Leadership in Critical Care

Dealing with aggressive behavior within the health care team: a leadership challenge

Patricia Hynes RN, MA, CNCC(C)[a,*]**, Niranjan Kissoon MD**[b,c]**, Cindy M. Hamielec MD FRCP(C)**[d]**, Anne Marie Greene RN, MN, CHE**[e]**, Carmine Simone MD**[f]

[a]*Intensive Care Unit, Mount Sinai Hospital, Toronto, Ontario, Canada*
[b]*Acute and Critical Care Programs, BC Children's Hospital, Vancouver, British Columbia, Canada*
[c]*University of British Columbia, Vancouver, British Columbia, Canada*
[d]*Pulmonary and Critical Care Medicine, McMaster University, Hamilton, Ontario, Canada*
[e]*Intensive Care Unit, Sunnybrook and Women's College Health Sciences Center, Toronto, Ontario, Canada*
[f]*Intensive Care Unit, Toronto East General Hospital, Toronto, Ontario, Canada*

Abstract During an interdisciplinary Canadian leadership forum [www.ice-ccm.org (click on the Conferences icon)], participants were challenged to develop an approach to a difficult leadership/ management situation. In a scenario involving aggressive behavior among health care providers, participants identified that, before responding, an appropriate leader should collect additional information to identify the core problem(s) causing such behavior. Possibilities include stress; lack of clear roles, responsibilities, and standard operating procedures; and, finally, lack of training on important leadership/management skills. As a result of these core problems, several potential solutions are possible, all with potential obstacles to implementation. Additional education around communication and team interaction was felt to be a priority. In summary, clinical leaders probably have a great deal to gain from augmenting their leadership/management skills.
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1. Introduction

Clinicians today frequently encounter situations in which they are ill prepared for the leadership and management challenges that they will face. In the critical care environment, resource limitations, increasing complexity of care, and diversity of personnel involved make a poorly prepared leader vulnerable. Moreover, the current complex and stressful work environment results in a greater need for strategies to manage stress and conflict. Clinicians who are solely schooled in patient care but assume leadership roles

are therefore at a great disadvantage. In this article, we highlight some of the challenges and suggest an approach to their management.

2. Background

Leadership skills are recognized as important across all disciplines within health care institutions. Leaders' skills are important to support quality (a level of professional practice that upholds accepted standards of care) and be responsive to the costs and needs of various partners in health care. To this end, necessary leadership skills include effective communication. Effective communication begins with an

* Corresponding author. Tel.: +1 416 586 4800x2610.
E-mail address: phynes@mtsinai.on.ca (P. Hynes).

understanding of one's own communication style as well as that of others and having the skills to resolve conflicts and facilitate change [1]. Furthermore, leadership training should be available for every team member because this has been shown to be effective both in reducing error and for building group cohesion in high-stress areas [1].

Given the complexity of today's health care environment, the practice of interprofessional collaboration and an integrated team approach to care delivery are imperative [2]. Interprofessional collaboration is a critical skill in that it requires the acknowledgment of many diverse opinions and the ability to reject some without offending any participant. The overall link is teamwork, and teamwork relies on effective leaders. This is contradictory to a multidisciplinary approach—where services may be coordinated but providers are not necessarily interactive [2]. Improved patient outcomes are more likely to occur by collective decision making. However, hierarchy has been cited as the major stumbling block for the practice of collaboration among health care providers. Leaders should foster a culture whereby all involved in collaboration should have an equal say, including the recipient of the services whenever possible [2]. Allowing everyone to have a say, however, does not mean that leaders may not have to make the ultimate decision. Good leaders make it easier for others to accept the final decision.

Although some administrative decisions rely on individual experiences and leadership skills, clinical decisions should, where possible, be evidenced based. Evidence in support of clinical practice should guide bedside interventions. Evidence should lead to standards of care and provide language around transparency and accountability [3]. The evolution of the evidence-based concept appears to fit comfortably with the emergence of interprofessional collaboration as previously described. In a discussion on the advances and limitations of new research evidence into the care planning of intensive care unit patients, Vincent [4] made an important point about working as a team. For all that can be said about advances in intensive care as a result of randomized controlled trials, he said, it is the application of knowledge that makes the difference in patient care [4]. For that, we need teamwork.

Cognizant of the importance of teamwork and the need to increase clinical leaders' exposure to leadership and management ideas, a group of Canadian interdisciplinary critical care leaders came together for a 2-day collaborative meeting [5]. Among other learning opportunities, small groups were presented with clinical scenarios that may highlight aspects of leadership and management failures. We were asked to review the following scenario, isolate the core problems, propose solutions, and identify obstacles to implementation.

3. Scenario

Members of an interdisciplinary cardiac arrest team approach the leader of a hospital cardiac arrest committee.

In their opinion, there are problems occurring during resuscitations that are concerning. Many of the cardiac arrest team leaders appear agitated while the arrest is in progress. At times, these individuals are shouting and displaying aggressive behavior. It is so distressing that others on the team feel that they cannot speak out and, as a result, believe that patients do not always get the appropriate treatment.

4. Identification of the core problems

The leader of the cardiac arrest committee should first recognize that, in situations such as this, it is very important to collect as much additional information as possible to fully appreciate the core problems. However, like in many situations, a great deal of additional information may not be readily available. Under these circumstances, several options are available. A thorough and complete investigation should be conducted immediately. This should include chart audits to review the documentation from the time of the arrests and interviews with individual members of the cardiac arrest team. A formal or informal debriefing to find out more about the problems encountered would also be helpful for the leader of the cardiac arrest committee, given that outcomes of cardiac arrests are not only limited to survival but also include equipment and process failure and medical error. In addition, observation of an actual cardiac arrest in progress may yield other useful information and may be a powerful tool for communicating with team leaders who may not be aware of their own leadership deficiencies. Video recordings of cardiac arrests have been used in the emergency department as a component of their quality monitoring processes and for training purposes for some time [6,7].

The group discussed key factors as potential contributors to the problem at hand. It is possible that the cardiac arrest team leaders lack an understanding of the importance of effective delegation and communication (both are leadership skills). The absence of these skills may lead to the behavior observed. This assertion is supported by an evaluation of 50 consecutive trauma resuscitations in which communication with the team was the main deficiency in the code team leader's performance [8]. The lack of communication skills and delegation during resuscitations is not unexpected when one considers the training provided. Although cardiac arrest team leaders have completed advanced cardiac life support (ACLS) training, the course remains focused on algorithms rather than on leadership. Beyond ACLS, few cardiac arrest teams require individuals to have additional leadership training. Potentially, this lack of training leaves team leaders feeling anxious and unprepared (which may have resulted in the behavior observed) when their primary role is as a leader rather than that of a clinician.

However, this inappropriate behavior may also be a symptom of other underlying issues that have not been resolved. For example, stress may be playing a role. The

responsibility of being a cardiac arrest team leader can be very stressful and perhaps more so on the off-hours, nights, and weekends, when senior supervisors are not in-house. It is interesting to note that seriously ill patients admitted through the emergency department on weekends carry a higher mortality rate than those admitted on weekdays [9].

The group also discussed that the cardiac arrest committee may not have established policies or standards for individuals' roles and responsibilities, codes of conduct, or other accountabilities related to cardiac arrest situations. Under these circumstances, clinicians may be unsure of the chain of command. Upon hearing "Code Blue," code team members rush to provide assistance to a patient because a positive outcome is less likely if ACLS is delayed. Given that the code team consists of clinicians from various hospital departments, who may or may not be familiar with each other's practice, the need for clarity around these issues is important.

Finally, even a well-established and managed team will, from time to time, encounter difficulties that may adversely affect performance. In this setting, factors that may account for suboptimal performance include lack of adequate skill sets, equipment failure, and fatigue or anxiety about transmission of disease and infection control precautions.

5. Proposed solutions

In addressing the problems raised by the code team members, there are a number of options available to the leader of the cardiac arrest committee.

Based on the findings of the investigations, appropriate recommendations can be made and changes instituted to address identified areas of concern. However, as a good principle, written standards should include well-defined roles for each of the cardiac arrest team members and a code of conduct. These should be circulated widely within the organization. The code of conduct should state unequivocally that aggressive behavior (over or covert) is detrimental for good patient care and working relationships and will not be tolerated [10]. A planned approach to implementation is necessary to ensure that education is provided in all clinical areas.

Opportunities to practice resuscitation skills and teamwork, using simulation technology and mock code situations, are possible strategies for enhancing clinicians' comfort with resuscitative interventions (even if they are ACLS prepared) and for developing their leadership skills. Most recently, the simulator has been used to study group dynamics. One recently published study showed that physician response time relates to outcome in that defibrillation was delayed, even when nurses were proficient in the skill [11]. This is undoubtedly an example of why proponents of interprofessional collaboration are cautioning health providers about the historical acceptance of hierarchy [2]. Simulation technology may allow us the opportunity for human factors research, but organizational culture must not be allowed to reject the necessary changes that will surely follow.

In this regard, the role of leaders goes beyond support of professional practice that upholds standards of care. Leaders should also assist their teams to behave according to organizational and team values such that teams will achieve operational targets. Leaders are responsible for patients and accountable to the professionals and the organization.

It should also be noted that leadership training works better when the focus is not only on leadership performance but also on the team. Egalitarian team leadership would suggest each team member being recognized as offering leadership, both by way of expertise and the ability to relate effectively to other team members. Remembering that every team member is not necessarily a team player puts the onus on designated leaders to determine team membership and the concomitant orientation/training to increase team effectiveness. With respect to cardiac arrest situations, it has been observed that training team leaders to direct individuals *and* therapy overloads an individual [12]. Team training, on the other hand, educates all code team members, thereby freeing the team leader from directing treatment interventions. Improved performance has been reported as a result [12].

If stress in individuals is determined to be an issue, this cannot be ignored. Stress is likely caused by an individual's being ill-equipped for the role. Importantly, the committee leader should meet with those affected and discuss the impact it may be having on their health as well as on work performance. If lack of education is the underlying factor, then this should be addressed. However, the leader should recognize that not all individuals are suited to emergency situations and in some cases may need to be reassigned. Moreover, a discussion as to whether team participation should be mandatory or voluntary may be warranted. In extreme situations, advice on stress management is available through most hospitals' human resources department and/or employee health office. It is essential that the cardiac arrest committee leader ensures that, as stress-related interventions are pursued, there is timely follow-up with the individuals affected to ensure that the problems are resolving.

Of note, education (particularly in relation to communication and team interactions) was rated as the most promising of the proposed solutions to address issues related to unacceptable behavior on the part of the cardiac arrest team leaders. Recognizing that mock codes require a lot of time and effort, it was felt that they would be the most effective if done properly with instructions on roles and responsibilities. A regular post code debriefing was also seen as valuable in that it is more informal, inexpensive, and may help resolve issues in a timely fashion.

6. Obstacles

Barriers to the proposed solutions were discussed. Fact finding, for example, is time consuming and becomes complicated when cardiac arrest records are not easily located or not completely filled out. However, this may not be a

significant barrier because in most instances aggressive behavior in health care providers is often well entrenched and well known within the organization. Also, not all team members value debriefing as a learning experience and trying to coordinate individuals' schedules is more challenging when intrinsic motivators are not present. Observing a cardiac arrest in progress would undoubtedly add to cardiac arrest committee leaders' understanding of the situation. In reality, such events are rare and often cannot be predicted. Mock codes would control for the issue of timing and are a viable alternative when they are run without intimidation or unrealistic expectations. However, mock codes are not the same as an arrest and (whether the arrest is real or mock) it is likely that team interactions would be affected by the presence of the leader of the cardiac arrest committee.

Advanced cardiac life support training for all staff would be ideal, but not all clinicians will maintain current certification. Mandating ACLS certification is a possibility but may not be feasible given the current fiscal environment and staffing shortages.

Perhaps most importantly, it was determined that it is important to create an action priority list once the core problems are illuminated, solutions are proposed, and obstacles are identified. The response should be timely, with feedback to all involved.

7. Conclusions

In this article, we have considered a situation involving inappropriate communication on the part of cardiac arrest team leaders as reported to the leader of the cardiac arrest committee and how he or she might respond to address this concern (Table 1). Dealing with aggressive behavior on the part of our colleagues in the clinical setting is not uncommon. Leaders faced with addressing this type of problem need to seek out timely additional information. Although understanding of the root cause will allow for more effective interventions and optimal resolutions, leaders frequently need to act without all information as seen in this example.

Obstacles to implementation should be considered in advance to allow for prioritization of the proposed solutions. As for most problems in many organizations, understanding

Table 1   Specific recommendations

1. Written standards and roles for team members
2. Appropriate training (clinical and leadership), including simulation
3. Periodic updates of skills (clinical, communication, problem solving, decision making)
4. Proactive individual and team behavior changes and strategies
5. Formulation and wide distribution of code of conduct
6. Active monitoring and rewarding good and discouraging bad behavior

the principles of quality communication is essential in preventing and resolving problems as they arise.

Acknowledgments

Appendix A. Relevant websites

Teamwork: Skills for Collaborative Work–http://www.vta.spcomm.uiuc.edu/
Conflict Management Test–http://www.queendom.com/tests/relationships/conflict_management_access.html
National Coalition for Dialogue and Deliberation–http://thataway.org
Facilitation Skills–http://www.petech.ac.za/robert/facilita.htm

References

[1] LaSalle G. Leadership and the emergency department. Emerg Med Clin North Am 2004;22(1):1-18.
[2] Davoli GW, Fine LJ. Stacking the deck for success in interprofessional collaboration. Health Promot Pract 2004;5(3):266-70.
[3] Page S, Merabeau L. Hierarchies of evidence and hierarchies of education: reflections on a multiprofessional education initiative. Learn Health Soc Care 2004;3(3):118-28.
[4] Vincent JL. Evidence-based medicine in the ICU. Chest 2004; 126(2):592-600.
[5] www.ice-ccm.org (click on the Conferences icon).
[6] Mann CJ, Heyworth J. Comparison of cardiopulmonary resuscitation techniques using video camera recordings. J Accid Emerg Med 1996;13(3):198-9.
[7] Weston CF, Richmond P, McCabe MJ, Evans R. Video recording of cardiac arrest management: an aid to training and audit. Resuscitation 1992;24(1):13-5.
[8] Sugrue M, Seger M, Kerridge R, Sloane D, Deane S. A prospective study of the performance of the trauma team leader. J Trauma 1995;38(1):79-82.
[9] Bell CM, Redelmeier DA. Mortality among patients admitted to hospitals on weekends as compared with weekdays. N Engl J Med 2001;345(9):663-8.
[10] Kissoon N, LaPenta S, Armstrong G. Diagnosis and therapy for the disruptive physician. Physician Exec 2002;28(1):54-8.
[11] Marsch SCU, Tschan F, Semmer N, Spychiger M, Breuer M, Hunziker P. Performance of first performers in simulated cardiac arrest. Crit Care Med 2005;33(5):963-7.
[12] DeVita M, Schaefer J, Kutz J, Dongilli T, Wang H. Improving medical crisis team performance. Crit Care Med 2004;32(2 Suppl):561-5.

Commentary

When the leader may need help

Hynes and colleagues address an important and complex issue in health care environments: that of team leader