



Implementing SAFER Responses to Misconduct and Responding to Biased Patient Requests ASAP

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Abstract

Background: In response to encounters involving misconduct, discrimination, and harassment toward healthcare workers, the Experience Training, Education, and Coaching (XTEC) team was tasked with empowering staff members to respond to biased requests and misconduct appropriately and consistently. The aim of this article is to discuss communication strategies for how to respond to patient bias and misconduct. **Methods:** XTEC developed a training program with two focused communication strategies: (1) SAFER, a stepped approach to respond to patient and visitor misconduct and (2) ASAP, an approach for responding to patient bias which we describe as requests related to race, religion, ethnicity, gender, and other personal attributes of staff. **Intervention:** SAFER ASAP workshops were delivered to 2154 health care professionals through 109 face-to-face training over a 15-month period between January 2019 and March 2020. All trainings were discussion- and scenario-based, ranging in duration from 60 to 90 min. Participants were given pre- and post-training test case scenarios, in which respondents wrote responses to a challenging behavior to assess skill attainment post-training. **Results:** Seventy-one percent demonstrated higher levels of response ability post-training, and 92% of respondents indicated they would likely recommend this training to others. **Conclusions:** SAFER ASAP is an effective communication training program for responding to patient and visitor bias and misconduct.

Keywords

United States, healthcare, patient misconduct, patient bias

Introduction

Problem Description

Ask almost any healthcare provider about their experiences with biased requests or verbal misconduct from patients, and you're likely to hear egregious stories. Comments reported in our own institution include: "you're worthless," "how did you get to be in your position?," "I want to see a provider with an American name," "I don't want a foreigner to cut me open and leave the country!." Sexual comments or actions taken towards healthcare staff include physical groping and asking, "Your husband is one lucky guy." Most clinicians do not know how to respond to these comments in the moment, and many of these incidents go unreported (1). A recent study of surgical residents demonstrated that of the incidents that are reported and can be studied, patients and patients' families were the biggest

source of gender and racial discrimination. Although mistreatment extends beyond gender and racial discrimination as defined in this study, over 50% of general surgery residents reported mistreatment which was associated with burnout and suicidal thoughts (2).

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In 2016, our institution implemented a Patient Visitor Conduct Policy to address patient behaviors that directly conflict with organizational efforts to create and maintain a safe, diverse, and inclusive workplace. The purpose is to ensure that patients receive timely and quality care while protecting employees, learners, and other patients from discrimination, harassment (sexual or otherwise), and nonviolent misconduct. The policy has 2 scopes. The first addresses requests from patients for any personal attribute of a provider such as gender, race, ethnicity, religion, and sexual orientation. While rare, exceptions were important to include in this policy, in part, because patient preferences can develop in response to past institutional experiences and perceived bias which could deter some patients from receiving care (ie, history of sexual assault) (3). The second scope of the policy addresses misconduct such as comments that are racist, sexist, derogatory, harassing, or demeaning.

Responding to Misconduct

Available Knowledge

Research on patient misconduct has revealed that improper and unacceptable behaviors exhibited by patients toward staff and even other patients are not a recent phenomenon (4–6). Increased sociopolitical polarization within the United States has contributed to increased incidences of patient misconduct, including at our institution. Healthcare providers who experience mistreatment report negative impacts on their mental and physical well-being, while patient-on-patient harassment can impede the victim's access to healthcare (6,7). Despite the prevalence of these behaviors, few resources exist to guide organizations and their employees on how to respond in the moment to patient and visitor misconduct. Through training, health care employees can feel more prepared and confident in addressing instances of patient misconduct, discrimination, and bias (8,9).

Rationale

In 2018, our institution tasked the Experience Training, Education & Coaching (XTEC) program with a quality improvement project. Its aim was to develop a communication training program for staff members on how to respond to non-violent misconduct. Equipping employees with the skills to address these behaviors requires a systems approach involving policy change, training, and empowerment (10). This article outlines the communication strategies put into place to address nonviolent misconduct.

Specific Aims

Two goals were established by the development team in the creation of training: goal 1: empower staff to shift their response from bystander to upstander (1) and goal 2: building staff capabilities to respond in the moment of a misconduct situation (6).

Methods

Program Design

The XTEC team developed a training program based on tracked inquiries and needs described through direct feedback. The acronym SAFER ASAP was developed for ease of recalling the approach and summarizing key steps. SAFER and ASAP are unique communication methods developed utilizing de-escalation strategies, empathic communication, and other communicative best practices that align with the institution's history, culture, and values (6,8,11). The acronym supports both goals of the training for messages of empowerment and communication methods of how to respond for increasing self-efficacy. The training program used problem-based learning to integrate key skills based on scenarios, participant experiences, discussion, and application of the communication strategies (12). Inviting participant experiences and generating discussion provides an opportunity to initiate solutions to patient misconduct. The SAFER approach highlights five key steps employees should take to address misconduct:

- **Step up** when you observe behavior that does not align with our institution's goal of maintaining a safe, diverse, and inclusive environment.
- **Address** the specific behavior with the patient or visitor by naming exactly what is inappropriate.
- **Focus** on our institution's value of "Respect" when you respond to the patient or visitor.
- **Explain** expectations and set boundaries for inappropriate behaviors.
- **Report** and document the incident.

Step Up

Our institution sought to help staff identify subtle forms of misconduct when it occurs. Although overt forms of misconduct such as blatant sexual gestures or derogatory language may be easy to identify, other more subtle forms of misconduct can be difficult to recognize. Additionally, while employees may recognize inappropriate behavior, they may have varying levels of tolerance for such words or actions. In addition, we sought to empower staff to step up for themselves as well as for others whenever misconduct is identified. During SAFER ASAP workshops, XTEC facilitators elicit experiences participants have personally encountered or witnessed. This reflective discussion offers an opportunity for the facilitators to encourage stepping up in situations that involve even slight microaggressions by patients or visitors.

Address

The primary goal of addressing misconduct with patients and visitors is to stop inappropriate behavior the moment it occurs. It is important to address behavior by specifically naming it back to the patient or visitor to clearly state what exactly is

inappropriate. Addressing the inappropriate behaviors of others can be a stressful experience for many individuals. Discomfort with confrontation, concerns of further escalating the situation, fear of the repercussion, or not knowing how to respond can discourage an individual from intervening. The XTEC team identified that recognizing and responding to inappropriate behaviors when they occur may not be enough to empower them to act; staff must also possess a heightened sense of personal responsibility to respond. The XTEC team emphasized the difference between uncomfortable situations and unsafe situations. Where it is assumed that nearly all discussions around misconduct are uncomfortable, that does not mean that addressing a behavior should be avoided. Anecdotal and personal accounts from staff participating in SAFER ASAP training varied greatly, ranging from situations that could be directly addressed by staff to those in which it was physically unsafe to address. Crises or other dangerous situations are not appropriate times to address behavior without first rallying support and ensuring staff and patients are safe. Additionally, the SAFER approach stresses the importance of assessing behavior in an objective fashion. Utilizing a subjective “comfort level” when assessing the severity of behaviors isn’t ideal. For example, one clinician with many years of experience in critical care settings reported being untroubled by egregious sexual comments made to them by patients. Conversely, a “less experienced” clinician disclosed significant distress and negative impacts on performance when experiencing very similar behavior. From our perspective, such differences represent the development of tolerance of certain behavior as the result of learning processes. Although such processes may be important for staff to experience over time, they are not believed reliable ways to determine what behavior is or is not appropriate. Rather, objective definitions of behavior (ie, patient making sexual comments about the appearance of a caregiver) were presented as a more objective way to assess the inappropriateness of behavior.

One factor that can influence an individual’s decision to intervene is based on Dovidio, Piliavin, Gaertner, Schroeder, & Clark’s 1991 arousal cost-reward model (13). This model suggests that an individual’s decision to help another is weighted by the costs of not helping against the costs and rewards of helping. Framing SAFER is an essential behavior in upholding our institution’s culture aids staff in decreasing the perceived costs of intervening and increasing the rewards of helping. By weaving these ever-present values into the key messaging of SAFER, facilitators encourage the training participants to view intervening as every employee’s personal responsibility. Moreover, salient examples of the “downstream effect” caused by failing to address behavior were shared with participants. Facilitators emphasized, and provided actual examples of, unaddressed, and unreported behaviors reoccurring in the future and impacting future caregivers.

Focus

Our institution’s value of “respect” serves as a compass to guide staff toward what is right for its patients, visitors,

and staff. Focusing on institutional values not only provides staff with the support they need when responding to patient or visitor misconduct but also reinforces the message that stepping up and addressing behavior is every employee’s responsibility.

Explain

Staff are encouraged to be assertive and professional in their communication; language that is too passive or aggressive can create confusion or unnecessarily escalate a situation. Staff remaining aware of their own emotions, reactions, and beliefs about a situation or individual patient is important as behavior is best addressed objectively. Additionally, while beyond the scope of this article, the implicit bias of staff, as pre-reflective attribution of qualities, is of concern. As such, general statements like “that’s inappropriate” or “calm down” must be avoided in order to reduce problematic behaviors and guard against over generalization of behavior by staff. Explaining expectations objectively and setting boundaries with patients early can help to create a safer atmosphere for all staff, patients, visitors, and even those who engage in misconduct. When staff address these behaviors, it is important to be specific in explaining what is expected to maintain a safe and inclusive environment. Employees should be firm, yet respectful in outlining the steps that will be taken should the inappropriate behavior continue. The workshop aims to empower staff to appropriately and consistently follow-through should behaviors persist. Like other healthcare organizations, our institution has policies and procedures in place to address repeated episodes of misconduct; it is important that employees are familiar with these processes and where to access them. SAFER ASAP workshops also involve informing staff of other relevant procedures and resources.

Report

Instances of patient and visitor misconduct observed or addressed by staff are reported to their team leader and documented through a specific electronic reporting tool. Reporting and documenting incidents of misconduct are also important in ensuring care teams across the institution are informed of previous incidents of misconduct. Data collected can better inform institution-wide messaging, training efforts, and policies.

Responding to Biased Requests (ASAP)

Historically, biased comments and requests by patients have been accepted in the healthcare setting as an acknowledgment to customer service and honoring patient preferences. However, institutions may not always have the resources to accommodate these requests. In addition, explicitly biased remarks are discriminatory and demeaning to healthcare

team members leading to feelings of distress and damaging the patient–provider relationship (14).

The ASAP approach assists healthcare staff with responding in the moment to biased requests. The framework consists of elements found in our institution’s Experience Model of Communication that is centered around mindful presence, transparency, empathy, and building a human connection. The ASAP framework encourages staff to:

- Approach with curiosity.
- Share back patient concerns or values utilizing empathic reflective listening.
- Align language with inclusivity and respect.
- Provide options when communicating with patients who make biased requests.

To illustrate, imagine a nurse seeing a patient for the first time. The nurse explains his or her role and obtains a health history prior to the physician’s arrival. When the nurse announces that Dr. Smith will be in shortly, the patient asks, *“Is Dr. Smith a Christian? If not, can you find me a Christian doctor.”* Because we don’t know the religious affiliation of our providers, it would be easy to simply state this to the patient and move on. However, utilizing the ASAP framework, the nurse would approach with curiosity: *“It sounds like you have some concerns about the religious affiliation of Dr. Smith. Can you tell me more about your concerns?”* The nurse would pause and share back the patient’s concerns to show understanding: *“It’s important to you to see a doctor who shares your religious beliefs.”* Sharing back the patient’s perspective before sharing our perspective is a way to show respect and consideration to what the patient believes is a valid request, even though the request is inappropriate. This step is crucial because the patient needs to feel heard. Next, the nurse’s explanation would align with the institutional goals of providing a safe, inclusive environment for all: *“Dr. Smith is a skilled and talented provider with an extensive background here at our institution. To maintain a safe and inclusive environment, we do not grant requests based on personal attributes such as [religion/gender/race/ethnicity/etc.]”* Finally, the nurse would state: *“If you would like, I’d be happy to go ahead and let Dr. Smith know that you are ready to be seen. You will be in excellent hands as patients find him extremely caring.”* By stating the policy and then asking permission to inform the doctor they are ready to be seen, the patient’s autonomy is respected and he or she can make the decision to proceed or seek healthcare elsewhere. The ASAP framework, including the above-outlined communication strategies, is taught as part of our institution’s SAFER ASAP training workshops.

Interventions

Methods

SAFER workshops were delivered to a variety of work teams across the institution including but not limited to inpatient

medical intensive care units, pulmonary-sleep medicine, hematology, radiation oncology, employee and community health, social work, addictions counseling, concierge services, and the medical center’s International Center. In sum, 109 face-to-face training sessions were provided to 2154 clinicians (physicians, residents, fellows, and advanced practice providers) and allied health staff (nurses, counselors, social workers, desk attendants, and health unit coordinators) over a 15-month period between (September) 2018 and (December) 2019. The sessions ranged in length from 60 to 90 min. SAFER workshops consisted of both voluntary learners, electively completing the course; and learners participating as a larger training effort in their department. Course objectives were as follows:

1. Explain the rationale for stepping up and setting boundaries when inappropriate behavior occurs.
2. Discuss components of SAFER with a goal of maintaining a safe environment.
3. Demonstrate skills and strategies to address patient bias and misconduct.

Evaluations were captured from 23 training sessions provided to 471 staff over two months between September and November 2019; of those participants, 391 completed an evaluation. Survey collection was discontinued after reaching our desired number of 450; however, trainings continued to be offered based on the integrity of the initial trainings and participant data indicating course objectives were met. Evaluations were distributed by the facilitator of each session. The evaluations were completed immediately prior to and following each training session but during the allotted workshop time. Course evaluations included questions targeting the degree to which stated course objectives were met such as confidence in responding to misconduct in the moment, confidence in the institution to support individuals, and likelihood to recommend the training to others. Evaluation questions used in the participant evaluation items used a 5-point response scale to measure the level of sentiment (Table 1). The team responsible for evaluating SAFER workshops used written responses from a case scenario to assess post-training differences in participants’ ability to respond using the SAFER framework (Table 2). Responses were coded by SAFER faculty as either containing or being absent the SAFER elements, including naming the specific inappropriate behavior (vs making general statements such as “stop that” or “calm down”), stating an institutional value, and setting an appropriate boundary, levels of response-ability post-training were assessed using this faculty-coded process.

Study of the Interventions

Results

A total of 391 pre- and post-training evaluations were returned for analysis. Evaluation return rate was high

Table 1. Study Survey Questions and Likert Responses.

Question	5-point Likert response
Rate the degree to which the learning objectives for this session were achieved or not achieved	Strongly disagree—Strongly agree
How confident are you that institution and your local manager would support you if you addressed inappropriate comments or behaviors with a patient?	Not at all confident—Very confident
How confident are you in your ability to address inappropriate comments or behavior with a patient?	Not at all confident—Very confident
How likely or unlikely are you to recommend this training to others?	Not at all likely—Very likely
You are working with a patient who begins making sexual comments that make you feel uncomfortable. In the space below write how you would respond to the patient (write what you would say).	

Table 2. Pre and Post Training Responses for Inappropriate Behavior.

Pre-response	Post-response
You cannot speak that way to any member of the team. It is inappropriate and will not be tolerated here. We are here to help you get better and will treat you with respect. We expect the same respect in return.	Mrs. X, your comments are making me feel uncomfortable. Please refrain from making them so I can continue to provide high-quality, compassionate, respectful care to you.
That is inappropriate and will not be tolerated. That is disrespectful and if it doesn't stop, I'm going to get my charge nurse involved.	These comments are inappropriate and disrespectful and do not align with our institutions' core values. I am going to ask you to please refrain from making those comments so we can maintain a professional, caring, and healing environment.
I'm sorry but this behavior is not tolerated. Please be respectful because I am just here to help you get better.	Your sexual comments are making me uncomfortable, and I cannot do my job in caring for you if it continues.
Please stop making those comments. If it continues, I will bring it to my charge nurse.	"Mr. X, your sexual comments are making me feel uncomfortable. I'm asking you to stop making comments like those so we can foster respect for each other. If this continues, I will report this to your care team and actions may be taken to adjust your care plan."
Those comments are disrespectful, not appropriate, and need to stop.	The sexual comments you are making are inappropriate and make me uncomfortable. In order to care for you and maintain a professional relationship, I will need you to refrain from such comments.
Those comments are inappropriate, and that kind of behavior will not be tolerated here.	To provide you with the best care, it is important that we keep this professional. I am going to ask you to refrain from making those sexual comments.
I am a professional and those types of comments are not appropriate. Please stop.	Your sexual comments are inappropriate and need to stop so that I can provide quality care to you. If you do not stop, I will have to leave and come back later.
That is not appropriate. I am here to care for you today and this is not something we should be focusing on.	Mr. X, those sexual comments are not appropriate. In order to provide you with the best care possible, we need to focus on your care. If these comments continue, I will need to bring this forward to the health care team.

(83%), given that pre- and post-training evaluations were distributed by the facilitator and collected at the time of training. Participants reported a positive reaction to the training, 92% (n = 358) indicating they would recommend the training to others. Training participant confidence in their ability to address patient or visitor misconduct was higher post-training, with 46% (n = 180) of respondents reporting greater confidence. Seventy percent (n = 275) of participants also reported higher confidence in the post-survey that the organization and their local management would support them if they addressed inappropriate behavior with a patient or visitor.

Participants were asked to respond to a case scenario during the pre- and post-training evaluation. Responses

were assessed for the inclusion of key SAFER ASAP elements. Incomplete responses were discarded, resulting in a smaller sample (n = 239) than with other evaluation items. Seventy-one percent (n = 170) of participants demonstrated higher levels of response-ability post-training.

Skill acquisition is a complex set of processes for which our evaluative methods were insufficient to assess with any great rigor. SAFER ASAP practices as domain-specific skills could not be measured "on the job" and we relied on written responses to scenarios that meaningfully represented knowledge attainment and hypothetical, not real world, application. While limiting, such evaluation provided us some measure with which to assess our learners' ability to

apply the knowledge acquired through training to academic examples of commonly reported scenarios within our institution. Additionally, the reporting of misconduct across the institution increased following the implementation of several related interventions, which included, but were not exclusively comprised of, SAFER ASAP workshops. Overall, a 3-fold increase in reporting behavior was observed over a 6-month period—3 months prior to and three months after the SAFER ASAP intervention.

Discussion

Summary

Previous studies that have analyzed the impact of patient misconduct training have focused primarily on medical students, residents, and physicians (1,2,8). However, patient and visitor misconduct can occur in any location within a hospital. This study expands the research on the impact of misconduct training by providing the training to nonclinician, hospital staff, in addition to clinicians.

The data from the SAFER ASAP workshops demonstrate the value of equipping healthcare professionals with strategies to address inappropriate patient behavior. In addition to providing staff with the strategies needed to respond to misconduct, participants of the training also reported a sense of appreciation to the facilitators for caring, listening, and assisting them with a sensitive and challenging topic. Several staff members reported carrying guilt, confusion, and fear over many years when reflecting on previous experiences of patient misconduct. Prior to the training, many staff either ignored misconduct or responded inappropriately, but when given post-training scenarios, staff responses were in greater alignment with SAFER ASAP strategies. Encouraging our staff to share their stories has opened leadership's eyes to some of the egregious behaviors that have occurred across the institution. This has resulted in the creation of a new program, The Patient and Visitor Conduct Program (PVC). An administrator provides oversight to the PVC, and a Senior Advisor and two Senior Specialists work together to support the practice with a means to report incidents to gain further awareness and enact institutional consequences to patient behavior, up to and including termination of patient care. Staff from PVC also register staff and track attendance for SAFER ASAP training; provide consultations, resources, and other support for patient and visitor misconduct; and strategize for future operationalization of responding to bias and misconduct.

Interpretation

Limitations

Limitations of particular note include the rigor of the evaluative methods and terminology used. Although our evaluation of SAFER ASAP strategies and training activities revealed important insights, the complexity of skill

acquisition, learning, and empowerment processes was significantly limited by the level of training evaluation resources at our disposal. Further limitations to note are that unconscious bias exists in all institutions, and this article did not address how this could impact the responses of staff to perceived patient bias. Strategies to address patients' and visitors' perceptions of staff misconduct are also lacking in this article. We recognize that misconduct is based on perception and staff beliefs about what qualifies as misconduct may not be the same as what the patient perceives. Differing accounts of the same event exist between patients and staff. Additionally, behavioral issues can often be tied to service failures. Our institution found that in 21.9% of the cases in which PVC assisted with setting expectations and boundaries with a patient, a corresponding care concern or grievance had been filed by the patient.

Conclusions

Future research should focus on the success of utilizing various training methods to arm healthcare staff with skills and strategies to respond to patient and visitor misconduct as well as strategies to understand and address staff bias and misconduct. In particular, assessment of SAFER ASAP strategies as domain-specific skills should occur within the healthcare environment with processes in place by which learner behavior can be assessed. Although we reference "empowerment" as a broad sentiment of willingness to engage in a behavior, the role of empowerment as processes of autonomy, self-determination, and responsibility should be explored more precisely, along with the influence these processes have on learning and behavior within the healthcare environment. The relationship between patient misconduct and perceived service failures should also be explored further. Additionally, the influence of in the moment and institutional consequences on the prevalence of misconduct should be investigated.

Authors' Note

Our Institutional Review Board declared this activity as exempt from review in accordance with the Code of Federal Regulations, 45 CFR 46.102.

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