care rather than cowering from a possible disruptive confrontation.

Candace is a trauma nurse. One Friday morning her patient had an adverse reaction to a medication that caused his temperature to stabilize at 104 degrees and put great distress on his kidneys.

A specialist for continuous renal replacement therapy (CRRT), Candace was convinced her patient was headed toward acute renal failure and believed they needed to begin therapy on him as soon as possible. The chief resident agreed that CRRT should be started immediately but asked Candace to first consult a nephrologist—which she did.

The nephrologist was dismissive and curt. He rolled his eyes as she pressed her point. When she asked if she could share some research indicating the best treatment option for the patient, he cut her off midsentence, pointed his finger in her face and yelled, “We will not be starting dialysis. Period.” And with that, he walked away.

In July of 2008, The Joint Commission issued a Sentinel Event Alert that Candace and her fellow nurses should not have to face abusive situations like this again. And for good reason.

The Silence Kills study, conducted by VitalSmarts and the American Association of Critical-Care Nurses, reveals that more than three-fourths of caregivers regularly work with doctors or nurses who are condescending, insulting or rude. A full third of study participants say the behavior is even worse and includes name-calling, yelling and swearing.

While these disruptive and disrespectful behaviors can be hurtful, what prompted The Joint Commission to address them as a condition of accreditation is the mounting evidence that these behaviors are also harmful. Their warning stated explic-

itly that “rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a serious threat to patient safety and the overall quality of care.”

The Joint Commission’s warning echoes the seriousness of this threat as uncovered in the Silence Kills study. According to the study, more than 20 percent of health care professionals have seen actual harm come to patients as a result of disrespectful and abusive behavior between physicians, doctors and staff.

Each year, one in 20 in-patients at hospitals will be given a wrong medication, 3.5 million will get an infection from someone who didn’t wash his or her hands or take other appropriate precautions, and thousands will die because of mistakes made while they’re in the hospital.

In a devastating example, one nurse tearfully told us of a diabetic patient who had a colon resection with a large surgical wound. He was complaining of nausea and his stitches were coming loose. The surgeon on call had a reputation for being rude and hostile when awakened, but when the patient continued to deteriorate late into the night she made the call.

The surgeon refused to come and check the patient and demanded that she simply reinforce the dressing on the wound until he could examine him the next morning. Ultimately the patient vomited, popped his stitches, and died from complications of his open wound.

Pervasive disrespect

The Silence Kills study found countless examples of caregivers who delayed action, withheld feedback or went along with erroneous diagnoses rather than face potential abuse from a colleague.

The data in the table shows that three-quarters of the health care workers surveyed experience some level of disrespect. For many, the treatment is frequent and longstanding. The correlations show that the more frequent the behavior and the longer it has gone on, the greater the workers’ intent to quit their jobs. In fact, these correlations are so strong (correlations where $r > .1$ are meaningful, here we find $r =$

.424, which is impressive) that disrespectful behavior is suggested to be a primary cause of people's desire to quit their jobs.

Discussing their concerns with the person who is responsible for the abuse is almost out of the question. Even more startling than the pervasiveness of disrespect is that more than half of participants reported that the disrespectful behavior had persisted for a year or longer. A surprising 20 percent said the problems had continued for five years or more.

It's not the conduct but the silence

The Joint Commission has taken an important step by requiring more than 15,000 accredited health care organizations to create a clear code of conduct demonstrating the unacceptability of disruptive behavior and laying the groundwork for holding caregivers accountable for their behavior.

While this is an important element of influencing behavior change, the research shows that there is something far more immediate and powerful individuals and leaders can do to drive change: They need to break the code of silence. Until they do so, they'll fail to mobilize social pressure to drive change.

The most powerful force over human behavior is social influence. No matter how motivated and able people are to behave appropriately, they encounter enormous social influences that will either catalyze their efforts to succeed or completely impede progress.

For example, when senior physicians don't wash up before treating patients, the likelihood that their residents will wash is less than 10 percent. In short, people will do almost anything to avoid rejection and to gain acceptance in their cultural environment.

Unfortunately, when it comes to confronting bad and abusive behavior, the vast majority of health

Silence Kills: The most common reason people fail to speak up in hospitals is because they adopt the attitude of "It's not my job."



Table 1

Nurses and Other Clinical Care Providers' Concerns About Disrespect and Abuse

77% are concerned about disrespect they experience.	This person is disrespectful or abusive toward them in at least a quarter of their interactions.	28%
	The behavior has gone on for a year or more.	44%
7% have spoken with this peer and shared their full concerns.	Correlation between the frequency of mistreatment and intent to quit their job.	r=.424 p<.001
	Correlation between the duration of abuse and intent to quit their job.	r=.190 p<.001

Source: Silence Kills 2005, VitalSmarts

Table 2

When the concern is...	Percentage saying it is difficult to impossible to confront the person
Incompetence	56% of Physicians 72% of Nurses and other clinical-care providers
Poor Teamwork	78% of Nurses and other clinical-care providers
Incompetence	59% of Nurses and other clinical-care providers

Source: Silence Kills 2005, VitalSmarts

care workers fall victim to negative peer pressure. In the face of disruptive behavior, they fail to exercise the enormous social influence they have. The study showed that when doctors or nurses see disrespectful or abusive behavior there is a less than seven percent chance they or anyone will effectively confront the person who has behaved badly.

The obvious reason is that confronting people is difficult. In fact, the majority of respondents indicated it is between difficult and impossible to confront people in these crucial situations. People's lack of ability, belief that it is "not their job," and low confidence that it will do any good to have the conversation, are the three primary obstacles to direct communication.

As a result of people's decision to choose silence over speaking up, disruptive behavior has lingered for years awaiting social disapproval, yet receiving none.

So if health care leaders want to not only secure the well-being of patients, but also increase employee retention and engagement, the most immediate and effective thing they can do is change this culture of silence. They need to substantially increase caregivers' skill and will to step up to crucial conversations immediately and directly when inappropriate behavior emerges.

Candace speaks

Candace was an exception to the rule of silence. She was one of the rare caregivers we found who was capable of confronting disrespectful behavior head on.

As the nephrologist walked away, she politely asked for another moment of his time. Though he was clearly aggravated, she calmed things by explaining, "I am not trying to challenge your expertise. I know you are well-trained for this decision. I apologize if it sounded as though I was being insubordinate. I know we

both want to do the right thing for this patient. May I please explain why I have additional concerns in this case?"

And with that small change in approach the entire conversation shifted. The nephrologist listened to her concerns and ultimately agreed to order dialysis—saving the patient's life.

But Candace's conversation didn't stop there. Had she walked away at that point, she would have done right by the patient, but would have failed to exercise social influence on the nephrologist's bad behavior.

Having reached agreement, she asked him for two more minutes. "Doctor, I suspect you found my approach to you a moment ago disrespectful. If so, I apologize. I recognize your expertise and will work harder in the future to address you as you deserve."

The nephrologist's eyes widened. She continued, "And doctor, I must ask the same of you. When I shared my concerns about the patient, you raised your voice, you rolled your eyes, and you spoke to me harshly. That doesn't work for me, either. May I have your word that you will not address me that way again, either?" He whispered an apology and never addressed Candace disrespectfully again.

Social influence—if wielded skillfully—is incredibly potent. The problem is it is rarely used. What shapes and sustains the behavioral norms of an organization are lots of small interactions. Unless and until social actions are positively aligned, the chance of influencing real change in the organization is slim.

So while the code of conduct may be an essential element to changing cultural norms in disruptive behavior, the conversations around it will ultimately determine the pace and pervasiveness of change in any hospital.

Can you teach people to talk?

Not surprisingly, the Silence Kills study found that the small number of "Candaces" who speak up produce far better outcomes for their patients, their colleagues and themselves. These skillful seven percent enjoy their jobs more, intend to stay in their positions longer, are far more productive and see better patient outcomes.

So we've studied what it takes to clone the Candaces of the world. We've found that there are recognizable, repeatable and learnable skills for dealing with crucial conversations. One hospital, Maine General Health, spent two years teaching these skills to its employees. The caregivers learned to speak up about issues and concerns they had formerly ignored.

For example, those who acquired greater skills were:

- 88 percent more likely to speak up when they saw someone take a dangerous shortcut.
- 83 percent more likely to speak up when they had concerns about someone's competence.
- 167 percent more likely to speak up when they saw someone demonstrate poor teamwork.
- 167 percent more likely to speak up when they saw someone be disrespectful.

A poignant example came from the heart of the operating room. In one OR, some of the staff had felt unappreciated by a feisty surgeon for a long time. After participating in Crucial Conversations Training, two members of the staff independently approached the surgeon and shared their concerns.

Humbled, the surgeon started to make small but significant changes in his approach—including, for the first time in a decade, thanking staff when they did a good job. The result was a

more unified and potentially safer team.

Four crucial conversations for leaders

Health care leaders who want to engage social influence to eliminate disruptive behavior will have to break the code of silence in four specific conversations:

Administrations must go public about the pervasiveness of concerns.

Most hospitals attempt to put a good face on disruptive behavior by dismissing it as a problem with “a few bad apples.” The truth, according to the Silence Kills study, is that it happens every day in most hospitals. The problem is much more pervasive than just a few bad apples. In order to influence change, leaders need to begin by acknowledging the frequency of concerns.

Caregivers must directly confront disruptive behavior.

Next, leaders need to invest substantially in increasing the will and skill of every employee to speak up when they see problems. The focus needs to be not just on confronting disruptive behavior, but on speaking up when people see mistakes, incompetence, violations of safety standards and more. The Silence Kills study identifies seven kinds of problems; fewer than one in ten people address these problems effectively, which can lead to burnout, disengagement, errors and worse.

Medical directors and nurse managers must respond appropriately to escalations.

The research also shows that the problem is not just upward, it’s sideways and downward. Nurses fail to speak up to their peers when they have concerns. Managers fail to confront direct reports. Medical directors give their underlings a “pass” rather than make waves. The silence is deafening in every direction—and lower level employees will not feel the expecta-

tion to address concerns if their leaders don’t lead the way.

Administration must back up sanctions when they occur.

The most common reason people fail to speak up in hospitals is because they adopt the attitude of “It’s not my job.” The second most common reason is the belief that “Others won’t back me up if I do.” For example, nurse managers worry that if they confront a disruptive doctor who brings a lot of money into a hospital, no one in administration will back them up. Administration must make it clear that if code-of-conduct violations occur, they will back up those who take appropriate action.

As the saying goes, “Silence betokens consent.” The pervasive and risky problems with disruptive behavior in hospitals today will not be eradicated by codes of conduct—although these are a worthwhile step in the right direction.

The real change will occur when we substantially increase skills in conversation—especially the emotionally and politically risky conversations we so consistently avoid. When this vast potential of social pressure is finally tapped, our hospitals will become healthier for patients and caregivers alike.



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When a doctor is overly stressed, patients, staff and organizations can suffer. The risk of bad outcomes and malpractice litigation also increases.

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