Question of the Week #29
Violence in the workplace

You work as a staff nurse for a medium-size community not-for-profit hospital with 9 OR’s and 2 cysto rooms. The staff is very stable, many of them having worked here for 10 years or more. Nurses are expected to both scrub and circulate a variety of cases, the majority of which are general and orthopedic. For the most part everyone enjoys their jobs, and you look forward to coming in to work every day, especially on those days when you are assigned to scrub.

One of the general surgeons, Dr. L., has a reputation for being difficult to work with. Although he is technically skilled, he has a short temper and is verbally abusive when things aren’t going well. It is difficult for this surgeon to obtain and retain surgical assistants because of his bullying behavior. Since he is one of the biggest providers of cases for your OR, his behavior has been overlooked by both nursing and medical administration. The charge nurse is careful not to put the same team in his room two days in a row as it is so emotionally draining to work with him.

Yesterday one of the more seasoned nurses, M.A., was scrubbed in for an open inguinal herniorrphy. The Army-Navy retractor she was holding slipped off the fascia as he was positioning it for her. Dr. L. swore and struck her across the wrist with the retractor. Another scrub person had to be called in to finish the case. An x-ray taken showed that M.A.’s wrist has been broken.

When you come in to work this morning, you note that you have been assigned to scrub for Dr. L. You are concerned not only for the patient’s safety, but your own. When you voice your concerns to the charge nurse, she tells you, "You’re the best scrub nurse we have. You'll be fine."

Please respond to the following questions:

1. Can you refuse to work with Dr. L.? Why or why not?
2. What can be done in this situation to promote a healthy work environment?
3. Does your facility have a plan in place to address violence in the workplace? If so, please provide a summary.

Response:

The operating room, with its traditional hierarchical team structure, the stressful and often unpredictable nature of its work, and its relatively isolated position in the facility makes it an ideal environment for fostering and if not encouraging, at least enduring, disruptive behavior. Many health care providers have either witnessed or been a recipient of behavior which would never be tolerated in the public sector.
This case study is based on an actual event that occurred...over 30 years ago. Although strides have been made in both recognizing and addressing abusive behavior (see references and resources) it is obvious from the discussion that this is not an isolated event. Rugieri (2012) provides a current and just as disturbing account of a surgeon’s relationship with his intraoperative team in which, unfortunately, he feels that this type of behavior is warranted.

Violent behavior can occur between doctors and nurses, as in this example, but may also be witnessed between more experienced and novice nurses, managers and staff, nurses and students, and patients and nurses. It is important to remember that workplace violence is not about competence or character attributes, but about a perceived imbalance of power. The effects of non-physical acts of violence (bullying, harassment, intimidation) may be as serious for the victim as physical assaults (Alexy & Hutchins 2006). There is also the possibility, as in our scenario, that non-physical violence may escalate into a physical assault.

In responding to the questions posed at the end of our scenario: There is the risk of being charged with abandonment when refusing to accept a patient care assignment. Typically the nurse must first establish a relationship with the patient before this could become an issue, but it would be wise to check with your state board of nursing for its regulations regarding declining tasks related to patient care. Morally, a nurse is not obliged to accept personal risks that exceed the limits of duty (Kuhn, 1995).

Nurses can address workplace violence by:

- recognizing signs and symptoms of increasing agitation: profanity, loud, rapid speech, fidgeting, and verbal threats. It’s difficult, but maintaining an attitude that helps diffuse anger may help to defuse the situation (DHHS, 2002). Don’t match the threats, and acknowledge the person’s feelings (e.g. “I’m frustrated with this case, also. What can we do to make things go more smoothly?”) If redirecting the abuser’s behavior to the task at hand doesn’t work, it’s time for additional interventions (see below).

- documenting the event, including verbal threats. This is the single most effective way to address the problem and work towards a solution. Generalities such as “he always acts that way” will not be useful. Be specific. Describe the event, provide dates and times, and have other people who witnessed the event sign the form. Some facilities have developed a separate occurrence form for reporting abusive behavior that decreases the time needed to fill out the form and streamlines the reporting process.

- reviewing the facility policy on workplace violence. The policy should clearly define and address the consequences for not only physical assault but also emotional/psychological abuse, and the relationship between the offender and the workplace (Alexy & Hutchins, 2006). If the facility does not have a policy, volunteer to sit on the committee to write one.

It is important to note, however, that by themselves “zero-” or “no tolerance” policies and a set list of sanctions for inappropriate behavior are not effective in solving the problem; a transformation in the culture of the facility needs to take
place. Developing and implementing a system within the department to address disruptive behavior empowers the staff to “own” the process and assists with the cultural change involved in dealing with the paradigm shift from a hostile to a healthy workplace.

- supporting their colleagues. There is truth to the old adage “strength in numbers”. The isolation associated with the operating room environment can encourage abusive behavior. Some facilities have developed a code-type of response to inappropriate behavior based on a rapid response concept, in which specially trained staff is called to intervene to address disruptive behaviors. One facility implemented a CODE PURPLE; when it was paged overhead, every available staff member and the manager responded to the room.

- following the chain of command in reporting the incident. Depending on the circumstances and the response to the above steps, assistance outside the department may need to be sought. In our case, both nursing and medical staff were aware of the issue, so it’s time to take the next step. Human resources, employee assistance, state medical and nursing boards, The Joint Commission, Occupational Health and Safety, and the National Institute for Occupational Health and Safety all support a safe work environment. Contact information for these organizations may be found in the resources at the end of this article.

Facility administrators must realize that abusive behavior transcends maintaining the status quo or ensuring a revenue stream. Low morale and high turnover also impact patient care. From a facility standpoint, disruptive behavior increases costs due to the need to recruit, replace, and orient new staff. Disruptive behavior and its deleterious effect on communication make it impossible for staff to perform at an optimal level, leaving the door wide open for patient errors. The Joint Commission (2008) has recognized the link between disruptive behaviors and medical errors. Effective Jan. 1, 2009, measures to address disruptive behavior will be included in two elements of performance in its new Leadership Standard, LD.03.01.01:

EP4: The hospital/organization has a code of conduct that defines acceptable and inappropriate behaviors.

EP5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

Joint Commission has made it a priority to look for evidence of meeting these standards during their surveys (which, like OSHA, may be unannounced).

Patient safety is contingent on staff safety. Improvements in identifying, reporting, addressing, and preventing abusive situations have raised awareness of the problem. Policies, procedures, and staff education are beginning steps in correcting an entrenched health care behavior. A shift in culture to promote collegiality, collaboration, and respect is needed to eradicate the problem.
Resources and references:


