Disruptive and Toxic Behaviors in Healthcare: Zero Tolerance, the Bottom Line, and What to Do About It

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In this economic downturn, healthcare leaders must attend to both the human- and bottom-line. Unfortunately, one significant problem affecting both—disruptive behaviors—has long been under the radar screen in healthcare. People who habitually exhibit these behaviors have been referred to in many ways: toxic, uncivil, and intimidating, to name a few. This article provides the results of the authors' research study of over 400 leaders and mitigation strategies for dealing with toxic, uncivil behaviors. In particular, it presents a three-point systems approach for intervention—one that is both proactive and reactive, and aligned with the new Joint Commission standards.

Key words: Disruptive; toxic; incivility.

This person does not share and wants to control all situations. She is one of the most difficult people that I have ever worked with; she shames, blames, and micromanages all aspects of the treatment. Only she can be right! She needs to be involved in everything. She belittles the team, undermines their delivery of care, points out all errors, and prevents others from learning and being accountable for their own performance.

From Kusy and Holloway's research study reported in *Toxic Workplace! Managing Toxic Personalities and Their Systems of Power.* San Francisco, CA: Jossey-Bass; 2009.

In this economic downturn, healthcare settings' attention to two bottom lines is critical—the human and the financial. Unfortunately, one significant problem affecting personal and financial costs has long been ignored: disruptive behaviors by healthcare personnel. People who habitually exhibit these behaviors have been referred to in many ways—toxic, uncivil, disruptive, and intimidating, to name a few. Our research study of over 400 leaders, 39% from healthcare organizations, revealed that 94% have had to deal with a toxic person at work.[1]

Shockingly, 25% of healthcare workers believe that disruptive behaviors are positively correlated with patient mortality, and 49% stated that intimidation by another practitioner resulted in misadministration of medication.[2] A 2004 survey by the American College of Physician Executives reported that 80% of doctors were disrespectful to staff, and a full one-third indicated that disruptive physician behaviors occurred on a weekly basis.[3] In their latest survey of 2100 physicians and nurses, a whopping 98% witnessed these problem behaviors.[4] And it's not just physicians and nurses. Researchers report abuse among many healthcare professionals—no one is immune![4]

These effects translate into miscommunication among team members, higher turnover, poor patient care, serious consequences in patient safety, and increased malpractice suits. The Joint Commission has mandated that effective January 1, 2009, all hospital organizations have policies and procedures in place that address disruptive and inappropriate behaviors among personnel.[5] The Joint Commission's action is the result of substantial

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research over the last decade that documents the insidious and serious effects of disruptive, toxic behaviors in healthcare cultures.

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Although there has been considerable attention given to the role of physicians as primary instigators of disruptive behaviors, they are not the only culprits. Felblinger has reported that "horizontal violence" of nurses against nurses is second only to physician-perpetrated events.[6] The Joint Commission's mandate is a clarion call for medical practices to design and implement strategies to create healthcare environments of respectful engagement that have zero tolerance for disruptive, uncivil, and intimidating behaviors by any professional. In this article, we will discuss first the characteristics of "disruptive" behaviors and their effects on healthcare culture, and then describe a systems model of intervention that addresses toxic and uncivil behaviors among staff.

DISRUPTIVE, TOXIC, UNCIVIL BEHAVIORS

Just what are disruptive, toxic, and uncivil behaviors? These types of behaviors have been studied in the management and social psychological literature for the last two decades and have been recognized as an increasing threat to workplace productivity, worker motivation, absenteeism, retention, and physical and emotional well being. Specific to healthcare research surveys, disruptive behaviors have included items such as yelling or raising one's voice, disrespectful interaction, abusive language, berating in front of peers and patients, condescension, insults, and abusive anger.[3] Our research found three primary types of toxic behaviors—Shaming, Passive Hostility, and Team Sabotage. Table 1 presents the specific behaviors that further describe these broad categories. As you can see from these descriptions, unlike sexual harassment or physical abuse, incivility is often more nuanced and is under the legal radar screen—making it considerably more difficult to manage and eliminate.

Table 1. Types of Toxic Behavior[1]

Shaming	Passive Hostility	Team Sabotage
Humiliates others	Distrusts opinions of others	Monitors team members' behaviors
Makes sarcastic remarks	Displays passive aggressive behavior	Meddles in teamwork
Takes pot-shots	Protects own territory	Uses authority to punish others
Points out the mistakes of others	Has difficulty accepting feedback	
	Is clueless that behaviors are toxic	

A HEALTHCARE CULTURE OF INCIVILITY

Much that has been written about verbal abuse and incivility is focused on the control or management of the instigator or the protection of the target. However, the proliferation of incivility is not just about a person acting disruptively; the proliferation of toxic behaviors is highly influenced by the organization's culture. The highly stressful environment of healthcare organizations is fertile ground for triggering disruptive and uncivil behaviors. The cultural shift from a paternalistic, physician-dominated culture to a team-based approach where *all members* are held accountable to the team has shifted staff's expectations and exercise of authority. Other economically driven pressures for production of billable hours and reimbursement constraints, and the short supply of some professionals, particularly nurses, have undermined the cohesion of teams. This shift in the delivery of care, power differentials within teams, and highly pressurized productivity demands give rise to short tempers, misaligned expectations, miscommunications, resentments, and power struggles among healthcare team members.

Because of their relative economic and positional power in healthcare systems, hospital administrators have largely tolerated physicians' verbal abuse and disruptive behaviors. Our research study[1] of leaders in organizations reported that toxic behaviors quickly spread within teams as a way to survive the verbal abuse and align with other members against the instigator. Ultimately, the widespread emotional negativity culminates in a hostile workplace that tolerates and facilitates the establishment of incivility as the norm. Thus any effective intervention plan must begin with a whole-system approach to combating the problem, not simply the reprimand and punishment procedures that have been typical of addressing egregious behavior in the past.

TOXIC ORGANIZATION CHANGE SYSTEM

The Joint Commission's call for a mandate to address professional incivility and disruptive behaviors of staff has challenged healthcare organizations to develop and implement policies and procedures to comply. Numerous approaches to the problem have been reported in the literature and range from targeted interventions with the instigator of the abuse to more comprehensive designs that address preventative education for leadership.[7] There has

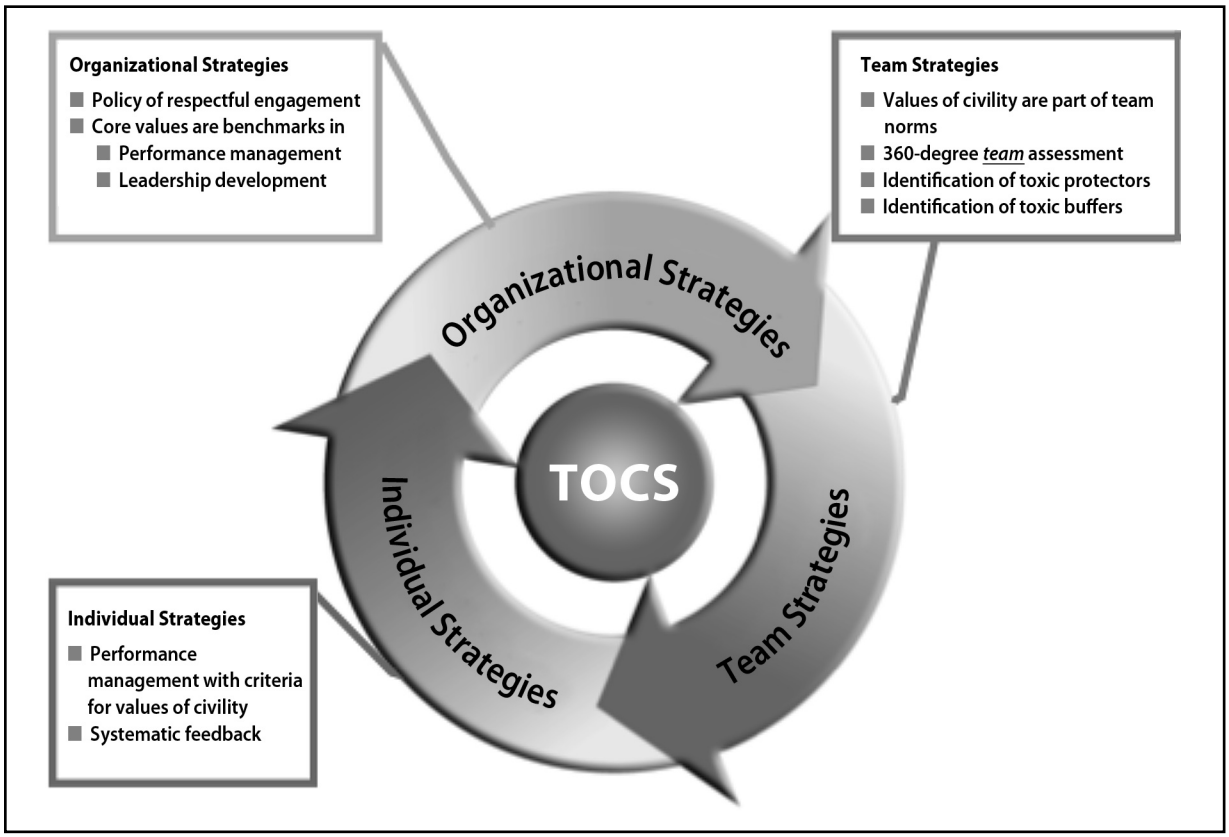

Figure 1. Toxic Organization Change System (TOCS) interventions.

yet to be reported a cohesive, systemic intervention plan based on the existing empirical literature that healthcare organizations might adopt. We have developed a systemic approach to disruptive behaviors that is particularly suited to the healthcare setting because of the complexity of healthcare delivery, issues of professional privilege, and the necessity for team collaboration.

Our cohesive model of intervention, the Toxic Organization Change System, tackles incivility at three levels of the organization—the organizational, the team, and the individual.

Our cohesive model of intervention, the Toxic Organization Change System (TOCS), tackles incivility at three levels of the organization—the organizational, the team, and the individual. At each level of intervention, there are specific strategies that can be employed both preventatively and remedially. The preventative strategies are developed with representative stakeholders and help to inoculate the organization from inadvertently facilitating toxic behaviors. On the remedial side, strategic interventions with instigators, targets, and teams are created after careful analysis of the system characteristics that have supported the behavior.

In summary, leaders using the TOCS model can identify areas that may be vulnerable to the proliferation of toxic behaviors and design strategies that coordinate their actions across policy, leadership education, performance management systems, and team-building. The program design will ultimately lead to a culture that honors civility and respectful engagement. This is a significant shift from the earlier and, unfortunately, still popular view of simply dealing with the "problem person" with warnings, reprimands, and coaching.

In this brief description of the TOCS model, we will present two primary strategies of intervention at each of the three levels of the organization (see Figure 1). (For a full description of preventative and remedial strategies of intervention see reference 1.)

ORGANIZATIONAL LEVEL STRATEGIES

At the organizational level, there are two primary strategies we recommend: first, the establishment of behaviorally specific values that address professional, courteous, and respectful behavior among staff and with patients; and second, the integration of these specific behaviorally defined values into the performance appraisal procedures.

It is critical that values be identified and defined using a "ground-up" strategy that brings together representative stakeholders from the organization. Values that

support respectful and courteous behaviors are created, defined, and illustrated with examples in a day-long retreat atmosphere using a "max-mix" process of engagement. The "max-mix" process has a "maximum mixture" of stakeholders from the entire organization, divided into what is commonly referred to as "max-mix" groups. For example, each max-mix group may consist of such individuals as a director, physician, nurse, patient advocate, and others as designated by the planning team.

We have heard many stories of values being created and reinforced by executive personnel without any involvement of those that are expected to adhere to them. These efforts typically result in both a lack of knowledge and compliance regardless of the worth of the values themselves. Staff involvement produces greater commitment, better results, and increased ownership. The values become a collective, "living" document that all members of the organization "sign-on to" when hired or at the point at which the values are disseminated.

Once the values of respect, courtesy, and civility are established by this process, they can be incorporated into the performance appraisal process. This step is critical to the successful reinforcement and enforcement of behaviors. We have seen several organizations give almost equal weight to those behaviors that reflect the values of the organization and the performance on task-specific criteria. Thus the Joint Commission's mandate should not simply be a mandate to monitor and reprimand, but a real opportunity to reward interpersonally effective behaviors that uphold codes of professional conduct and positive relational work. Leaders need to be educated on how to make the values a living part of the organization.

In summary, the specific steps to successfully implement these organizational strategies are: (1) develop concrete, behaviorally specific values of respectful engagement with representative stakeholders through a process of dialogue; (2) have members of the organization sign-on to the values; (3) integrate the values into the performance management system; (4) establish criteria related to the values that are given almost equal weight in performance appraisal; and (5) educate managers, directors, and other key leaders on the reinforcement and enforcement of the values both in summative and formative evaluations.

TEAM STRATEGIES

Our research corroborates the finding that it is not only the "toxic" instigator behaving badly, but also many team members who take on similar destructive behaviors to protect themselves to survive.[1,8] When no action is taken to terminate this escalation, the behaviors become a "normal" part of team functioning. In this section, we outline three primary intervention strategies that we have found to be particularly effective: (1) assessing the team functioning and identifying those individuals or processes that perpetuate the negative climate; (2) understanding "toxic protectors" and "toxic buffers"; and (3) rebuilding healthy team norms.

Team Assessment

We use the Campbell-Hallam Team Development Survey (TDS).[9] Essentially, the team receives evaluations from within the team through its team members, and from outside the team through individuals who have opportunities to observe the team as it works. The survey identifies team strengths and weaknesses to stimulate discussion about the most significant team issues-hence, its 360-degree *team* assessment format.

Important in the context of incivility is the opportunity for a facilitator to open up a dialogue about the best and worst of the team. Team members already know who is violating the civility norms, but they probably do not understand completely the impact of these behaviors on overall team functioning and each person's role in reinforcing these bad behaviors. This instrument does not measure toxicity. However, what it does, and does effectively, is to cull out the critical issues arresting team success that have been associated with workplace incivility.

Understanding Toxic Protectors and Toxic Buffers

In our research, we identified two team roles—*toxic protectors* and *toxic buffers*—that inadvertently perpetuate the power of the toxic behaviors. *Toxic protectors* are those individuals who protect the toxic individual because they have something to gain from the individual continuing to be tolerated by the team. The protector's special interests fall into three categories: special social relationships, productivity, and unique expertise.

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Toxic buffers differ from the protectors because their motivation is to protect the team from the toxic behaviors. They become interpreters for the toxic team leader and *soften the blow* of the message while making excuses for the leader's disruptive behavior.

Unfortunately, people in these roles only prolong the toxic situation by making it difficult for others who have the authority to take action to become aware of the problem. The research corroborates these effects. Pearson and Porath found bad behaviors have the following effects in organizations[10]:

- 12% of victims of toxic people quit;
- 48% decreased their work effort;

- 47% decreased time at work;
- 38% decreased work quality;
- 68% said their performance declined;
- 80% said they lost time worrying about it;
- 63% lost time avoiding the person; and
- 78% said their commitment to the organization declined.

We have found that this has a powerful effect on protectors and buffers as they see in "the numbers" the widespread effect on team collaboration, retention, and motivation. The intervention needs to be focused on giving the toxic protector and toxic buffer direct feedback on their roles in reinforcing toxic, uncivil behaviors.

Team Norms of Civility

The process of identifying and clarifying values is most successful when team leaders are able to depend on the organizational values that uphold a civil behavior. Assuming that the organization has identified concrete and behaviorally specific values, the leader then engages the team in how these apply to their work environments. When organizational values include explicit descriptions for respect within the organization as well as with clients and other key stakeholders, the team can build on this foundation to examine and create ways that the team lives these values. Team building around the value of respect helps prevent, or at least reduce, the probability that toxic behaviors will be tolerated and enabled.

Organizations that put their money where their mouths are engage in a 60-40 split at the performance review time where staff members receive their bonuses and reinforcement based on an almost equal distribution connected to both the task and the values work.

To translate the organizational values into team-oriented values, we suggest that the leader plan a team development session. Critical to the team-building process are the review of the organizational values and the translation of these values into behavioral norms. The team and each member should make a plan on how to keep the norms reinforced and a part of everyday functioning. We have received many creative ideas from our clients that range from giving e-mails of appreciation to handing out V.I.P. cards for acts of consideration and care within the team. On the other hand, acts of incivility need to be noted and addressed directly either by the target of the behavior or the team leader.

Individuals will have more courage to address the instigator when they know that the team as a whole has signed on to a "zero tolerance" policy for disruptive verbal behaviors. In circumstances where the organization has not promulgated formal procedures for handling disruptive behaviors, leaders can still begin work with their team to design these values. To start the process, leaders can engage the team in a values clarification process to identify values around civil engagement and translate these into the associated behavioral norms.

The key issues in any of these interventions are: (1) follow-up with specific consequences for any violations of the behavioral norms; and (2) leaders upholding these values in both their own and others' day-to-day operations. Team leaders should require that team values become part of the performance management process—both informally through conversations when team members see values abused or upheld, as well as formally by including them in such systems as annual goals. We suggest that the leader notify everyone that each staff member will be assessed on two criteria: the "real" work one has to do every day as part of their normal tasks, and the "values" work that reinforces the team norms. Staff members receive their bonuses based on both the task and the values work.

INDIVIDUAL STRATEGIES

The most common approach to solving problems of incivility is to give the instigator feedback. Our research discovered that feedback, as a sole strategy is largely ineffective.

Why? Because most toxic, uncivil persons are not aware that they are disruptive! But there is a way of giving them feedback when the other larger systems are in place on the organizational and team levels. A number of health management leadership programs include the delivery of feedback and conflict resolution as one part of their educational training. In some instances, if the instigator is receptive to feedback and has consistent and frequent follow-up evaluations, this strategy might work. The probability of it working will greatly increase if the person delivering the message has the authority to implement consequences for noncompliance and if the organization has strong policies and procedures dealing with incivility.

In the TOCS approach, we encourage team leaders to engage multiple assessors to provide feedback. Hearing from team members who work for the person and those to whom they report is equally important because some toxic persons are chameleons and display inappropriate behaviors only to those in less powerful positions—that is, in the vernacular, "kiss up and kick down."

Many reporting systems of incivility err by focusing solely on reporting problematic incidents of disruptive behavior. This has been a prevalent approach in the response to the Joint Commission's mandate and not surprisingly because traditional tools for reprimanding physician misconduct have been either an ineffectual reprimand or a severe litigious response. An appraisal system

that regularly gathers data from the key players will keep the leader better informed and the employee well aware of the quality of his or her own relations within the unit or team. In general, the following guidelines apply to performance appraisal processes:

- Collect feedback (by the appraiser) from key stakeholders.
- Set behaviorally specific objectives related to the behavioral change you're seeking from the toxic person.
- Set a time line for periodic review of the toxic individual's progress.
- Include the individual's self-designed professional goals for growth.
- Include behavioral criteria related to respectful engagement.

It's difficult to give feedback to highly productive and renowned physicians. Hicks and McCracken point out that appealing to their sense of personal ambition and competitiveness, and data-driven feedback can be effective.[11] Bauman also provides specifics on how and when to intervene with disruptive physician behaviors.[12] However, even with effective feedback approaches, change may not take place, and termination might become necessary. Such action becomes more viable when the organization's policies and procedures regarding disruptive behavior stipulate that performance appraisal must be done consistently, in writing, and filed. Because instigators generally have a pattern of abuse, having a record of incidences establishes a pattern of misconduct and adds weight to the grounds for termination. With the promulgation of the Joint Commission standards, healthcare leaders must be prepared to terminate employment of "star" healthcare providers who habitually flaunt their power to intimidate and humiliate others. Remember 12% of victims quit, 68% are less productive, and the costs of recruiting replacement staff range from 1.5 to 2.5 times the person's salary.

In summary, can individual interventions create sustainable change in toxic behaviors? Our response is a qualified yes, under these conditions:

- Interventions are conducted within an organization that has clear consequences for toxic behaviors—and team leaders, managers, or their top executives exhibit them.
- The performance appraisal system includes behaviorally specific criteria related to civility and respect.
- Consistent, systematic feedback includes the views of all relevant stakeholders and is individualized to the person's personal stake in change.

CONCLUSIONS

Although much has been written about the more serious types of personal impairment, such as alcoholism, mental illness, physical aggression, and sexual harassment, the toxic effects of incivility on the culture of healthcare are only now being unveiled. Incivility—backstabbing, gossip, angry outbursts, condescension, and sabotage—can quickly become the norm of operations and with it costly and sometimes fatal errors in patient care. It is now time to extend the same courtesy and respect among healthcare professionals and staff as is assumed for customers of healthcare. To create change from "cultures of toxicity" to "cultures of respect" a whole-system approach must be implemented. In this article, we have outlined strategies that work at all three levels of the organization—large-scale values development with all stakeholders represented, team assessment and norm building, and individualized feedback including criteria on interpersonal behavior. Now it's up to leadership to take action. It's in your court—or operating room, or executive suite, or nurse's station, or wherever your staff work. ■

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