Ep59 | When Healing Hurts: Workplace Violence, Conflict, and the Future of Healthcare Safety with... Transcript

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Check out joingelt.com. That's j o i n gt.com. If you work in healthcare, you already know this. Conflict is everywhere in the O, in labor and delivery, in committee meetings, between physicians, nurses, administrators, and teams that are all trying to do the right thing. But here's the problem. Most of us were never trained to handle conflict well. We learned procedures. We learned diagnostics, [music] but we didn't learn how to navigate the moments when Q professionals strongly disagree.

That's why I developed the Spark Framework. Spark stands for stop, pause, ask, don't assume, reflect, and respond, and create a path forward.

Introducing the Spark Framework

It's a practical system designed specifically for highstakes healthc care environments through [music] keynote talks, residency workshops, and spark master classes. I [music] teach physicians, nurses, and healthcare teams how to turn destructive conflict into productive conversations that strengthen teams and improve care.

If your hospital, residency program, or medical conference is looking for a speaker on conflict, communication, and leadership, and healthcare, [music] I'd love to work with you. You can learn more in the show notes. Because in medicine, conflict is inevitable, but handled well, it can make teams stronger.

>> [music] >> In every operating [music] room, in every ward, in every clinic and every team meeting, a silent battle bruise, conflict, negotiation, >> [music] >> identity. Welcome to the Scalpel and Sword podcast where I, Dr. Lee Chararma, physician and conflict analyst, explore the hidden negotiations beyond modern medicine. Let's trade burnout for boundaries [music] and learn the art of healing with precision and power.

[music] Hello my peaceful warriors and welcome to the Scalp and Sword podcast. I am your host Dr. Lee Chararma, physician and conflict analyst. And I know this is a topic that we don't like to talk about, but it's something that unfortunately so many of our brothers and sisters in healthc care have had to confront. We hear about a surgeon in California who was shot because a patient wasn't getting opioids. We hear about a nurse that was attacked by a patient she was taking care of on the ward who for whatever reason wasn't able to get his psychiatric meds.

Why Workplace Violence in Healthcare Matters

We hear about medical assistants who get hit from patients coming in because they're mad they're not getting their calls answered fast enough. And unfortunately, these are not isolated incidents. These are realities in the modern health care system. And because they're realities, just putting our head in the sand is not going to make healthc care better. It is something we actively want to explore, discuss, and hopefully get really positive and practical tools we can use to help protect ourselves and our colleagues. And I can't think of anyone better to have this conversation with than Scott Hutton. Scott has a PhD in workplace violence and occupational health from the University of Cincinnati. He has worked actively on healthc care workplace violence prevention and I am so thrilled to have him on the podcast today. Scott, welcome. >> Thank you Dr. Chararma. Thank you for all your work in this

space. It really does matter.

>> I'm really glad you're here and please call me Lee for the duration of this. Always always love to know because you obviously feel this topic is important enough that you devoted your PhD to it. What was the impetus for you to start to study this topic? >> Sure. So, a couple of things. So half of it is I'm a nurse by calling and so I started out as a nurse on occupation psych unit and we saw significant rates of disruptive behavior within that population and I got a master's in nursing but I also got a master's in business and workplace violence is really bad for the bottom line of hospital and I saw both human cost and just raw financial cost and it just didn't make any sense. to me and so I felt that trying to do something to get the needle around this really was something worth doing and so that's why I spent many years uh getting my PhD in this area. That is a fascinating perspective and I think that's one that so often anytime we're talking about major policy change in healthcare if we are appealing to administration if we're appealing to our business executives that part of the way that we do push our platform forward is to say this is not just a patient or just a professional workplace problem. you're spending money on this because it's a great skill set you have that having these two hats on made it just way more easy for you to help implement policy since you're able to speak both of those languages. It made it easier once you get over the kind of wow factor because the numbers we're talking about with healthcare executives are just the American Hospital Association just put out a document maybe in January of this year looking at the cost of workplace violence to a health care system and it was just astronomical. So when you walk into your seauite office to talk to them about violence prevention, you give them these numbers, they don't believe you.

Understanding the Scope and Causes of Violence

And because people don't think that violence is a problem in healthcare, even though it's most violent not only the workplace in all workplaces, so it's incredibly violent and because our seafood doesn't necessarily see that, you get over that. Once you get over that, then people are willing to buy in.

And sometimes they say give resources, but I think that's a wrong way round because it's actually redeploying resources cuz we're going to pay. The question is, are we going to pay to keep people safe? Are we going to pay when people are injured and walk away from their job with us and you know, old associated medical bronx, but we're going to pay for workplace violence and healthcare. And so once you get your seuite on board with that, it really does seem to help move the needle forward on keeping employees safe and engaged. Right. >> Right.

>> So it's kind of a win-win. >> And it speaks directly to I think one of the biggest problems in healthcare workflake violence is I think the lack of awareness of the scope of the problem. I mean it's the seauite like you said but I think even when you start getting into hospitals and smaller areas for example I think in big cities and I think in California in New York in big cities big states I think those stories unfortunately are so much more common and so much more prevalent. And so I look at a place like I am in Alabama in my small community hospital and I think it's really hard for them to wrap their heads around the fact that this problem really is everywhere. So the fact that you're having to go into a seauite and talk about not only the scope of the problem you can't even discuss it in the human terms you have to put this in a financial term as well. Yeah, absolutely. I can't remember the exact statistic. I'll get it to you afterwards, but it's one in four nurses.

So, even in the smallest rural hospital, you one in four nurses are going to experience violence this year. >> I mean, it is literally everywhere in healthcare anybody anytime. So, thought scaffolding wise, it's about 90% of the violence in healthcare is affective violence, which means it is people reacting negatively in situations. So, you know, somebody's in pain and so they're on medications that are doubling their frontal loes and so they've got impulse control issues and they act out violently. And that's about 80% of the violence we see in health care. And because of that, the people who are at the point of service, so the people you said at the open, right? So your people who check people into hospitals, nurses, physicians, dietetic staff who go into the room to deliver trays, anybody who is at the point of service is at a significantly increased risk for workplace violence in healthcare.

That is a tremendous point because I think one of the things that you just said is that the people who are in the context of that patient representing the health care system, this person who walked into my room, even if it's the person who's carrying my mule in, at that point in time, that person is the health care system to me. And because they are the health care system to me, my frustration in the health care system will be directed at them. Even if the

dietitian may have nothing to do with the reason I'm frustrated and mad and like I said, I'm in a very vulnerable situation. My frontal lobe is not functioning because I'm in pain. I'm terrified. And this person who is in front of me now will bear the brunt of all of my frustration.

>> Exactly. Well said.

Policy Gaps and Reporting Barriers

So, one of the things and I really want to get into this because I think a lot of times when people talk about workplace violence and I think this also speaks to why it is underrecognized and not necessarily under reportported but probably something that is not quite as high on our radar is that this kind of affective violence where we're yelling and screaming which is just as damaging. I mean, if you're on the receiving end of that person screaming at you, that is so many ways just as damaging as potentially someone actually engaging in physical violence. And the fact that this is occurring directly relates to the attrition we're seeing in healthcare. >> Yep, that's right. And we've actually been able to show in medical students that medical students who experience higher rates of verbal disruptive behavior leave the profession. And we know that nurses who experience more workplace violence also leave the profession. And think about how sad it is that you've made it all the way through med school and you know because you've been called every name but your given name. You're leaving the profession because you can make money easier elsewhere without this kind of damage to your emotional state. Right.

>> And I think we're seeing that not just nationally, Scott. I think we're seeing that internationally. The National Health Service in the UK did a survey of their medical students and they're not even out yet. Right. So these are third and fourth year equivalents that are already saying 40% of them don't want patient facing jobs, >> right?

>> It's terrifying because we're investing so much in this education in a health care system that desperately needs providers and yet because of these things that are happening to them, they're already wanting to leave. I mean, we've already got a shortfall of healthcare professionals. This is only going to contribute. So obviously most of these institutions, hopefully all of them have some type of prevention policy, something in place. So where are our current policies lacking since we're still very kneedeep in this problem?

>> Yep. So there's a couple of different opportunities for policy improvement. Several states have taken the lead in protecting health care workers, but that's kind of a patchwork problem and it's at the state level. There is no national guidelines around workplace violence and healthcare workers. So that's a real opportunity to kind of level set as a nation. You know, this is what we think we should do for our healthcare workers. I also think that the joint commission has some really good standards and a really good model around workplace violence prevention and it's worth going to look up. It's based on an article that was published in JAMAM up a couple years ago. It's a really great system, but the joint commission system is so much stronger than any of the laws out there. the laws are lagging behind and substantially so in a way that is putting people at risk. And so I think that we need to kind of get some of those laws to be more standardized across states and then to be closer to what the science supports is a good workplace violence prevention program. So that's where I think we have some gains to make yet in our philosophies. >> And this is a really important point. I think this is something at least in Alabama, we actually are pushing for legislation now because a lot of our emergency room physicians have joined together as a professional organization to sort of push this across because they do I mean again just like you were saying before the point of contact in the system for patients coming in unfortunately may be the ER and so they are bearing a large amount of this burden. So they are the ones who are pushing for this legislation change but you're right it's still a state- driven effort. It's not something that's federal and in comparison to I think some states that have legislation that's really strong in terms of what's happening in terms of being incarcerated and things like that that there's real teeth in that legislation. I think Alabama is still definitely lacking in that regard. So I agree with you the idea of having you know standard set by the joint commission. We have to have something that's equal that's going on in the law too. There has to be something there that's very substantial.

Why don't we treat this because this is such an important issue for healthcare. We have so many other safety issues that are built in you know the joint commission of course this is their wheelhouse. We have patient safety that we really drill down on. For what reason do you think we have been lagging behind in provider safety? >> Yeah, I think it's a couple of things.

So I think this some of it is the false dichotomy that you either have to protect patients or you have to protect staff. Right.

How Leaders Should Respond After an Incident

You said something earlier about it being under reportported and that's absolutely right. One in five reports of workplace violence are reported. So about 20%. And when you talk to people about why didn't you report this? It's things like, well, I didn't want to get the patient in trouble or it just comes with the job or this is just what it is and he didn't know what he was doing and kind of all of these things that where staff are selfstigmatizing it. It's important for people to understand fundamentally that we are not in the workplace violence space. We're not in the blame game. We're not looking to blame anybody. I'm not blaming the staff. I'm not blaming the patient. I'm not blaming anybody. I just need the behavior itself to stop. Right? So, it is not only okay with me, I understand why somebody with dementia who is unaware of who they are, unaware of who their loved ones are, gets startled every time a stranger walks into their room, even if that healthcare worker was just there 30 seconds ago, and strikes out. I'm not blaming that patient. It's a medical condition, right? >> And I'm not blaming that staff. They're just trying to get their job done. What we need is an environment where we're actually protecting both of those people from that behavior happen. And I think that stigma is why this isn't treated like patient safety.

>> Oh my gosh, I love this so much. I want to drill down on this because this is awesome. So I love how you frame this is that so often in terms of policy we build this as an eitheror. It's either patient safety provider or safety. And one of the biggest things in conflict resolution and in terms of building durable solutions is the idea that everybody can win. Everybody can actually benefit when we're making good policy. When we're building good processes that there doesn't have to be winners and losers. everybody can actually thrive if we work on this policy process and create a system. So, I love how you frame that because we're not talking about one person doing something wrong. We're not talking about the patient doing something wrong. We are accepting that the patient has an illness or something going on there and we actually are taking the behavior. We're isolating the behavior something.

this is what our concern is and this is what we're trying to isolate as something that we make sure isn't harming anybody else in the system. And I think that's really important because if you look at the trauma bonding and the trauma informed leadership processes that go on in healthcare and I think that's something that people are more aware of. Dr. Stephanie Berley who's been on the podcast before is a trauma-informed leadership coach. She does amazing work and she was the first person who really introduced me to this.

But one of the things that she talks about is so many people in healthcare, so many of us that are drawn to this profession do this because we have had trauma at some point in our lives and we feel for other people who have had trauma experiences and as a result we want to support them and help them. But from what you just said, and it's so interesting because I agree with you, we feel so deeply for the patient. We empathize so much with them that it's hard for us to report this and we know that reporting actually would be a more accurate representation of numbers which means we would actually do something about it. >> Right. That's exactly right. Well said.

>> And I absolutely love how you frame that. So, as we know, we're becoming more and more aware and we look at the different facets of workplace violence.

And I think what you said earlier about having the different types and maybe why certain types are maybe not as recognized, I think is really pivotal.

So, let's say if you're a healthc care leader, you're nurse manager physician and you witness or are aware of a workplace violence incident, what should that leader do, and how should that leader respond?

>> Great question. So, couple of things. Immediately, you always want to ensure physical safety, right? So, you see something happen, the first thing you want to do is make sure nobody's pleading, right? So, make sure everybody's okay. Once you get through that initial everyone is physically okay, then the hard work of psychological safety and rebuild and not victim blaming and the really high viability organization models or the just culture I guess would be the subsection need to come in to help support the staff and to also help support the patient. And let me explain that just a little bit. Say you're a nurse manager on a unit. We know that as patients become disruptive, they

get less care time. So the actual time you spend with a patient who has a history of disruptive behavior is less than a patient who is not disrupted. Which makes sense, right? It makes perfect sense that human beings don't want to be in that environment >> except it causes a stigmatization of the patient which actually causes a downward spiral where more disruptive behavior occurs. It's like as a leader you've got to thread the needle of supporting staff, making sure they're okay, letting them step away from the unit, right?

Supporting Clinicians and Reducing Isolation

Even if that means as a leader you need to take up some of their assignment, get in there and do that. Support your people. We are in the business of supporting our people. That is our business. And so you need to support them. Make sure you're using all your trauma informed skills. Give them time away if they need it. Allow them to decompress and think about maybe switching an assignment. So that kind of how you take care of the staff. And then as far as the patient goes, look for what we can do to help this patient not lose control again. And that could be something simple like putting a sign on the door that says every time you walk in here, make sure you approach from the foot of the bed and introduce yourself to make sure they're alert. Right? Or it could be working with them around whatever it is. You said something in the beginning about somebody didn't feel the call was being answered quickly enough. Right. Very common problem in our med search spaces. Having a clear understanding of we will answer your call every whatever it is. Making sure that's reasonable, right? Staff can't be in one patient's room all the time where we don't have that kind of nurse patient ratios. Yeah. But kind of setting those expectations I think are kind of what the leaders should be doing after they see a disruptive event.

>> And even if they just hear about a disruptive event is many times these are making them in a change a shift report, right? >> And cleaning up in post. So, this is so cool because I love how you're talking about this as the leader or somebody who is really helping the staff and the system after an event has occurred that it's not just physical safety, psychological safety, but also making sure that we're still providing care. We haven't lost the mission. And this goes back to what I loved about the fact that, you know, patient and professional safety are not a zero- sum game. that as we're working through this, we're actually going back to root causes. Why did the violence happen to begin with? What was happening? Because if I don't go back to the root thing that sort of led to the violent event to begin with, I can make sure my staff is safe. I can make sure that my patients okay, but I'm going to set myself up to have this again. So, I have to actually look at the systemic causes to what led to the event because I think that's something that get missed sometimes. >> I think it's >> in terms of that. So, one of the things that physicians are not good at, and I think we're getting better, but we're basically not good at it, is we're not necessarily great at working in teams. I think the medical students coming up, we definitely see they're getting more of that team- based education. And those of us who work in healthcare now, especially with the work I do, it's definitely helping physicians see that they are not just alone, that they are just abandoned. And, you know, all right, go to it. and you actually have a support staff who care about you and want to see you be successful. One of the things I think I've seen in terms of physicians who have been through these episodes of workplace violence is they feel very alone. They feel like they have been through this process. They have reported. They have sought help, but they still kind of feel like they're being told it's a them problem and not a system problem. How would you help a physician who felt like they needed to ask for help or going back into a practice situation feel like maybe they're not so alone? >> Absolutely. I'll take Ben just a second.

I want to start by saying I'm sorry to anyone that's listening to this that was blamed for workplace violence they experienced. It's not your fault. I need you to hear that. Returning to your question, we know kind of even outside of workplace violence and probably much more in your domain than mine. We know that isolation makes traumatic experiences worse. It just fundamentally does. And you're right, the way that our current model is set up where physicians may not be employees of the hospital, but maybe a third party where they're coming in from their practice or, you know, they're a different group unto themselves creates kind of an isolation on the unit. What I think makes them much stronger is not only to discuss it because it is unconscionable somebody made it feel like it was your fault. I know that happens out there and we still need to discuss it. We're not alone because like I said, one in four nurses, it is some ridiculous amount of physicians have experienced workplace violence. You are not alone.

Practical Prevention Tips for the Next Shift

And the other thing I would say is you need to tell your team on the units because they need to know for their

safety so they don't experience what you experience because again we need to get to the root cause but also because we need to make it more okay to talk about this stuff in the public environments and physicians lead the way with that. So physicians are our care leaders and I think you all are going to continue to be our cheerleaders moving forward. You lead the team. You are the physician and that bravery will both help you not feel as alone but also helps at the culture of it's okay to talk about these things when they do happen so that we can get them out of the shadows and start dealing with.

>> I think that's beautiful Scott and thank you for speaking directly to physicians and anybody in healthcare who feels that way. I'm so grateful you said that. I think for physicians, it's hard for us sometimes to be transparent and be vulnerable. We feel like we are, as you said, sort of out there doing our thing and we feel like we have to be strong and we have to act like we always know what we're doing. And I think part of the beautiful thing about being vulnerable with your team is you get them to buy into everything you are doing. And you will find so much more support by being vulnerable and transparent with your team. And that's a hard sometimes thing for physicians to do. But I think the first time you sort of take that leap and say, you know what, I'm just going to tell you what's going on in my heart today. And you find this overwhelming sea of support, I think that just allows you to continue to be transparent with your team. And I think that only builds stronger teams and honestly safer workplaces and better patient care. I think it all falls into place. And sometimes it just takes one person saying, "I had this experience happen." and because I had this experience happen, I'm gonna share this with you and this is where my head is right now. And then all of a sudden, you find that you have this team behind you. I think that's awesome.

>> Absolutely. So, if you are a nurse or a doctor and you're walking into your next shift, your next day, whatever you're doing, what are three things that you would encourage clinicians to think about in terms of long-term versus even short-term protection from workplace violence?

>> Yep. Let's look at it like a three-legged stool. So for your next shift, one of the things I would encourage people to remember is workplace violence is always a combination of kind of two things. It's always a combination of something that's impeding the executive function of the person. So that could be anything. High blood sugar, low blood sugar, dementia, it could literally be anything, but anything that impacts our executive function and a loss of control. So, one of the really simple things, and I said it earlier, that I would encourage you to do when you're going into your next shift, is make sure when you walk into a patient's room or a patient comes into your office for a wellness check or whatever it might be, check to make sure they're actively with you. And I suggest you do that by introducing yourselves.

And the social pleasure you would be able to introduce themselves back, right? and then kind of make sure that they are cognitively with you because if they're not, you know, you're at a significantly higher risk of disruptive behavior occurring and it might be time to get yourself a little help before you do whatever it is, right? So that's just a fundamental skill that seems to help prevent workplace violence. Just make sure they're actually with you.

>> Okay, >> so that's see what do you do on your next ship. I think that the second line of that is what do you advocate for in your health care systems. So in addition to a robust workplace violence program and like I said the joint commission has that I think that some meaningful change towards shifting the perspective. So let me walk that out. lots of hospitals now.

You walk into hospitals and they have posters at the doors and at the elevators saying we're not going to tolerate and then there is a laundry list of inappropriate behaviors you're not going to tolerate. That is a great idea. It shows leadership support. It sets a behavioral standard. Here's where that could be so much better. If you go into hospitals in Ireland, they also have signs, but instead of their signs saying, "We're not going to tolerate," and then a laundry list of things they're not going to tolerate, they say, "Thank you for continuing to be kind to our staff. We're working really hard and want to do our best." And it's that thank you for continuing hook because it presupposes not that you're going to do one of the things on this list, which is good. That sure would be snow signage, but it presupposes you're already doing a great job and we want you to keep doing that and thank you for doing it.

Culture Change, Advocacy, and Closing Thoughts

>> I just that is those kinds of pivots away from a blaming game, don't do these things to a let's fix the problem,

you're doing a great job and keep doing it. If you can get your leadership to buy into that is a great path forward to the hospital level. And then the third school is what you opened with and that is having our professional organizations. So AMA or AHA or ANA, you know, pick your organization, work with our lawmakers to get better laws on the books because we do there are cases where what we need is a legal solution. And so those are the three things, short, medium, and long term. >> No, that's phenomenal. I love the idea of making sure the patient is with you. I love that because I do think we sometimes underestimate the power of that introduction when we're interacting with a patient. It's like, "Hey, how are you?" There are so many things that you can get from, "Hi, I'm Dr. So ando. Hi, I'm Miss So and so." And you can look in that patient's eyes and you can hear that response. And if you're really sort of attuned to that, then that actually gives you what should be the tone for the rest of that interaction. And if you feel like that is off in any way, then okay, this is your opportunity. Let's make sure we're not walking into something that's going to be potentially harmful. I also think it's really cool when you talk about the signs in Ireland that positive messages trump negative messages every single time that we're actually saying that when you're building that I always think too because this happens in negotiations that if you start to set the negative rules don't do this, don't do this, don't do this, what's the first thing that people want to do in the negotiation? Well, they're going to think about doing those things. But instead, if you say, you know, I'm really happy you're here. Thank you for being civil. Thank you for actually interacting in a really positive way because this is how we're going to get peaceuilding done. People are going to sit up and they're going to smile a little bit more and they're going to be a little more bought into the process because you've made a positive assumption about them and not a negative one. So I think that is beautiful because I don't think we think about how much that means in that situation. I think it's also really great that you mentioned working through organizations for legislative change. I think physicians are really bad about this, thinking that organized medicine doesn't do anything. They're not actually helping move the needle or actually make positive change. I think they are. And I think if you actually combine your resources, you know, you think about one physician or one nurse telling a story to a legislator, that's powerful. You think about a hundred doctors or a hundred nurses going to testify and bringing these actual stories of things they've experienced to a body of legislators and this is how you make change >> 100%.

>> I think that's beautiful. I love the work that you're doing. You've already kind of given us some homework assignments and I love that you've given us that. You've even spoken directly to people who've survived violence or people have experienced it and I love that as well. If you could, you are in Washington. You have the power to make any single one policy change in healthcare today. You say it and it'll be done. What would that be?

>> That's a great question. Maybe not policy change. >> Okay. >> But if I could make one magic wand change as you know. >> All right. Yep. It would be for everyone, I suppose, but particularly for health care. I don't know who first wrote this. I will find and get it to you. But somebody said, "People really only want to know three things. I see you. I hear you. And we're going to be okay." And if I could wave a magic wand and have patients see providers as I see you, I hear you, and we're going to be okay. and have providers see patients as I see you, I hear you, and we're going to be okay. I think that will bend the curve. And I think anything we can do to move in that direction. Now, again, it's a magic wand moment. You can't legislate that. You can't because that is what happens when the door is closed and a provider and a patient are together in that magic moment of delivering care. >> That is awesome. That is absolutely beautiful. Scott, I want to thank you so much for being here today. This has been an amazing conversation and I really hope that all the people who are listening today, all of our physicians, all of our nurses, all of our healthcare professionals, I hope that you will really feel supported and loved. I hope you feel safe the next time you're at work and every day thereafter. And I hope that we'll continue to work for all of our colleagues in healthcare because I think that really is what we all want. all of us, patients, staff, we all want to feel safe where we work and we want to feel seen and heard and know that we're going to be okay. So, thank you so much for being here. This has been great. >> Joey, it's been my absolute pleasure.

Thank you and thank you for your work in this space. >> For all of our peaceful warriors who have joined us today on the scalpel and sword. If this episode spoke to you, please share it with a colleague or a friend. Please feel safe, feel supported, feel seen and heard. And until next time, be at peace. Every [music] episode is an invitation to speak, to negotiate, to choose. I'm Dr. Lee [music] Chararma. Join the dialogue by subscribing to Scalpel and Sword. Until next [music] time, peaceful warriors, may your choices be sharp and your voice [music] be even sharper.

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