Bullying, Incivility, and Disruptive Behaviors in the Healthcare Setting: Identification, Impact, and Intervention

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SUMMARY • Bullying, incivility, and their associated disruptive behaviors are insidious and destructive forces with negative consequences that require identification and intervention at the individual and organizational level. Costs incurred secondary to these insensitive behaviors are substantial and involve matters of patient safety, absenteeism, turnover, turnover intentions, organizational commitment, and employee healthcare. Factors that increase the risk of hostile behaviors include changing hierarchies, conflicting loyalties, stress, and the state of the science. Each organization has the responsibility to develop processes for managing threatening and intimidating actions. New criteria are proposed to guide the implementation of successful programs.

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INTRODUCTION

Civility matters. Bullying, incivility, and their associated disruptive behaviors are insidious and destructive forces that have costly, negative consequences at the individual and organization level. The Joint Commission emphasizes the immediate obligation to address hostile behaviors in the Sentinel Event Alert “Behaviors that Undermine a Culture of Safety” (Joint Commission 2008). Organizations are now accountable for adherence to new standards and creation of a code of conduct that supports a safe work environment.

Individuals do not always come into organizations with a clear idea of what constitutes considerate conduct. Administrators are in a pivotal, powerful position to spearhead development of a code of conduct that clarifies appropriate behavioral norms for all professionals. Before any behavioral change can occur, a mutual understanding of what constitutes bullying, incivility, and their associated disruptive behaviors is essential.

CHARACTERISTICS OF INCIVILITY

Incivility is a lack of regard for others (Andersson and Wegner 2001) and has three identifiable characteristics. Incivility is:

• Psychological in nature;
• A form of low intensity, inconsiderate conduct; and
• Associated with an ambiguous intent to harm the target.

The question of intent to harm distinguishes incivility from bullying or other forms of aggressive behavior.

DISRUPTIVE BEHAVIORS ASSOCIATED WITH INCIVILITY

Disruptive behaviors associated with incivility include the following: rude comments, disrespectful verbal attacks, offensive or condescending language, lack of collaboration, disregard for interdisciplinary input about patient care, public criticism, subtle or overt verbal aggression, name calling, ethnic slurs or jokes, sexual comments, yelling, screaming, attacking a person’s integrity or professional reputation, patronizing others in any discipline and at any organization level, requesting input from others when decisions are already made, superficial listening, blaming team members when something goes wrong, blaming others in front of a patient or patient’s family member, lacking empathy, taking credit for someone else’s idea or work, and withholding important information (Table 1).

Incivility involves a violation of workplace norms that promote respectful, interpersonal interaction. When incivility prevails, considerate behavior becomes increasingly rare. Rather than speak out, professionals begin to quietly tolerate disruptive behaviors to avoid becoming the next target. In some instances, professionals who exhibit overly considerate behavior may actually run the risk of being singled out for ridicule or ostracized because they are not being “tough enough.” Support for professional behavior gradually disappears, curt behavior becomes acceptable, and the environment becomes increasingly toxic. Institutionally pervasive incivility spills over into interactions with patients and has been shown to have deleterious effects on patient safety (Rosenstein and O’Daniel 2005).
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Characteristics of Bullying

Bullying differs from incivility. Bullying goes beyond incivility and consists of the repetition of aggressive, deliberate, psychological, or physically disruptive behaviors that cause purposeful harm to another individual or group. Bullying has three identifiable characteristics. Bullying is (Lutgen-Sandvik, Tracy, and Alberts 2007):

• Repetitive behavior that occurs at a minimum of twice a week;
• Long-term behavior that continues for a minimum of six months; and
• Behavior that occurs in situations where the person(s) targeted find it difficult to defend themselves and halt the abuse.

Bullying occurs in situations where the bully has the advantage of real or perceived power over another person (Salin 2003). This type of power is held by administrators as well as other professionals.

Incivility, Bullying, and Disruptive Behaviors

Disruptive behaviors are associated with both incivility and bullying. When incivility and bullying are ignored, disruptive behaviors escalate and the intensity of these behaviors increases. Examples of escalating types of disruptive behaviors include: throwing objects, slamming down telephone receivers or cell phones, purposefully damaging equipment, using contaminated equipment on a patient, and unnecessarily exposing others to contaminated fluids. The potential for disruptive behavior associated with incivility to routinely progress to repetitive, disruptive bullying behavior is currently under study. Whether or not these types of behaviors occur on a continuum, they all have serious consequences.

Interdisciplinary and Horizontal Incivility and Bullying

Incivility and bullying both occur within and among disciplines and have critical consequences. Most verbal abuse involving nurses is instigated by physicians (Johnson, DeMass, and Marker-Elder 2007). When repetitive verbal assaults and intimidation escalate, this hostile behavior eventually interferes with delivery of patient care and results in unsafe clinical performance. In one study 70 percent of nurses reported they often or sometimes encountered condescending language or voice intonation and 23 percent reported personal encounters with strong verbal abuse by physicians/prescribers. In this same study 49 percent, or almost one-half of the respondents, stated that intimidation interfered with the manner in which they clarified medication orders or dispensed medication, or they actually administered medication despite concerns (Institute for Safe Medication Practices 2004). The consequences of this are alarming.

Bullying and incivility also are demonstrated by nurses toward nurses, which is called “horizontal violence.” The number of cases instigated by nurses is second in number to physician-perpetrated events. Early on, many nurses discover their peers have the power to consistently withhold precious procedural and educational information. Information about informal organizational mechanisms is often powerful and may be inaccurately communicated or
concealed to undermine colleagues. Continued verbal and non-verbal shunning is also a disruptive bullying behavior that eventually impacts retention. When newly hired or veteran nurses have an unusual amount of difficulty adjusting, a comprehensive evaluation includes an investigation for the presence of bullying, incivility, and associated disruptive behaviors in the workplace.

**Organizational Factors Affected by Incivility, Bullying, and Associated Disruptive Behaviors**

There is a financial cost to any system that consistently functions at a suboptimal level. The cost of incivility, bullying, and associated disruptive behaviors is evident in the following areas: turnover, turnover intentions, absenteeism, organizational commitment, patient safety, and employee healthcare. As previously discussed, incivility is pervasive and bullying prevalence rates are between 1 percent and 4 percent (Einarsen 2000). When incivility, bullying, and associated disruptive behaviors are ignored or not adequately addressed, the consequences are exponentially serious and expensive.

**Turnover and Turnover Intentions**

According to the U.S. Bureau of Labor Statistics, approximately 233,000 additional jobs will open for registered nurses each year through 2016, in addition to the 2.5 million existing positions (U.S. Bureau of Labor Statistics 2009). In an effort to fill these open positions, many agencies upgrade working conditions. Despite upgrades and additional incentives, incivility, bullying, and associated disruptive behaviors continue to plague healthcare settings. When these behaviors are present, turnover (Rosenstein and O’Daniel 2005) and turnover intentions increase (Donovan, Drasgow, and Munsen 1998; Maxfield et al 2005). Many nurses who would otherwise prefer to stay at the bedside flee from direct patient care to avoid workplace hostility.

The nursing profession still consists primarily of women, and as more opportunities become available, they are less likely to tolerate threatening behavior. Experienced nurses can open their own private practice as advanced practice nurses, return to school for a change of profession, work in alternate types of healthcare settings, or retire. Nurses report disruptive behavior as an important factor in job satisfaction and morale and 31 percent of nurses said they knew of at least one nurse who had left an organization as a result of it (Rosenstein and O’Daniel 2005). When turnover increases, agencies often end up recruiting inexperienced registered nurses and absorb the associated recruitment and orientation costs. Unless disruptive behaviors are dealt with, nurses arrive and then leave through a costly and constantly revolving door.

**Absenteeism**

Historically, absenteeism is also an issue when bullying exists (Barling and Phillips 1993). If changing jobs or careers is not an immediate, viable option, absenteeism serves as a substitute coping mechanism. Avoiding workplace aggression becomes both a practical decision and a means of self-protection from intimidation. Absenteeism may become morally acceptable to otherwise dependable nurses who are fearful and stressed because of bullying. When nurses are absent they are paid for sick time, and added costs associated with locating and reimbursing their replacements are incurred.
Decreased Organizational Commitment
Contending with a bully decreases organizational commitment (Barling and Phillips 1993; Leather et al 1997). In a competitive healthcare environment organizational commitment is a valuable commodity. When organizations sanction or ignore bullying behaviors, professionals lose confidence in their administrators and their organizational commitment declines. When dedication and commitment decline, the impetus for creativity and innovation is lost. For this reason, it is financially advantageous to develop a dynamic environment that is not conducive to bullying behaviors. In reality, it is financially unconscionable and irresponsible not to.

Patient Safety
The financial risks related to patient safety are high. In the presence of incivility, bullying, and disruptive behavior, safety issues surface constantly. In a nationwide survey of administrators, nurses, and physicians, between 53 percent and 75 percent of respondents reported a strong link between disruptive behaviors and the clinical outcomes of patient safety, errors, adverse events, and quality of care. Twenty-five percent of respondents reported a link between patient mortality and disruptive behaviors (Rosenstein and O’Daniel 2005). This same study reported that as many as 75 percent of administrators, 86 percent of nurses, and 50 percent of physicians had witnessed disruptive behavior exhibited by a physician. Disruptive behavior from a nurse was witnessed by 75 percent of administrators, 72 percent of nurses, and 47 percent of physicians. These results are indicative of the immediate need for a serious commitment to develop and implement comprehensive, interdisciplinary processes and programs to address this issue.

Employee Healthcare
Targets of workplace bullying endure their pain for an average of 22 months (Namie 2003). This is a long time, especially considering the financial and emotional costs to the institution. Bullying victims suffer from physiological and psychological symptoms (Mikkelsen and Einarsen 2002) that affect patient care. Insomnia with nightmares leads to sleep deprivation and impaired ability to focus on important patient-related details. Anxiety and depression alter concentration and irritability affects communication and interaction. Low self-esteem resulting from the abuse renders the bullying recipient susceptible to continued mistreatment. Targets of bullying can also develop post-traumatic stress that requires use of sick-time and psychiatric services. When post-traumatic stress is severe, some targets feel they will never function normally or return to work (Leymann 1996). As the financial cost of treatment increases, the financial burden is compounded by the loss of intelligent, highly talented professionals who exit dysfunctional organizations.

Organizational Factors that Facilitate Incivility, Bullying, and Disruptive Behaviors
Having a solid grasp of organizational conditions conducive to the emergence of bullying and disruptive behaviors is essential. Healthcare organizations consist of members of numerous disciplines, all of whom generally
understand the need for collaboration and some of whom also express themselves with less than civil behavior. Under certain circumstances, bullying and disruptive behaviors may emerge as pervasive and destructive forms of communication. Changing hierarchies, stress, the state of the science, and conflicting loyalties are factors that impact civility in the work environment.

**Changing Hierarchies**
Healthcare organizations have numerous hierarchies. These hierarchies consist of interdisciplinary groups of professionals with strong role identities and strong opinions. These professionals come with increasingly higher levels of education and the expectation that their clinical expertise and ability to synthesize vast amounts of information is valuable. When talented groups of professionals are successfully organized into functional teams, critical thinking occurs at a collaborative level and conflict, disruptive behavior, and bullying is minimized. However, collaboration becomes strained when professional groups vie for intellectual power and engage in turf disputes. Bullying becomes more common when divisively competitive, non-supportive work environments are left unattended.

**Stress and the State of the Science**
High levels of stress also complicate the environment. Healthcare organizations are unpredictable and evolve rapidly. The state of the science changes daily. Administrators are challenged to attain state-of-the-art resources and still be cost-effective contenders in a competitive market. In an unstable economy, the stress of uncertainty increases. As uncertainty and stress intensify, irritability surfaces. Attention to stress halts the progression of untoward behaviors and the subsequent spillover of these behaviors to the care of patients.

**Conflicting Loyalties**
Healthcare organizations are expected to be both consumer-oriented and fiscally responsible. Integration of financial accountability with patient and community centered goodwill is a crucial component of long-term organizational survival. Although the health, safety, and welfare of the patient should be the primary concern, healthcare professionals must simultaneously advocate for the patient, the welfare of the community, the healthcare institution, and their individual disciplines. This advocacy ideally results in interdisciplinary, collaborative, team efforts to solve problems, to analyze and synthesize information, and to define creative interventions.

However, when individual egos become involved, patient advocacy may not be strong enough to serve as a moderator. If any discipline loses commitment to the team, warring factions develop, progress is hindered, and the environment becomes a haven for disruptive and bullying behaviors that jeopardize patient safety (Rosenstein and O’Daniel 2005). When these inappropriate behaviors get out of hand, the organization can become a breeding ground for bullies. Individuals become bullies in response to being bullied and the problem escalates (Nathanson 1992).

**Practical Intervention Strategies**
Civility starts with commitment. Avoid avoidance. The Joint Commission (2008) recommends standards, a code of conduct, and action suggestions to prevent and eliminate behaviors that undermine a culture of safety. In addition to education
and accountability, The Joint Commission calls for development of a code of conduct and enforcement of a zero tolerance policy. One such policy originates from the American Association of Critical Care Nurses (AACN 2004; AACN 2005). The AACN standards include emphasis on authentic leadership, skilled communication, true collaboration, effective decision making, appropriate staffing that matches patient needs and nursing competencies, and meaningful recognition.

The AACN Standards for Establishing and Sustaining Healthy Work Environments are endorsed by the American College of Chest Physicians, American Thoracic Society, Society of Critical Care Medicine, Society of Hospital Medicine, American Nurses Association, Association of Nurses in AIDS Care, and the Emergency Nurses Association (AACN 2007).

These interdisciplinary endorsements are positive indicators that an increasingly civil healthcare environment is emerging. Each organization has the responsibility to develop and implement a process for managing disruptive and intimidating behaviors. There is minimal research or precedent to guide establishment of practical and successful programs of action. In light of the current lack of clear direction, the following criteria are proposed for program development:

- Workable programs must encourage buy-in by busy stakeholders across all disciplines.
- They are offered by committed individuals.
- These programs are amenable to quick, consistent presentation and sustainable over time.
- They include memorable reminders that are easily available to everyone throughout the system on a daily basis, such as a list of steps taught with acronyms to use when confronted with hostile behaviors.
- They are part of any orientation and reinforced as routinely as CPR training. They are, in fact, a type of CPR for the organization.
- Above all, they are soundly supported by strong and committed administrators at all levels.

There are tough challenges ahead for programs designed to eliminate disruptive behaviors that have been deeply and historically engrained in healthcare settings. Visionary programs created by innovative minds withstand these challenges and help cultivate more caring and considerate healthcare cultures.

Conclusions
Civility starts with commitment. When an organization becomes a civil place to work, patient needs are met and everyone benefits. The identification of characteristics associated with incivility and bullying entails the multidisciplinary education of all stakeholders. Once the definition of these behaviors is clear, programs can be developed that enhance the smooth and safe function of the organization. Creation of a civil working environment is everyone’s responsibility and is necessary to protect patient safety, cut the costs of hostile behaviors, and retain a healthy, experienced workforce. Successful programs are generally innovative, user friendly, concise, and comprehensive. Sustainable programs are not only implemented but reinforced on a routine basis. Well-established pro-
grams demonstrate that civility is a way of life that can be taught, internalized, and rewarded.

REFERENCES


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