The New Healthcare Landscape: *Disruptive Behaviors Influence Work Environment, Safety, and Clinical Outcomes*

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Hospitals across the nation address the challenge of disruptive behavior every day. Disruptive or intimidating behaviors can be manifested in overt ways, such as verbal threats, yelling, or throwing things, or in more passive ways, such as condescending language or lack of response to telephone calls or pages. Many professional organizations, for example, the American Medical Association, the American Organization of Nurse Executives (AONE), and the American College of Healthcare Executives, have endorsed zero tolerance of these behaviors in the workplace because of their effect on productivity and the safety of the environment.

The power gradient is one of the major underpinnings of disruptive behaviors. Such behaviors can occur between like professionals—nurse to nurse, physician to physician, pharmacist to pharmacist—or between those in different professions, such as nurses and physicians. The focus of this discussion is disruptive behavior between nurses and physicians.

THE PROBLEM IN HEALTHCARE

Disruptive behavior between physicians and nurses is a problem that interferes with patient safety and adversely affects the teamwork in the work environment needed to ensure positive clinical outcomes. According to the American Medical Association, disruptive behavior is defined as "a style of interaction with physicians, hospital personnel, patients and family members, or others that interferes with patient care."[1] Patients and families assume that physicians and nurses are genuine partners in communication and will work effectively to meet their needs. Both physicians and nurses have acknowledged the importance of

the relationship between these 2 professions and have identified how the changes in healthcare have affected the relationship and expectations. Although physician and nurse leaders can describe many positive changes and advancements that have occurred over the past 5 decades, there continues to be issues related to communication breakdowns that affect the work environment.

Beyond the power gradient, there are a variety of contributing factors related to disruptive behavior. These factors include a lack of understanding of the problem; lack of infrastructure to address the issue; lack of policies and procedures; and lack of support from leadership to resolve the issues in a consistent and meaningful way. A major obstacle in addressing the issue is the lack of acknowledgement that disruptive behavior is a serious problem. Although physicians and nurses report witnessing disruptive workplace behaviors, they concomitantly report that they lack the tools to correct the behavior and/or may choose to ignore the situation and not become involved.

EVOLUTION OF THE PHYSICIAN–NURSE RELATIONSHIP

Stein[2] identified the relationship in the "doctor–nurse game" as very special and requiring a high degree of mutual respect and cooperation. Although he described the relationship as hierarchical in nature, he identified the forces preserving the "game" and offered ideas for change. Leaders in academic nursing and medicine also wrote about the issue during the 1960s and suggested a need to re-evaluate and expand mutual expectations.[3] Both professions increased the mutuality and visibility of their partnership through the development of the National Joint Practice Commission.[4] The Commission was initiated in 1971 by the American Medical Association and American Nurses Association. Its mission was to address the concerns of hospital nurses, improve teamwork, and address heavy workloads reported by both physicians and nurses, which caused frustration. The Commission's work, funded by the Kellogg Foundation, included a survey of 4 hospitals that had worked on changing the physician–nurse relationship with identified success. The survey used a variety of measures to assess physician and nurse satisfaction, and included interviews of patients, physicians, and nurses from these organizations. The Commission published the results and found that those organizations with higher levels of physician and nurse satisfaction reported that the "primary nurse" model yielded the best results. In the early 1980s, as advanced practice nurses were being integrated into the healthcare environment and were influencing changes in the traditional patient care decision-making model, the American Medical Association withdrew their support from the Commission, ending this visible and national partnership. During the 1980s, although both medicine and nursing were significantly involved in the planning and implementation of diagnosis related groups (DRGs) and determining DRGs' influence on care coordination and patient outcomes, nursing was challenged by a severe nurse shortage; this led to the appointment of a National Commission on Nursing. The Commission brought to the forefront significant issues related to practice, education, and research.

By the 1990s, dramatic changes in both patient care delivery and nursing education were underway, and new issues related to the physician–nurse relationship occurred. The evolution and advancement of nursing practice and the expanded nursing role, particularly the nurse practitioner role, were often perceived as negative by physicians. These changes in nursing were viewed as infringing on physician practice and in direct competition for reimbursement.

In the intervening years, there has not been any organized national effort to address the issues involved in the physician–nurse relationship. The lack of attention has contributed to "silo" thinking and a lack of partnership in addressing critical issues affecting patients and both groups. In addition, there continues to be limited opportunities for the 2 professional groups to jointly socialize the health professionals of the future, and consequently build partnerships and understanding during medical and nursing education.

The improvements that have occurred in enriching physician and nurse communication have come primarily from the work of professional groups, such as the American Association of Critical Care Nurses' "Silence Kills"[5] and work done by the American Congress of Obstetrics and Gynecologists (ACOG) and Association of Women's Health, Obstetric, and Neonatal Nurses (AWJONN) on perinatal safety. These initiatives have used a combination of survey data, interviews, and observations to identify obstacles and then use the information to provide education and hold people accountable for expected behaviors. Driven by both objective and subjective data, these programs have improved physician–nurse communication and strengthened teamwork. Organizational support for the training and for sustaining the behavioral expectations are crucial for program success.

REPLICATING A PHYSICIAN–NURSE DISRUPTIVE BEHAVIOR SURVEY

The American College of Physician Executives (ACPE) addressed the issue of disruptive behavior by conducting a survey of its members in 2004[6] and repeated the survey in partnership with the AONE in 2009, confirming that disruptive behavior continued to occur and affect the work environment.[7] In 2013, Main Line Health (MLH), a 5 hospital system located in suburban Philadelphia, replicated the ACPE survey: over 700 providers participated.[8]

Using the 2009 ACPE survey for comparison, the 2013 survey findings were similar in type of disruptive behavior and frequency of occurrence (*Table 1*). Yelling continued to be the primary disruptive behavior, followed by degrading comments and insults. Although there was a slight decrease in the perception of disruptive behaviors, the change is not clinically significant. The respondents from both the 2009 ACPE study and the MLH study indicate that the problem of disruptive behavior still overwhelmingly exists in their organizations. Survey participants from ACPE and MLH also reported that their organizations did not offer specific training related to disruptive behavior.

The findings from the 2013 MLH survey were surprising and somewhat disappointing to MLH physician and nurses. The