Part II: Disrespectful behaviors
Their impact, why they arise and persist, and how to address them

In 2013, ISMP conducted a survey on bullying, incivility, intimidation, and other forms of disrespectful behavior that have run rampant in healthcare while many remain silent or make excuses to minimize the profound devastation that disrespectful behavior leaves in its wake. These behaviors range from overt acts of abuse and bad behavior to insidious actions so embedded in our culture that they seem normal— gossip, for example. Any behavior that influences the willingness of staff or patients to speak up or interact with an individual because he or she expects the encounter will be unpleasant or uncomfortable, fits the definition of disrespectful behavior.1 See Table 1 on our website (www.ismp.org/sc?id=352) for examples of disrespectful behavior.

In our October 3, 2013, issue of the newsletter (www.ismp.org/sc?id=342), we published the results of our survey (Part I), which clearly exposed healthcare’s continued tolerance of and indifference to disrespectful behavior. Despite more than a decade of emphasis on safety, little improvement has been made. Widespread disrespectful behaviors in healthcare persist unchecked and are found at all levels of the organization and among all disciplines of staff. The stubborn strength of this problem lies in its quiet ability to undermine critical conversations.1

In Part II, we delve into the impact of disrespectful behaviors, why they arise and persist, and how to address them.

Impact of disrespectful behaviors
Disrespectful behavior chills communication and collaboration, undercuts individual contributions to care, undermines staff morale, increases staff resignations and absenteeism, creates an unhealthy or hostile work environment, causes some to abandon their profession, and ultimately harms patients. These behaviors have been linked to adverse events, medical errors, compromises in patient safety, and even patient mortality.2,3 Disrespect causes the recipient to experience fear, anger, shame, confusion, uncertainty, isolation, self-doubt, depression, and a whole host of physical ailments such as insomnia, fatigue, nausea, and hypertension.2 These feelings diminish a person’s ability to think clearly, make sound judgments, and speak up regarding questions or concerns. Disrespectful behavior is also at the root of difficulties encountered in developing team-based approaches to improving care.4 Patient confidence has also been undermined by disrespectful behaviors, making patients less likely to ask questions or provide important information.

Why disrespectful behaviors arise
Disrespectful behaviors can arise in any healthcare setting, and both the stressful nature of the environment and human nature play roles in this destructive behavior. Human beings are wired for survival. We are driven to function in “survival” mode when forced to cope with difficult personal frustrations and system failures. Disrespectful behavior is often “survival” behavior gone awry.1 Although personal frustrations and system failures do not excuse disrespectful behavior, they often create a tipping point by which an individual is pushed over the edge into full-blown disrespectful behavior. Characteristics of the individual, such as insecurity, anxiety, depression, aggressiveness, and narcissism, can also kick in and serve as a form of self-protection against feelings of inadequacy.4 Cultural, generational, and gender biases, and current events influencing mood, attitude, and actions, also contribute to disrespectful behavior.3 Practitioner impairment, including substance abuse, mental illness, or personality disorder, is often at the root of highly disruptive behavior.1

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Solid controls needed for demo training devices. There's a new twist regarding the use of demo medication products and other devices used in simulation training for students and professionals in schools and health systems. The concerns we expressed previously centered on look-alike demo products found stored in patient care areas alongside actual medications, thus risking accidental administration. We wrote (November 28, 2013) about an incident where staff identified a misplaced carton of demonstration (demo) only emergency syringes of EPINEPHrine injection in one of their crash carts (Figure 1). More recently, we discussed a serious error where an EPINEPEN (EPINEPHrine) trainer device was used for treatment during a code (February 27, 2014). The patient did not regain consciousness. Last week we heard about a different issue with demo devices that's a major cause for additional concern. A university is reviewing its procedures after dozens of students in their medical assistant program injected each other with solution from vials of a Pocket Nurse Demo Dose product meant to resemble 0.9% sodium chloride injection (www.ismp.org/sc?id=341). The solution, labeled “Sodium Chloride Injection,” was not approved for human or animal use and was not sterile. About 30 students received an average of 10 injections over the past 2 semesters, and the solution tested positive for bacteria, according to news accounts. Fortunately, none of the students have developed health problems from the misuse. The vials were labeled for instructional use, not for injection, and the description “Demo Dose” also appeared on the package. Nevertheless, Pocket Nurse products are made to look like the real thing, so, as we have seen, unless their presence in classrooms is properly controlled, they can be misused. If your education department, simulation lab, or associated nursing school is using these or other demonstration products, their availability must be strictly limited to classroom use. Instructors should account for each demonstration product at the end of class to assure they don’t travel outside the room in someone’s pocket and later reach an area used to communicate proper use of demo products to all who use them when instructing students.

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Differences in communication styles and power dynamics can also play a role. For example, physicians may get frustrated when nurses present information in more detail than they believe is necessary. Nurses may get frustrated when physicians do not seem interested in the information provided. These differences in communication styles can lead to disrespectful behaviors. The hierarchical nature of healthcare and a sense of privilege and status can lead those at the top of a hierarchy to treat others lower on the hierarchy with disrespect. A sense of autonomy can also undermine passive disrespect, such as a resistance to collaborate with others or follow procedures that promote safety. Unfortunately, the victims of disrespectful behavior may feel they have no choice but to become perpetrators themselves. They don’t quite know how to get their arms around the problem, so they tolerate the behavior or simply join in.

Why disrespectful behaviors persist

Healthcare organizations have fed the problem of disrespectful behavior for years by ignoring it, thereby tacitly accepting such behaviors. The healthcare culture has permitted a certain degree of disrespect and “aggressive crudity” while considering this a normal style of communication. Studies have shown that disrespectful behaviors are tolerated most often in unfavorable work environments, but it is unclear whether poor working conditions create an environment where the behaviors are tolerated, or if the disrespectful behaviors create the unfavorable environment.

Organizations have largely failed to address disrespectful behavior for a variety of reasons. First, the behavior typically occurs daily but often goes unreported due to fear of retaliation and the stigma associated with “whistle blowing.” Disrespectful behaviors are difficult to measure, so without robust systems of environmental scanning to uncover the behavior, leaders may be ignorant of the problem. Leaders may also be unaware of the behavior if managers shield them from this information because they view it as a personal failure. If disrespectful behaviors are known, leaders may be reluctant to confront individuals if they are powerful or high-revenue producers, or they may not know how to handle the problem. It’s not a topic taught in training programs, so leaders may hesitate to take on a problem for which there is no obvious solution.

Regardless of the reasons for disrespectful behavior, none justify inaction. According to our 2013 survey, only a quarter of the respondents felt their organization dealt effectively with disrespectful behavior. The deep sense of frustration threaded through the comments from our survey respondents suggest that the time to act is now.

Addressing disrespectful behavior

1. Set the stage

Establish a steering committee of trustees, senior leaders, middle managers, physicians, pharmacists, nurses, and other staff. Have the committee educate itself about disrespectful behavior, define the behavior, list examples of the many forms it can take, and establish an action plan that specifies how to identify disrespectful behavior, respond to it, and measure the success of organizational efforts. Responsibility for addressing the problem belongs to the leaders, who need to raise awareness of the problem, inspire others to change, communicate respect as a core value, articulate their commitment to achieving it, and create a sense of urgency around doing so.

2. Establish a “no retribution” policy for those who report disrespectful behavior. This policy must be established at the very onset of organizational efforts to reduce disrespectful behaviors.

3. Open the dialogue about disrespectful behavior by surveying staff about the issue using surveys from ISMP (www.ismp.org/survey/disrespectful), the Agency for Healthcare Research and Quality (www.ismp.org/sc?id=343), or Rosenstein and O’Daniel as templates. Incorporate questions about disrespectful behaviors in safety rounds. Hold focus groups where frank discussions can be held with objective facilitators to keep the conversation productive. However uncomfortable, dialogue on this issue is crucial to the development of...
more effective and respectful ways of interacting with each other.

II. Establish a code of conduct
Create a code of conduct (or code of professionalism) that serves as a model of interdisciplinary collegial relationships (different but equal) and collaboration (mutual trust and respect that produces willing cooperation). Clearly articulate the standard of behavior desired as well as unacceptable behaviors—don’t assume staff know this, so be clear. Another crucial factor to consider—all staff must believe in the code of conduct. Addressing disrespectful behavior must start with an absolute belief by all staff that no one deserves to be treated with disrespect, even in the wake of an error. Furthermore, the code of conduct should not allow any exemptions. As long as those who generate the most revenue are excused from responsibility for their actions, the code of conduct will have little impact on anyone else’s behavior.

III. Establish a communication strategy
Establish a standard, assertive communication process for healthcare staff who must convey important information. Stating the problem along with its rationale and a potential solution can improve assertive communication. Numerous communication techniques are available to help staff accomplish this, including:

1. SBAR (www.ismp.org/sc?id=344): the person communicating the crucial information covers the Situation, Background, Assessment, and Recommendations
2. D-E-S-C script (www.ismp.org/sc?id=354): Describe in objective terms what you observed, heard, or perceived; Express concerns using “I” statements and non-judgmental terminology; Specify or inquire about an alternate course of action; discuss both positive and negative outcomes
3. TeamSTEPPS (http://teamstepps.ahrq.gov): Team Strategies and Tools to Enhance Performance and Patient Safety, an evidence-based teamwork system to improve communication and teamwork skills among healthcare professionals

A 2010 study also offers insight into the key skills used by nurses who have spoken up about typically undiscussable issues. The skills include explaining your positive intent and how you want to help both the caregiver and patient, using facts and data as much as possible to support your concern, avoiding frustration and anger, and other actions that are summarized in Table 2 on our website (www.ismp.org/sc?id=352). The study also found that these skills were not enough—it took extraordinary courage to speak up because the nurses often believed they were violating norms, accepted practice, and rules. The American Nurses Association offers Tip Cards: Bullying in the Workplace that identifies behaviors on one side and effective responses to the behavior on the other side.

IV. Manage conflicts
An escalation policy must be established to manage conflicts about the safety of an order when the standard communication process fails to resolve an issue (www.ismp.org/sc?id=346). Staff must know who to call to aid in getting a satisfactory resolution. Be sure the process provides an avenue for resolution outside the typical chain of command in case the conflict involves a subordinate and his/her supervisor. Following a Two Challenge Rule is one option. Used in highly reliable industries with excellent safety records, the rule requires communication of critical information twice to the same person. If there’s no resolution, the matter is automatically referred to at least one other person before a final decision is made. Another option is a tool from aviation, the Most Conservative Response Rule (MCRR). In the event of an impasse, this technique suggests that the involved staff accept the most conservative (and safest) option being considered. If a concern is not addressed, staff need a clear and immediate process to take the matter to another or refer it to a timely ad hoc group for peer review. If the patient’s condition requires immediate attention, a rapid response team can be called if available.

V. Establish interventions
Develop an intervention policy that has full leadership support to consistently address continued on page 4 — Behaviors
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disrespectful behaviors. An effective policy includes zero tolerance for disrespectful behaviors regardless of the offender’s standing in the organization, fairness to all parties, consistency in enforcement, a tiered response to infractions, a restorative process to help people change their behavior, and surveillance mechanisms. Levels of interventions might start with coaching and proceed to progressive discipline as warranted. The intervention policy should clearly articulate the behaviors or repeated behaviors that will be referred for disciplinary action, and how and when the disciplinary process will start. The focus of an intervention should be on building trust and holding staff accountable for making better behavioral choices. The importance of a prompt, predictable, and appropriate response to an alleged violation cannot be overemphasized. In all cases, those who report or cooperate in the investigation should be protected against retaliation.

The intervention policy should also require addressing any system issues that amplify and perpetuate the disrespectful behavior. Common system problems include issues that affect workloads, staffing, budgeting, education, communication, handoffs, physical hazards, and environmental stressors. Individual behaviors can also be altered through system improvements.

VI. Train staff
Provide mandatory hospital-wide education for all staff about the impact of disrespectful behavior and appropriate professional behavior as defined by the code of conduct. Provide skill-based training in communication methods, relationship building, business etiquette, behavioral techniques to confront and address disrespect, conflict resolution, assertiveness training, team training, and how to report disrespectful behaviors. Use role-playing, vignettes, or aggression scenarios to strengthen skills associated with assertive communication, conflict resolution, and interpersonal interactions. One health system provides leaders with a toolkit that includes talking points regarding the impact of disrespectful behavior, the code of conduct, definitions, surveys, communication/teammate guides, key articles and intranet resources, “no retribution” policy, and a letter from the chief executive officer outlining full leadership support.

VII. Encourage reporting/surveillance
Implement a confidential reporting/surveillance program for detecting disruptive behavior and measuring compliance with the code of conduct. A formal reporting program and an informal process for unwritten reports should be offered, and anyone who experiences or witnesses disruptive behavior should be encouraged to report the event. The “no retribution” policy for reporting should be well known to staff and/upload. Periodic updates should be provided to reporters about addressing disrespectful behaviors, but individual details should remain confidential.

No organization should assume that the absence of reports of disrespectful behavior means it is not occurring. Other means of surveillance to identify disrespectful behaviors should be employed, including feedback from patients and families, staff and patient surveys, focus groups, informal dialogue, peer and team evaluations, and making direct inquiries at routine intervals (e.g., during safety rounds). Surveys appear to be the most reliable surveillance tool.

VIII. Create a positive environment
Certain aspects of the workplace environment are key to combatting disrespect, including a fair and Just Culture, respectful management of serious adverse events, and transparency so staff feel safe talking about disrespectful behavior without fear of reprisal. Another factor is visible leadership commitment to a respectful culture, which requires leading by example. Leaders should set the tone with an attitude of mutual respect for the contributions of all staff, remain open to questions and new ideas, and reward outstanding examples of collaborative teamwork, respectful communication, and positive interpersonal skills. Using key communication tools such as email blasts, leaders can maintain an ongoing dialogue about respectful behaviors with the entire organization to help assure staff that leadership commitment to a respectful culture is not fleeting.

References appear in left column.