

**THE JOINT COMMISSION TELECONFERENCE ON
DISRUPTIVE BEHAVIOR AMONG HEALTH CARE PROFESSIONALS
WEDNESDAY, JULY 9, 2008**

CATHY BARRY-IPEMA: Hello, and welcome to the Joint Commission's news conference about new efforts to stop intimidating and disruptive behavior among health care professionals. The Joint Commission's president, Dr. Mark Chassin, Dr. Peter Angood, who is the Joint Commission's vice president and chief patient safety officer, and Grena Porto, who is a member of The Joint Commission's Sentinel Event Advisory Group, a registered nurse by training and senior vice president of Marsh in Philadelphia, will talk about why this is an issue that threatens patients' safety and the steps that are being taken to reduce this type of bad behavior as well as answer your questions.

Before we get started, I want to let you know that a complete press kit that includes the *Sentinel Event Alert*, bios for Dr. Chassin, Dr. Angood and Dr. Grena Porto and other related information is available on the Joint Commission website at www.jointcommission.org. It is now my pleasure to introduce Dr. Mark Chassin.

DR.MARK CHASSIN: Thank you for joining us to talk about a problem that goes under-reported, threatens patients' safety, and has become so ingrained in health care that it's rarely talked about or managed effectively. We're talking about intimidating and disruptive behaviors by doctors, by nurses, by pharmacists, executives, managers; few caregivers are immune. And it's a problem we have to begin talking about candidly and comprehensively so that we can fix it. How do we know it's a problem? The Joint Commission has maintained a database of serious adverse events for many years and in continuously analyzing those data, we find that failures of simple communication among caregivers

underlie many, many of these adverse events. One of the most important barriers to good communication is the intimidating and disruptive behaviors we're talking about today.

The first thing to realize is that we're talking about a spectrum of different behaviors that encompasses passive-aggressive behaviors like refusing to answer questions or answer pages, condescending or demeaning attitudes, verbal abuse, all the way to physical threats that jeopardize safety. And that's really the second point. These behaviors are not just unpleasant when they occur in the workplace, they create an unsafe patient care environment. And the third point is that these behaviors are not limited to the small number of individuals who demonstrate them very frequently. Surveys show that the majority of caregivers have experienced these behaviors personally and they get in the way of the kind of trust that is necessary to produce safe care.

There's a history of intolerance and indifference to intimidating and disruptive behaviors and by allowing this type of behavior to go unchecked, health care organizations are tacitly condoning it. Today, The Joint Commission is saying that enough is enough. Safe patient care is dependent on trust, teamwork and a collaborative work environment among caregivers. There's no room for these kinds of intimidating and disruptive behaviors, no matter what the reasons for them are and no matter who exhibits them. Yes, there are very real stresses in health care because the stakes are high, health care professionals are often pushed to the breaking point mentally and physically, but there's a right way and a wrong way to manage that stress. Patients expect and deserve the care, compassion and professionalism that most health care workers show every day, and it's important for organizations to take a clear stand by defining the behaviors that threaten patient safety and by refusing to tolerate them.

This *Sentinel Event Alert* gives organizations the strategy to do just that, and new Joint Commission standards that take effect January 1, 2009 up the ante by requiring

accredited health care organizations to create a code of conduct that spells out very clearly what is acceptable and what is unacceptable behavior and how unacceptable behavior will be handled equitably and across all professional boundaries. This *Sentinel Event Alert* and the new standards present a real opportunity to change a culture that has no place in health care today, an environment that has to be focused more than ever before on assuring safety and quality.

Now, to talk more specifically about the *Sentinel Event Alert*, here's Dr. Peter Angood.

DR. PETER ANGOOD: Thank you Dr. Chassin. As a surgeon with 25 years experience and someone whose primary job now is to find ways to help make health care safer, I know and appreciate just how intimidating and disruptive behaviors impact patient care. A surgeon who berates the OR team for daring to ask a question, a nurse who exhibits passive aggressive behavior with her peers or his peers, a pharmacist who makes it clear that no double checking of this pharmacist's work is necessary; these are just a few examples, but these are how mistakes are made when people are compromised from doing their jobs properly or they fail to speak up when they see poor behaviors occurring right in front of them often. It's also how patients don't receive optimal care, because their caregivers are not working together as a team, they're not communicating and they don't trust each other or even believe that a team effort can successfully occur.

This is why we're issuing this alert, to raise awareness of this problem, to provide health care organizations specific steps to help put an end to this intimidating and disruptive behaviors phenomenon. One of the first things is to develop a code of conduct in the organization and to have related policies and procedures to educate and teach all of the health care team members about professional behavior, including actually reinforcing the

basics, such as courteous phone interactions, proper business etiquette and general people-to-people interactions. After these basic sorts of approaches, organizations must also hold all of the team members accountable for modeling desirable behaviors, consistently enforce the code of conduct in an equitable fashion across all different types of disciplines and professions, and then consistent enforcement is particularly important for those individuals who are often perceived in organizations to have a lot of political power, who may be generating large revenues for the organization; those individuals should not be let off the hook. By doing so, that allows the intimidating and disruptive behaviors to continue flourishing and to be tolerated.

Organizations should also be comprehensive in how they address the issue, creating a zero tolerance policy, get the physician leadership involved, make it clear that anyone who reports bad behavior won't face retribution, determine when and how disciplinary action should begin, and make the organizational and medical staff policies mutually supportive and complementary. Another important recommendation is to create a reporting system and to be non-confrontational in dealing with these issues so that it's clear that this is part of an organizational commitment to the health and well being of all staff and patients. Creating a tiered approach for counseling is highly successful. There are numerous other strategies outlined in the Alert and we'll be happy to go into more detail about them and to answer specific questions in a little bit.

As was mentioned, we also have new standards that are related to these issues. These are included in our Leadership and Medical Staff chapters and they are important chapters for health care organizations to follow. But, most importantly, the important thing to take away from this Alert and from these new standards is that we can and should do a better job of ending unacceptable behaviors in health care. We owe it to the patients that depend on us, and as caregivers we owe it to ourselves to help continuously improve our

professional approaches and our behaviors. I hope that health care organizations and caregivers will use this Alert to focus on this serious problem and will implement many of these known solutions as described in the Alert. And now Grena Porto will share her thoughts on this topic as well. Thank you.

GRENA PORTO: Good afternoon. I'm really pleased to be part of the Joint Commission's Sentinel Event Advisory Group and to have had a part in the development and release of this *Sentinel Event Alert* on disruptive and intimidating behaviors. As a nurse, many years ago, I came across this problem and as a health care consultant I have seen it repeatedly, more recently in my work. Some examples I have seen are a physician who has repeated temper outbursts in patient care areas in front of not only staff but patients and their families as well. The nurses are so intimidated by this physician that they avoid calling him to discuss patient care issues, a nurse who is so intimidating to her colleagues that they are afraid to tell her that they think her patient may be in trouble. That patient is later transferred to the ICU for worsening of his condition, a surgeon who physically hit the staff member who made a minor error during a procedure. The others who witnessed this say nothing and don't report it because they are afraid they may be next, an administrator who berated staff at a meeting to discuss the department's performance. That same administrator was later surprised that the staff had not shared with her the underlying reasons for some of the performance problems.

What has been most frustrating for me is that in every case the organization was aware of the problem but failed to deal with it effectively. I think this happens for a lot of reasons. Sometimes the disruptive person is a very powerful person, such as a physician who admits a lot of patients to the hospital and therefore produces high revenues. Sometimes the supervisors and administrators excuse the behavior because they don't

understand the impact this has on patient care. They think that's just how the person is and that it doesn't really hurt patients. I have even seen cases in which the behavior was viewed as evidence of that individual's commitment to quality. They say things like "he just does that because he's so devoted to his patients." And in many cases the leaders simply don't know how to tackle the problem and they therefore avoid it.

But as Dr. Chassin said, avoidance and inaction are no longer options. This *Sentinel Event Alert* clearly illustrates how disruptive and intimidating behaviors undermine a culture of safety. Critical elements of a culture of safety include empowerment of all staff regardless of rank to speak up when they think there's a problem that could put a patient at risk, helping colleagues to avoid errors by asking things like "are you sure we're supposed to operate on the right leg instead of the left," freely reporting and discussing errors in close calls so that they can learn from them, and making suggestions to improve patient care without fear of reprisal. Taken in this context, it is easy to see how disruptive and intimidating behaviors prevent a culture of safety from taking hold and flourishing. In the absence of a culture of safety it is simply not possible to provide safe care consistently and reliably.

I think this *Sentinel Event Alert* provides health care organizations with two really important tools: one is a mandate to act and the second is a roadmap. For those organizations that have avoided dealing with this problem, and I have seen many, the time has come to act. For those who have already taken this on, and I have seen many of those as well, this *Sentinel Event Alert* will provide them with new ideas and approaches. It is important to recognize that dealing with this issue can be difficult and unpleasant work and it takes a lot more than a disciplinary approach to get the job done. While in some of the more egregious examples I noted above it may seem that discipline is the best and only option, the reality is that a much more comprehensive approach is needed to really make a difference.

Health care work settings have traditionally been very hierarchical as you have seen on every medical show on television, although I'm happy to say things seem to be changing. In recent years, health care settings have also become very complex and stressful and we have perhaps lost sight of the importance of mutual respect and a non-threatening atmosphere. This is especially true if we are to attract new talent to the industry, something that is desperately needed. So we really need to look at this challenge as more than just dealing with bad actors, although that is certainly part of it. We need to create an atmosphere of learning, of appropriately assertive questioning, of collaboration to avoid errors, and of mutual respect and professional fulfillment. This is what this *Sentinel Event Alert* is really all about. And we need to do all of this not because it's what's good for health care workers, but because it's really what is needed to keep patients safe.

Thank you for your time and thanks to the Joint Commission for its leadership in this area.

CATHY BARRY-IPEMA: Thank you Grena and thank you Dr. Chassin and Dr. Angood. I would like to now open it up for questions.

REPORTER: If you could just remind me what it means to have a sentinel event? I mean, so if you're adding this to your list of sentinel events, first of all how many sentinel events are reported by hospitals a year and what this would mean to a hospital? I mean, is this the first step toward possibly losing accreditation or could you just walk me through that?

DR. PETER ANGOOD: A sentinel event is any unanticipated outcome for a patient that creates death or a major disability and this is the type of an event that organizations should be reporting to the Joint Commission as part of the accreditation contract processes. And

that allows for the organization to make it known that that event has occurred, but most importantly it puts into place the processes for doing an analysis of that event, a so called root cause analysis, and then to also develop an action plan around those events so that the organization learns from that, hopefully then makes changes so that event will not occur again in the future. It also allows us to utilize the information in our database to help educate other organizations about the specifics of these types of or variety of events. Over the years, we've accrued nearly 5,000 of these significant sentinel events and we still feel, however, that's just a very small minority of those that are occurring and we continue to encourage organizations to report these types of events so that we can all learn from them overall. As Dr. Chassin mentioned earlier, communication is one of the major items that pops up in virtually all of the sentinel events, and that's why we continue to focus on communication and related communication issues such as intimidating and disruptive behaviors.

DR. MARK CHASSIN: I'll just add just to be crystal clear, we're not saying that these intimidating or disruptive behaviors are sentinel events, but rather our analyses of the causes of sentinel events have led us to understand that these kinds of behaviors create environments that are unsafe, which foster communication failures and other errors that lead to sentinel events and that's why we're focusing on them in this *Sentinel Event Alert*.

REPORTER: How might this lead to licensing problems for a hospital or a accreditation problem for a hospital? Would this now be part of the Joint Commission surveys for hospitals where surveyors are looking for these incidents and asking questions about these incidents and behaviors?

DR. MARK CHASSIN: The standards that are referred to in the *Sentinel Event Alert* are going into effect in January of 2009 and require hospitals to have policies and procedures in place that include a code of conduct that defines what kind of behaviors are unacceptable and how the hospital will manage them. So, in the course of a survey, it is entirely possible that a surveyor would observe this kind of behavior and then would look to see what the hospital is doing pursuant to the standards to get rid of it. So yes, this with respect to the standards, the behaviors as observed during a survey, or evidence of them observed during a survey could certainly lead to a citation that would contribute to a hospital's failing or having an adverse accreditation determination.

DR. PETER ANGOOD: It's the standards that the surveyors will review when they visit organizations. The recommendations listed in this Alert are just that. They're recommendations and they are not specific that surveyors will utilize. It's the standards that the surveyors utilize in their reviews.

REPORTER: Yes, I would like to ask in a little more detail how surveyors might address this during a tracer that would take place during an accreditation survey? In other words, would they be interviewing staff about this kind of behavior and asking them questions or will they merely be making observations?

DR. MARK CHASSIN: Yes, they would certainly do both. In tracers that take them to all different parts of the hospital, they would be interviewing staff, they would be interviewing patients, asking questions about "what would you do if you saw this kind of behavior or saw that kind of situation?" And gauging the responses and then asking what the hospital policy and procedure are that the staff could follow if they found something that was unsafe or they

observed a behavior that was intimidating or disruptive. So it would be both direct observation and questioning of staff and patients and families.

PAT ADAMSKI, DIRECTOR, STANDARDS INTERPRETATION AND OFFICE OF

QUALITY MONITORING: Well just to mention that these particular requirements in the standards are part of an overarching requirement that wants leaders to create and maintain a culture of safety and quality throughout the organization so there are several pieces to that which are outlined in the standards and they're all very much interrelated. And one of the things that is critical in the success of developing this culture and having a code of conduct and processes that are actually effective is making sure that the staff and the medical staff at all levels are very well educated as to the process and what they can do when they witness this type of event or activity or maybe are a part of a bigger situation that's going on so that the staff are very well aware of what their next step should be and can be, what kind of resources are available for them and then what kind of follow up information they're going to receive as this activity unfolds and is addressed by leadership. So there are a lot of steps that are going to need to be taken and it's really critical that everybody is well informed and aware of what their role is in the process.

REPORTER: I have two questions actually. The first is I understand that it's taken the Joint Commission a while to address this issue. It was supposed to be a patient safety goal earlier, so I'm wondering first why now? And the second question I have is that requiring a code of conduct and a process to manage these destructive behaviors may be good standards, but the health care workers that I have talked to have said that this has been an endemic problem for years and they're a little suspicious that this will actually lead to culture change. How confident are you that that will occur?

DR. PETER ANGOOD: I'll take first stab at it and then I'll perhaps ask Grena to comment as well. Why now? Well we have been very much aware of this issue and the preponderance of disruptive behaviors for a long time. We have a variety of methods and venues in which we try to help influence and change health care. Obviously, the standards being one of them, the Patient Safety Goals being another, and the *Sentinel Event Alert* being a third. Within our sentinel event advisory group, we had deliberated quite extensively whether or not to have this become a Goal, but then we recognized that the standards were being revised and that the Leadership chapter was specifically taking this on and so we thought that in terms of placement of the issues putting it into the standards would be the optimal approach. Profiling it within the *Sentinel Event Alert* then helps us to bring this to the forefront and the Patient Safety Goals are then able to address other equally high priority items. But the standards was the method that we chose. Grena, do you want to perhaps make a comment? You've been part of those deliberations all along, and then maybe we'll let Mark close it off on the second question.

GRENA PORTO: Sure. I think the why now question is an interesting one and I can just give you sort of my personal take on it. I think once we started taking patient safety as sort of a central goal and strategy in health care, it kind of shone a bright light on a number of problems that for years we sort of didn't pay a lot of attention to and I think this is one of them. As we started to talk to staff about the importance of culture, of communication, of collaboration, of questioning, all of those things, this problem kind of stood out like a sore thumb. So in my mind I think that's why we now have to deal with it, even though as you say, for a long time we sort of took a step back and said well that's not really such a big deal. So that's kind of my theory. And there is some things in the literature that would back that up.

DR. MARK CHASSIN: I'll just add a couple of additional points and then respond to your question about how effective this approach can be in really changing the environment. I think the other dimension to this problem that has really only become more clear in the last few years is that this, as I said at the outset, is not just a problem that is limited to a few individuals who are habitual demonstrators of these behaviors. The behaviors are much more widespread and they affect large numbers of caregivers and probably the majority, as the *Sentinel Event Alert* says, the majority of episodes are not exhibited by the habitual intimidators, and that's a part of the problem that organizations have to get their arms around, in addition to the fact that it's not just the most egregious and most extreme versions of these behaviors that are harmful. Obviously, verbal abuse, physical threats, throwing things, are the most spectacular examples, but the less aggressive behaviors are just as harmful in creating a culture of silence that doesn't speak up when problems arise with patients because of long standing intimidation.

So I think the time is right to address the full spectrum of this problem. Now will one document solve the problem? Clearly not. We have a lot of work to do across the industry in reversing what has taken many, many years to build up in many organizations. But the first step is acknowledging that many organizations have an ingrained problem, the problem is multi-dimensional, there often are several standards for tolerating these behaviors as others have mentioned. Physicians often get away with more than chief nurses and chief nurses often get away with more than first year new graduates and nurses often get away with more than housekeepers and orderlies. So equity across different professional disciplines and across different levels of seniority is a very important principal to maintain here and I think we started the ball rolling with respect to all health care organizations that we accredit. That is some 17,000 organizations and programs and we expect that with the

emphasis in the standards, in the *Sentinel Event Alert* and with health care organizations throughout the coming months and years, that we'll start to make significant progress in this very difficult problem area.

REPORTER: I was wondering when the recommendation about the tiered non-confrontational interventional strategies, does the Joint Commission have any idea about who should be doing this? In other words should doctors be speaking to doctors and nurses to nurses or is that something that should be left up to every hospital to determine?

DR. MARK CHASSIN: I'll take the first stab at answering that. I think that it is particularly important to recognize given the spectrum of these behaviors and the fact that they do occur among caregivers that are not habitual intimidators, that the smaller the episode that can be identified the more readily it is likely to be managed and those are the kinds of episodes that should be managed outside of the disciplinary process. To offer mediation, for example, between caregivers, if the incident occurred between a nurse and a physician or within a physician hierarchy between a junior resident and a senior resident, the situation can often be diffused by a non-disciplinary approach that is mediated by a multi-disciplinary committee of those who are in authority in that particular service area. Then as the incidents escalate in terms of their severity and seriousness, then of course you have to think about whether discipline is necessary, but by dealing with the smaller episodes, the less serious ones without discipline, I think that is one of the important ingredients in establishing a safe culture.

DR. PETER ANGOOD: I would re-emphasize that. There is always a tendency to focus on those large scale items that as soon as it happens, within 10 minutes everyone in the

organization knows it's occurred. But actually the culture shift and the culture change comes from establishing those codes of conduct, the policies around them, and then focusing heavily on those smaller events so that day to day peer interactions and peer pressures help create the change and make it consistently there. It's not a big deal when a physician walks up to another physician and says, "You know, it looked like it was a little rough going there the other day; is there anything that we can do to help out" and show some mutual support, understanding, as opposed to a punitive and very adversarial approach. That'll take care of the majority of these situations. Obviously though, some individuals have recurring behaviors or as the episodes get grander in scale, then there needs to be more scaled up approaches, and with very recognizable consequences.

REPORTER: So do you think they should be having these cups of coffee sorts of conversations?

DR. PETER ANGOOD: Well, in terms of trust and confidence, peer to peer is often times the best first step. But that's going to be dependent organization by organization. Depending on specific type of events, for these smaller types of issues that we're talking about, peer to peer works better. For the larger scale though, as was mentioned by Dr. Chassin, the multi-disciplinary approach is the better approach to address these situations.

DR. MARK CHASSIN: I would suggest that one approach that I have seen work is for a particular service, where this is a problem, to create a nurse/physician lead committee with the service chief and the chief nurse on that service in partnership agreeing that they will be the source of the mediation when this problem crosses professional boundaries, and that can result in a very non-adversarial mediation environment to bring the individuals together

who had a problem, behavioral problem, and understand what led to it and what a more appropriate response would have been to a particularly stressful situation. When it's within a professional boundary, within the nursing boundary, within pharmacy, within the physician profession, then the ordinary professional hierarchy can deal with it. But under the same rubric, that this is a partnership among all caregivers on the particular service to create a safety culture.

REPORTER: This question is for Grena. Have you ever been in the middle of one of these types of interactions and how did you handle it?

GRENA PORTO: It's an interesting question. I have been in the middle of them, both as a consultant and actually as a nurse. Well, thinking back to a few years ago when I was a nurse, in that particular instance it was a physician who was very vocal and angry and frankly I didn't do anything. I was a staff nurse, I looked around and I saw that no one was going to take this on and I was not going to step out and do it myself. This was a long time ago, so things have perhaps changed and certainly I have. I know a lot more about it than I did then. But I don't think I was unique. I think a lot of staff nurses are in the same place. They see something they know is wrong, but they look around and they expect more senior people to handle the problem, and if that doesn't happen they're certainly not sticking their necks out. So that was kind of my experience as a nurse.

As a consultant, when I've seen the behavior, of course my role is entirely different in the organization and I don't really have any standing in the organization to take action, but I always let the CEO know. I don't even try to just communicate with department heads or whatever. I feel that the CEO needs to know that this is going on. And so that's what I've done. In one case that happened, the behavior that occurred while I was there was so

egregious that I went directly into the CEO's office and action was taken that day. So I was relieved on one hand that it had been addressed, but puzzled on the other hand that it took that for something to actually happen.

REPORTER: And what are some steps that nurses can take to be more assertive when these types of things go on?

GRENA PROTO: I can start addressing that and maybe ask Dr. Angood and Dr. Chassin to join in, but I think that assertiveness is a key part of this, but it's not the only sort of, or even maybe the most important. I think appropriate assertiveness is something that we have to work with staff on and so you know my advice to a nurse is don't back down if you think you are right. However, nor would I go and try to go a couple of rounds with someone that looks like they might become violent or you know nor would I try to engage in sort of a circular argument with somebody who is just not going to see it your way. Sometimes I think you need to mobilize other resources, mediation which I think was mentioned is important. I think part of what our challenge is in dealing with this is that health care professionals have not received training in either conflict resolution or even diffusing an escalating argument and I think that's something that's needed. I think that's something that nurses would value, that they would benefit from and I think all clinicians, frankly. So my advise to a nurse is try to diffuse the situation if you know how, but if you don't, I wouldn't try to you know sort of get the upper hand. I would try to mobilize other resources, charge a nurse, other people in the area to sort of help with the problem.

DR. PETER ANGOOD: This actually leads to the importance of an organization having policy and codes of conduct in place so that those nurses and front line staff are aware that

they've got some back up and that established behavior is expected. If an organization does not have those in place and you've got a relatively junior nurse, as an example, facing off on some 25-year experienced physician, they will feel lost and they will feel like they have no place to go. So the importance of these codes of conduct and policies to help them back up and the processes in place are very, very important.

DR. MARK CHASSIN: I would just add one additional comment to emphasize what Peter said, if the organization does not have that kind of process in place when that nurse goes to her supervisor and says, "I just had this confrontation, there's an unsafe situation," the supervisor is likely to say, "He's been like that for years, there's nothing we can do about it. Just go on about your business." And that's how unsafe situations persist and turn into unsafe environments and unsafe cultures.

REPORTER: Thank you for addressing this issue and for taking my question. It's almost a follow on to the last question. During the accreditation survey, what will be the level of protection for staff nurses reporting these kinds of issues to the surveyor?

PAT ADAMSKI: We have requirements and accreditation participation requirements that says organizations are obligated to educate their staff and their medical staff about their ability to report concerns regarding patient safety and quality, and this certainly would fall into that area, to The Joint Commission without fear of reprisal or retribution. So the surveyors are always open to taking that information from the staff and in fact they do query staff to see if they are informed about that particular requirement and their ability to report. So the surveyors really do go out of their way to assure that staff are informed about this and they are available to discuss any concerns that the staff may have when the surveyors

are on site in addition to the staff's ability to contact The Joint Commission directly through our Office of Quality Monitoring to report any activity that they believe is in conflict with that requirement.

REPORTER: Can you give numbers from your analysis of your database of sentinel events, for example, and what percentage of events was there intimidating behavior from a doctor that contributes to the events? Anything like that you can give us?

DR. PETER ANGOOD: Unfortunately, we don't have that level of detail within our database. We do know that 70 percent of our sentinel events have communication related to those issues. As we've paid more attention to this issue in the last couple of years, we've begun to discuss how to restructure our database so we'll capture that better, but we don't have it right now unfortunately.

CATHY BARRY-IPEMA: Thank you to all of our participants and to all the reporters who have joined us today. If you have any further questions, please call our Media Relations Unit at (630) 792-5175. Again, thank you all for joining us and have a good day.