Patient Safety Tip of the Week

October 2, 2018

Speaking Up About Disruptive Behavior

One of the biggest barriers to patient safety is a culture that discourages healthcare workers at all levels from speaking up. We've discussed disruptive behavior in multiple columns and noted how it has a negative impact on both staff morale and patient care. In our January 2011 What's New in the Patient Safety World column "No Improvement in Patient Safety: Why Not?", we echoed the theme of John Nance's book "Why Hospitals Should Fly" that we have failed to create a true culture of safety in healthcare.

Then in our March 29, 2011 Patient Safety Tip of the Week "The Silent Treatment: A Dose of Reality" we highlighted a study "The Silent Treatment. Why Safety Tools and Checklists Aren't Enough to Save Lives" by AORN (Association of perioperative Registered Nurses) and the AACN (American Association of Critical-Care Nurses). They honed in on **three "undiscussable" issues**: **dangerous shortcuts**, **incompetence**, and **disrespect**. They found that 4 out of 5 nurses participating in the study admitted having concerns that one or more of these three "undiscussables" were potentially causing patient harm and that very often they did not discuss the issues with the party doing the undiscussable (who could be another nurse or a physician or other healthcare worker). In some cases they were more likely to bring the undiscussable to the attention of a supervisor. But even the nursing supervisors participating in the study admitted that they often did not confront the offending party or take appropriate action.

In that column we also highlighted a 2007 American College of Physician Executives (ACPE) Quality of Care Survey (Steiger 2007) that revealed numerous issues considered by physician executives to be obstacles to quality of care or patient safety. But in many of the cases the perceived obstacles were failure of the system as a whole to deal with incompetent, impaired or disruptive physicians. Below are some of the quotes from respondents to that survey:

- "An interventional cardiologist with questionable skills (is) being allowed to continue with endovascular procedures because he's part of the dominant cardiology group."
- "One of our highest volume cardiac catheterization physicians routinely exercises questionable judgement. All in administration acknowledge this but do not 'rock the boat.'"
- "Orthopedic surgeons are tolerated in their unprofessional behavior and erratic delivery of care, as long as they keep booking their spines and total joints."
- "An orthopedist who is terribly out of date and refuses ED call, but is intimidating and generates big bucks for the hospital."

Then in our July 2012 What's New in the Patient Safety World column "A Culture of Disrespect" we discussed Lucien Leape's provocative concept that disrespectful behavior goes well beyond the classic "disruptive" behavior (the physician yelling and screaming, perhaps throwing things) and that some of the more passive forms of disrespect may have consequences that are even more detrimental.

And in our September 22, 2015 Patient Safety Tip of the Week "The Cost of Being Rude" we discussed several studies showing how physicians or nurses being rude to each other can impact patient care and patient safety.

The basic tenet of all these columns is that a culture which discourages people from speaking up allows perpetuation of undesirable behaviors that ultimately may lead to adverse patient events and to problems with staff morale, retention, and turnover.

Johns Hopkins Medicine addressed this issue head on. Following discovery of serious misconduct by a physician, the Hopkins medical system commissioned a study to assess why healthcare workers fail to speak up and then to implement a program to encourage "voice" (Dixon-Woods 2018). In the "diagnostic" phase, confidential interviews with both senior leaders and frontline staff were conducted by a group of independent researchers.

Two main themes emerged as reasons for reluctance to speak up:

- generalized fearfulness at almost every level
- concern that nothing would result from speaking up

The former was the result of a hierarchical culture "where territories and autonomies were often fiercely defended by powerful individuals and their allies". They described the "untouchables": individuals, usually senior physicians, who were able to engage in transgressive or disruptive conduct with impunity, often because of their positions of power or ability to generate revenue. (Hey! Didn't we hear that in the quotes in that 2007 ACPE Quality of Care Survey we noted above?). The behavior of the "untouchables" created conflict-laden working environments that led to poor teamwork and difficulties in staff retention. Gaps between policy and practice were created and there was "normalization of deviance". We've discussed "**normalization of deviance**" in several of our columns. This is where the culture of the system has led to acceptance of a certain deviation from proper practice as being "normal" and allowed that deviation to be performed by many individuals. The deviation has been used so frequently without serious adverse consequences occurring that staff no longer consider it abnormal.

But just as important was the perception, by both frontline staff and senior leaders, that their concerns were not always taken seriously or that nothing happened when they spoke up.

The results of that "diagnostic" phase probably don't surprise any of you. Such problems occur at the majority of healthcare organizations in this country, even at respected organizations like Johns Hopkins.

So what do you do about them? Hopkins took a 4-step approach:

1. Publicly share the study findings
2. Coordinate and formalize mechanisms to identify, assess, and remedy disruptive behavior
3. Training in leadership behaviors to encourage voice
4. Build capacity to have difficult conversations

The results of the interviews were shared in multiple venues, not only in departmental or unit meetings but also in "town hall" type meetings that were well attended. Simply discussing the issues led to a perception that openness was now encouraged and staff began to come forward and speak up just as a result of those meetings. They then built upon an existing program, "Safe at Hopkins", which focused on disruptive, bullying, or violent behavior and sought to intervene early. With strong support from upper levels at both the hospitals and medical school and university in the form of a Physician Executive Oversight Committee, interventions included graduated steps that would escalate if the unwanted behaviors continued.

In addition, leaders (for example, department directors) were provided with training and tools regarding voice opportunities, including how to deal with reported concerns and identifying and investigating disruptive behaviors. This included a 30-minute e-learning module followed by a two-hour interactive simulation workshop which leaders practiced having difficult conversations. Department directors often appreciated that the details collected in the "Safe at Hopkins" program provided "cover" and helped them in dealing with those difficult conversations with physicians with whom they were intervening.

Kudos to Johns Hopkins Medicine and the outside researchers/consultants who recognized this problem, delved into the causes, and implemented the program to address those causes. Being able to "speak up" without fear of retribution and knowing that your concerns will be addressed and lead to positive change are critical to having a culture of safety.

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"

Some of our prior columns related to the "culture of safety":

April 2009	"New Patient Safety Culture Assessments"
June 2, 2009	"Why Hospitals Should Fly...John Nance Nails It!"
January 2011	"No Improvement in Patient Safety: Why Not?"
March 2011	"Michigan ICU Collaborative Wins Big").
March 29, 2011	"The Silent Treatment: A Dose of Reality"
May 24, 2011	"Hand Hygiene Resources"
March 2012	"Human Factors and Operating Room Safety"
July 2012	"A Culture of Disrespect"
July 2013	""Bad Apples" Back In?"
July 22, 2014	"More on Operating Room Briefings and Debriefings"
October 7, 2014	"Our Take on Patient Safety Walk Rounds"
July 7, 2015	"Medical Staff Risk Issues"
September 22, 2015	"The Cost of Being Rude"
May 2016	"ECRI Institute's Top Ten Patient Safety Concerns for 2016"
June 28, 2016	"Culture of Safety and Catheter-Associated Infections"
April 2017	"Relation of Complaints about Physicians to Outcomes"
April 2017	"Joint Commission Sentinel Event Alert on Safety Culture"

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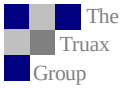

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