Patient Safety Tip of the Week

September 22, 2015 The Cost of Being Rude

Our July 2012 What's New in the Patient Safety World column "A Culture of Disrespect" summarized what Lucian Leape considers to be the number one problem in patient safety today: we have a **culture of disrespect**. Leape noted that the problem is not just that of the obvious disruptive physician who yells at people, throws things, etc. Rather, there are much more subtle behaviors that are equally disrespectful and all are threats to teamwork and patient safety.

Now researchers in Israel have done a very clever randomized controlled trial in a simulated environment that demonstrates the negative impact of rudeness on diagnostic and procedural performance (Riskin 2015). They recruited participants from 24 NICU teams at 4 hospitals in Israel and told them they would participate in a recorded simulation involving a premature infant with necrotizing enterocolitis and would be observed throughout the simulation by an expert from the US. Half were allocated to a "rude" observer and the other half to a "neutral" observer. The "rude" observer began with a comment to the effect "…I can't say that I'm impressed with the quality of medicine in Israel" and later added other unflattering comments. A team of NICU personnel, blinded to the group allocation, then reviewed the recorded simulations and the written documentation (diagnoses, orders). Nine items each were used for evaluating diagnostic performance and procedural performance, and single items for information-sharing and help-seeking.

Rudeness negatively affected both the overall diagnostic and procedural performance and most of the individual items for each. Using multifactorial testing they found that rudeness, by itself, was responsible for about 12% of the variation in medical performance. Rudeness was also negatively associated with information-sharing and help-seeking. Information-sharing was associated with diagnostic performance but not procedural performance. On the other hand, help-seeking was associated with procedural performance but not diagnostic performance.

The authors discuss previous research showing that rudeness can interfere at the individual level with working memory. But the current study makes it clear that rudeness has a negative impact on collaborative processes. They also note that the rudeness in this scenario came from an "outside" source and speculate whether the negative impact might be even greater if the rudeness came from a medical colleague, or was directed at a specific target, or if the intensity, length or frequency were greater.

This is a very enlightening study and confirms what we and others have always observed about the importance of civility in improving a culture of safety and positively impacting

outcomes. It really validates Leape's postulate that even "mild" forms of incivility and disrespect have a detrimental impact on patient care.

But what about more severe forms of incivility? Another new study, this one from Australia and New Zealand (Royal Australasian College of Surgeons 2015), demonstrates that bullying and harassment is common among surgeons and has a detrimental impact on patients. The Expert Advisory Group used a combination of surveys and qualitative methods (personal accounts) to address the issues. Key findings were:

- 49% of Fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment
- 54% of trainees and 45% of Fellows less than 10 years post-fellowship report being subjected to bullying
- 71% of hospitals reported discrimination, bullying or sexual harassment in their hospital in the last five years, with bullying the most frequently reported issue
- 39% of Fellows, trainees and international medical graduates report bullying, 18% report discrimination, 19% report workplace harassment and 7% sexual harassment
- the problems exist across all surgical specialties and
- senior surgeons and surgical consultants are reported as the primary source of these problems

Especially troubling is that there were some surgeons who did not believe that these problems exist. The researchers also acknowledge an important gap – they were not able to assess the views of those who had withdrawn from surgical training. Several themes emerged. There was strong sense that "known bullies are untouchable" and consensus that the worst offenders were a few people who wielded power. That accountability was not connected to behavior led to a perception of poor performance management in the workplace. Bullying was seen as intergenerational, with surgeons modelling their behavior on bad behaviors from previous generations. Especially significant was that bullying was part of a "**toxic culture**" in that it often affected whole surgical or workplace teams or units rather than being limited to individual surgeons. Hierarchical issues were critical and bystanders were often silent. Fear of reprisal or concern about positions were prominent.

They also found that gender inequity and lack of cultural diversity were both causes and effects of the culture.

Many senior and supervising surgeons were felt to lack interpersonal skills and to not value "soft" clinical skills such as team leadership. They often felt that not being critical is also "soft". In particular, they often seem to be in a conflict between being "a strong leader" and the expectations of collaboration and teamwork.

A major problem identified was fear of speaking up about the issues. Fear of reprisal, fear that those who speak up will be seen as "weak" or unsuitable for surgery, fear of career "suicide", lack of trust in the people who would handle complaints, and feeling that there

will be a lack of consequences for perpetrators were all identified as barriers to speaking up.

The report goes on to make several recommendations to the Royal Australasian College of Surgeons regarding cultural change and leadership, surgical education, and handling of complaints.

While the above study was specific to surgery in Australia and New Zealand, we have little doubt that a similar study in most countries would have similar findings. Our March 29, 2011 Patient Safety Tip of the Week "The Silent Treatment: A Dose of Reality" included many examples of failure to speak up, with similar barriers.

In an attempt to identify and improve behaviors that threaten team performance and patient safety a recent study (Nurudeen 2015) did "360 degree" evaluations of surgeons at 8 academically affiliated hospitals with a common Code of Excellence. Three hundred and eighty-five surgeons in a variety of specialties underwent 360-degree evaluations, with a median of 29 reviewers each. Beginning 6 months after evaluation, surgeons, department heads, and reviewers completed follow-up surveys evaluating accuracy of feedback, willingness to participate in repeat evaluations, and behavior change. They found that surgeons and department heads generally felt the feedback was accurate. 60% of the surgeons responding reported making changes to their practice based on the feedback. 70% of the reviewers thought the evaluation process was valuable though only 32% reported perceiving behavior change in the surgeons.

Forms of disrespect come from a variety of sources in healthcare. The most common ones arise from the hierarchical structure that still pervades our healthcare systems. But **"horizontal" or "lateral" violence/bullying/harassment** is also significant and nursing is a primary occupation at risk. This refers to harmful behavior demonstrated in the workplace by one employee to another who is in either an equal or lesser position. An excellent and well-referenced overview of lateral violence in nursing was done by Christie and Jones (Christie 2014). They note that lateral violence is most often directed at new nursing graduates, nurses new to the organization, and night shift nurses. While the behaviors may be overt, they are more likely "masked and subtle" and may be escalated even to the point that they become a "normal" part of culture on the unit. Victims suffer stress, sleep disturbances, negative self images, anxiety, physical disturbances and even suicidal behaviors. Ultimately they have low job satisfaction and may leave employment or even leave the nursing profession. It can lead to poor patient care and it can also become very costly for an organization due to absenteeism and increased staff turnover. Therefore, it needs to be recognized early and nipped in the bud. Approaches for organizations and individuals are discussed in the Christie article and another by Becher and Visovsky (Becher 2012).

The American Nurses Association has recently released a new position statement on incivility, bullying and workplace violence (American Nurses Association 2015), essentially calling for zero tolerance of these behaviors. That document is very well referenced and has links to a variety of useful tools. It emphasizes that incivility and

bullying may not only include actions taken but also actions not taken. It emphasizes the negative impact that incivility and bullying can have not only on target individuals but the whole organization, including patients and bystanders. Adverse effects may be physical, psychological, financial and social. It notes that incivility may include rudeness, gossiping, spreading rumors, refusing to assist a coworker, name calling, condescension, public criticism, and other actions. It also specifically warns about email and social media as vehicles for incivility and bullying. **Bullying** is defined as repeated unwanted actions intended to humiliate, offend, or cause distress in the target individual. It also describes workplace "**mobbing**" as a collective form of bullying (it even notes that sometimes the target of "mobbing" is actually an exceptional employee). It also has strong sections on workplace violence, which we'll save for a future column.

The ANA position statement goes on to outline the responsibilities of nurses and employers to establish a culture of respect, identify and track instances of incivility, bullying and workplace violence, and use evidence-based strategies to deal with the issues. For primary prevention all must be cognizant of their own actions taken and not taken and communication with others. RN's need to participate in development of relevant policies and procedures for dealing with these undesirable behaviors. One specific recommendation is that RN's should **establish an agreed-upon code word or signal to seek support when feeling threatened**. The document provides examples of actions that promote respect and professional demeanor.

Employers must ensure that employees have the opportunity to participate in development of relevant policies and procedures and must share the organization's commitment along with those policies and procedures with everyone in the organization. Employers must have a zero-tolerance policy regarding incivility and bullying and procedures that include reporting mechanisms, policies preventing retaliation, investigation protocols, use of neutral third parties, and ways of providing support, conflict resolution, and education.

The ANA document further describes steps and actions that a targeted individual should take when bullying or threatening behavior occurs and the roles witnesses must take.

And other sources of rudeness, incivility or disrespect may include hospital administration, patients and families, news media, and others. The Riskin study suggests that rudeness or other forms of disrespect may likely impact patient care regardless of source. It's therefore incumbent upon all of use to identify not just the overtly disruptive workers in healthcare but also those perpetrating the more subtle forms of disrespect and incivility.

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]"

References:

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American Nurses Association. Incivility, Bullying, and Workplace Violence. New Position Statement. Effective Date: July 22, 2015 http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html

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