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Patient Safety Tip of the Week

March 22, 2022

Not Just Politicians That Behave Badly

It seems these days that disrespect and rude behavior have become "normalized" in many facets of our society. One need only look at behavior of politicians or interchanges on social media. Healthcare is not immune to this phenomenon.

ISMP (Institute for Safe Medication Practices) was one of the first organizations to describe such behavior in healthcare and point out how it serves as a barrier to a culture of safety. In 2004 (ISMP 2004) reported on responses to a 2003 survey. Respondents noted that intimidating behaviors were not attributable to physicians/prescribers alone. They encountered a surprising degree of intimidation among other healthcare providers as well and repeated occurrences of intimidating behavior did not arise from a single menacing individual. Subtle forms of intimidation were more frequent than more explicit forms. 88% of respondents encountered condescending language or voice intonation (21% often); 87% encountered impatience with questions (19% often); and 79% encountered a reluctance or refusal to answer questions or phone calls (14% often). Almost half of the respondents reported more explicit forms of intimidation, such as strong verbal abuse (48%) or threatening body language (43%). Incredibly, 4% of respondents even reported physical abuse.

Another ISMP survey in 2013 (ISMP 2013) largely echoed the 2003 survey. ISMP concluded "The results of our 2003 and 2013 surveys expose healthcare's continued tolerance and indifference to disrespectful behavior. These behaviors are clearly learned, tolerated, and reinforced in the healthcare culture, and little improvement has been made during the last decade."

In 2005 a very valuable contribution to patient safety came from AACN (American Association of Critical-Care Nurses): "Silence Kills. The Seven Crucial Conversations for Healthcare" (AACN 2005), results of a survey of nurses, physicians, administrators and a variety of healthcare workers. The survey highlighted 7 issues of concern that have largely flown under the radar. One of those 7 issues was "Disrespect". The survey revealed that 77 percent of nurses and other clinical-care providers work with some who are condescending, insulting, or rude. 33 percent work with a few who are verbally abusive—yell, shout, swear, or name call. Many of the issues were considered

"undiscussable". Even the nursing supervisors participating in the study admitted that they often did not confront the offending party or take appropriate action.

So, why don't people speak up and share their full concerns? 59% of nurses and other clinical-care providers said that it was difficult or impossible to confront the person showing disrespect or abuse. Lack of ability, belief that it is "not their job," and low confidence that it will do any good to have the conversation were the three primary obstacles to direct communication. Other obstacles include time and fear of retaliation. Some don't want to make others angry or undercut their working relationships, so they leave difficult discussions to others or to another time, and never get back to the person.

But a quarter to half of the respondents did discuss the problem with coworkers or with the person's manager. But they often noted that the purpose for discussing these problems with coworkers was not to solve problems. Rather, it was to "work around them, warn others about them, and blow off steam".

The Joint Commission issued its Sentinel Event Alert #40 "Behaviors that undermine a culture of safety" in 2008 (TJC 2008). It cited the 2004 ISMP report and indicated that both overt activities and more passive examples of disruptive behavior can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. It issues suggested actions for hospitals, including "zero tolerance" for intimidating and/or disruptive behaviors.

But it was Lucian Leape and colleagues (Leape 2012a, Leape 2012b) who really got the attention of the medical community with their series on the "Culture of Disrespect" (see our July 2012 What's New in the Patient Safety World column "A Culture of Disrespect"). He and his colleagues described disrespectful behavior in 6 categories. While we all easily recognize the first category – the disruptive physician – such account for a relatively small proportion of the problem. Moreover, the disruptive physician is easiest to recognize and probably easiest to take action on. But Leape's main point is that the behaviors in the other categories are the more subtle parts of the continuum of disrespect and collectively the far bigger problem. Most of the culture of disrespect is rooted more deeply in the highly hierarchical environment in medicine where the physician has been traditionally accorded a stature at a different level than everyone else. Leape notes that remains a huge barrier in a time when we have to rely on growing multidisciplinary teams to manage increasingly complex medical conditions.

Importantly, while some aspects of disrespect are due to characteristics of individuals, Leape emphasizes that disrespectful behavior is also learned, tolerated and reinforced by the hierarchical hospital culture.

Most recently, ISMP reported on yet another survey done in 2021 (ISMP 2022) and it showed that disrespectful behaviors in healthcare continue to occur at an alarming rate, demonstrating little or no improvement, and in some cases, worsening. In 2021, respondents reported that "disrespectful behaviors persist unchecked, they are not

isolated events, they are not limited to only one or two offenders of a single gender, and they occur in both lateral (peer-to-peer) and hierarchical working relationships."

The prevalence and frequency of the disrespectful behaviors was largely similar among the 3 ISMP surveys, though between 2013 and 2021 there was an increase in making negative comments about colleagues and leaders.

Importantly, most respondents have not been satisfied with organizational efforts to address disrespectful behaviors. 70% of the respondents in 2003, 52% in 2013, and 65% in 2021 reported that their organization or manager would support them if they reported disrespectful behavior, but only about one-quarter of all respondents (39%, 25%, 25% respectively) felt that their organization had effectively dealt with disrespectful behaviors.

The COVID-19 pandemic may have exacerbated the problem, with a more stressful healthcare environment, poor staffing levels, excessive workloads, power imbalances, and the ever-changing science and data associated with COVID-19 treatments.

And the issues clearly have a potential impact on patient safety. 47% of respondents admitted to feeling pressured to accept an order, dispense a product, or administer a drug despite concerns about its safety, and 35% had concerns about a medication order but assumed it was correct rather than interact with a particular prescriber.

Guo et al. just published a systematic review on the impact of unacceptable behavior between healthcare workers on clinical performance and patient outcomes (Guo 2022). After winnowing down a huge list of articles dealing with unacceptable behavior, they were left with 36 studies for inclusion in the review. They found considerable variability in the quality and methodology of the included studies. In general, the studies reporting on perception of respondents demonstrated a negative impact on quality of care, patient outcomes, patient safety, and workplace productivity. This was substantiated by a smaller number of higher quality studies with more rigorous methodology and more objective outcome measures. We also discussed some of the consequences of rude and disrespectful behavior in our September 22, 2015 Patient Safety Tip of the Week "The Cost of Being Rude" and our August 2019 What's New in the Patient Safety World column "More on the Cost of Rudeness".

The term "microaggressions" has been used to refer to 'commonplace behavioral indignities whether intentional or unintentional communicating hostile, derogatory or negative attitudes toward marginalized groups.' Implicit bias, microaggression, prejudice, and stereotyping may play a role in the persistent healthcare disparities seen among marginalized groups (Ehie 2021).

Even academic medicine is not immune to disrespectful behavior, as evidenced by a recent exchange at an oncology conference in which several participants were rude or condescending (Nelson 2022).

It's clearly not just physicians that are exhibiting intimidating, rude, or disrespectful behavior. Over the past decade there has been much written about so-called "lateral violence" and bullying among nurses. And responses from administrators have often been less than satisfying. An article in Becker's Hospital Review (Becker 2016) described the acronym L.I.S.T.E.N. used by Phyllis Quinlan, PhD, RN, an authority on bullying in multiple venues, to guide nurse leaders in investigating nurse bullying:

L: Lean into the situation.
I: Insight is the goal.
S: Solving the reason for the behavior is not your job.
T: Take notes.
E: Engage human resources early.
N: Never share an opinion.

The really bad behavior in our minds is that clinical leaders and hospital administrators often tolerate the disrespectful behavior, thereby sanctioning it and inadvertently leading to its adoption by others. Medical students, resident physicians, nursing students, etc. all see examples of disrespectful behavior that go unchallenged and then begin to adopt such behavior themselves as the "norm".

A recent article on patient safety "culture" (French 2022) in InSight+, a newsletter of the Medical Journal of Australia, described **4 characteristics of organizational culture** as described in an article from the Harvard Business Review (Groysberg 2018). Culture is:

- **Shared** – culture is not an individual phenomenon, nor is it simply the average of individual characteristics. It exists as shared behaviors, values, beliefs and assumptions that manifest as unwritten rules of behavior (how we do things around here).
- **Pervasive** – culture permeates every level of a group, although it is not monolithic and can vary widely within an organization. It manifests in collective behaviors, physical environments, group rituals, stories, and legends. Other aspects of culture are less overt, such as unspoken assumptions, mindsets, and motivations. Culture is a way of seeing and also not seeing and can lead to collective blind spots to important issues.
- **Enduring** – culture continuously evolves through shared experience and problem solving. Its endurance is partly explained by the attraction-selection-attrition model. People are drawn to organizations with characteristics similar to their own; organizations are more likely to select individuals who seem to "fit in"; and over time those who don't fit in tend to leave. Culture becomes a self-reinforcing pattern that grows increasingly resistant to change and external influences. It can reduce organizational flexibility and adaptability – deeply held values and beliefs are slow to change.
- **Implicit** – the effect of culture is subliminal. People are instinctively hardwired to recognize and respond to it. Unconscious assumptions about behavioral norms are taken for granted. Culture acts as a kind of silent language, a shared understanding that facilitates cooperative action.

Unfortunately, those same 4 characteristics we see in positive cultures may also be features of organizational cultures that are counterproductive (i.e. when the disrespectful behavior is what is shared, pervasive, enduring, and implicit). Which type of culture best describes that of your organization?

Stay tuned! The upcoming Part II of ISMP's 2022 report will explore how to address disrespectful behaviors in healthcare.

Some of our prior columns on the impact of "bad behavior" of healthcare workers:

January 2011	"No Improvement in Patient Safety: Why Not?"
March 29, 2011	"The Silent Treatment: A Dose of Reality"
July 2012	"A Culture of Disrespect"
July 2013	""Bad Apples" Back In?"
July 7, 2015	"Medical Staff Risk Issues"
September 22, 2015	"The Cost of Being Rude"
April 2017	"Relation of Complaints about Physicians to Outcomes"
October 2, 2018	"Speaking Up About Disruptive Behavior"
August 2019	"More on the Cost of Rudeness"
January 21, 2020	"Disruptive Behavior and Patient Safety: Cause or Effect?"
April 6, 2021	"ISMP on Just Culture"

Some of our prior columns related to the "culture of safety":

April 2009	"New Patient Safety Culture Assessments"
June 2, 2009	"Why Hospitals Should Fly...John Nance Nails It!"
January 2011	"No Improvement in Patient Safety: Why Not?"
March 2011	"Michigan ICU Collaborative Wins Big").
March 29, 2011	"The Silent Treatment: A Dose of Reality"
May 24, 2011	"Hand Hygiene Resources"
March 2012	"Human Factors and Operating Room Safety"
July 2012	"A Culture of Disrespect"
July 2013	""Bad Apples" Back In?"
July 22, 2014	"More on Operating Room Briefings and Debriefings"
October 7, 2014	"Our Take on Patient Safety Walk Rounds"
July 7, 2015	"Medical Staff Risk Issues"
September 22, 2015	"The Cost of Being Rude"
May 2016	"ECRI Institute's Top Ten Patient Safety Concerns for 2016"
June 28, 2016	"Culture of Safety and Catheter-Associated Infections"
April 2017	"Relation of Complaints about Physicians to Outcomes"
April 2017	"Joint Commission Sentinel Event Alert on Safety Culture"
October 2, 2018	"Speaking Up About Disruptive Behavior"
August 2019	"More on the Cost of Rudeness"
January 21, 2020	"Disruptive Behavior and Patient Safety: Cause or Effect?"

April 6, 2021 "ISMP on Just Culture"
July 27, 2021 "Sustainability"
September 2021 "Ambiguous Language in the OR"

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