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Patient Safety Tip of the Week

January 21, 2020

Disruptive Behavior and Patient Safety: Cause or Effect?

We've done many columns, listed below, on the association between disruptive behavior and adverse outcomes from a patient safety perspective. Multiple studies have shown that healthcare professionals who exhibit disruptive behavior are more likely to be associated with poor patient outcomes or adverse patient safety events.

But what about the other potential interpretation of the association, i.e. that the disruptive behavior might be the result rather than the cause? Some new research actually raises that possibility.

Heslin and colleagues (Heslin 2019) analyzed 314 reports of disruptive behavior, involving 227 healthcare professionals, at a single institution over a 2-year period. They compared both reporter accounts and involved party responses to determine if disruptive behavior was inherent to the surgeon or the hospital environment and its relationship to patient safety. 76% of involved parties had only a single event. All involved parties were physicians, 2/3 being attending physicians and 1/3 residents.

Surgical, medical, and other specialties were the involved parties in 48%, 25% and 27% of reports, respectively. High intensity environments (OR, ICU, etc.) made up 56% of the total.

Perceived unprofessional behavior or lack of communication was present in 70% and 44% of events, respectively. They found a significant direct relationship between the stress of the clinical situation and the egregiousness of the behavior. The following factors were associated with potential patient harm: unclear hospital policies, the involved party being a surgeon, and urgent competing responsibilities. The authors concluded that unclear policies and urgent competing responsibilities in the surgical environment create stress, leading to conflict. That most involved parties had a singular event suggests the environment as the primary contributor.

In an interview with Anesthesiology News (Frangou 2020) the investigators said "To us, this is an indication that further resources are needed to address the systemic stressors

that can lead to frustration that is perceived as disruptive behavior, resulting in event reports for individuals who are most often focused on delivering high-quality patient care.". They note that efforts to improve the culture of communication in hospitals might not be addressing the root causes of many cases of disruptive behavior.

They also noted that reported cases involving a physician who had been reported for more than one incident of disruptive behavior were less likely to be related to a patient safety event.

Reported causes or contributing factors included:

- unclear expectations (70%)
- work overload (47%)
- ineffective help (41.4%)
- difference in medical practice (31.2%)
- unclear policies (29.6%)
- personality conflicts (28.3%)
- hospital capacity (20.7%)

Some incidents involved more than one factor.

We've had plenty of experience dealing with disruptive physician behavior over the years. And, yes, there are always 2 sides to every story. While you cannot dismiss the disruptive behavior, you do need to listen to and look for events or circumstances that may have served as triggers for such behavior. Our own experience would identify inadequate resources (personnel or equipment/supplies), overwork, and fatigue as the most frequent contributing factors.

Contrary to what Heslin et al. found, we often saw such triggers in system issues even for those "repeat offenders". So, a good rule is to always look at the entire picture, even in cases where that physician has exhibited more than one episode of such behavior. **But beware**: be very sure that your investigation and actions do not serve to deter anyone from coming forward with such complaints against healthcare professionals. We've certainly seen examples where actions taken by Medical Executive Committees have appeared to show retribution to those who came forward. That leads to a culture that is detrimental to both patient safety and workforce morale in general. In fact, we might argue that the biggest factor contributing to disruptive behavior is a culture that tolerates such behavior.

So, is there a lesson here? Yes. When we see something that violates a patient safety concept, we need to look for a root cause or contributing factors. You have heard us before state that when you come across a workaround, you always need to look for reasons that workaround was used (i.e. a root cause). The same probably applies in cases of disruptive behavior, perhaps more so when the "offending party" has no history of previous disruptive behavior. If you identify an instance of disruptive behavior, you must deal not only with the individual and the behavior, but also look to see what system factors may have contributed to that behavior.

Some of our prior columns on the impact of "bad behavior" of healthcare workers:

January 2011	"No Improvement in Patient Safety: Why Not?"
March 29, 2011	"The Silent Treatment: A Dose of Reality"
July 2012	"A Culture of Disrespect"
July 2013	""Bad Apples" Back In?"
July 7, 2015	"Medical Staff Risk Issues"
September 22, 2015	"The Cost of Being Rude"
April 2017	"Relation of Complaints about Physicians to Outcomes"
October 2, 2018	"Speaking Up About Disruptive Behavior"
August 2019	"More on the Cost of Rudeness"

References:

Heslin MJ, Singletary B, Benos K, et al. Is Disruptive Behavior Inherent to the Surgeon or the Environment? Analysis of 314 Events at a Single Academic Medical Center. (Abstract #8) American Surgical Association Annual Meeting 2019 https://meeting.americansurgical.org/abstracts/2019/8.cgi

Frangou C. Disruptive Behavior Mostly Arises from Systemic Causes, Study Finds Most Cases Involve Physicians With No History of Abusive Behavior. Anesthesiology News 2020; January 3, 2020 https://www.anesthesiologynews.com/Online-First/Article/12-19/Disruptive-Behavior-Mostly-Arises-From-Systemic-Causes-Study-Finds/56914?sub=52153C6B7C3BB349A4FFAFB1611190E8862F46281279B07E9A816426066&enl=true&dgid=U080421119&utm_source=enl&utm_content=1&utm_campaign=20200106&utm_medium=button

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