Incivility in Healthcare – A Systems Approach

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The link between civility, workplace safety and patient care is not a new concept. The 2004 Institute of Medicine report, emphasised the importance of the work environment in which healthcare professionals provide care. [1] Workplace incivility that is expressed as bullying behaviour was reported by at least 1 in 5 respondents in the NHS Staff survey in 2018. [2] Almost half of these go unreported and that number seems to be falling.

Workplace bullying (also referred to as lateral or horizontal violence) is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms;

- Verbal abuse
- Threatening, intimidating or humiliating behaviours (including nonverbal)
- Work interference – sabotage – which prevents work from getting done

There are five recognised categories of workplace incivility

- Threat to professional status (public humiliation)
- Threat to personal standing (name calling, insults, teasing)
- Isolation (withholding information)
- Overwork (impossible deadlines)
- Destabilisation (failing to give credit where credit is due)

The results of the Race at Work 2018: The Scorecard Report 3 published one year after The McGregor- Smith Review: Race in the workplace found that 1:4 British black, Asian and minority ethnic (BAME) employees were reporting being exposed to incivility in the workplace across all sectors. The results highlighted that BAME people in the workplace were ambitious, but there was a lack of opportunity and a strong desire for opportunities that was not being fulfilled. This was a waste of talent, energy, enthusiasm and expertise. The UK workplace is still not considered a conducive environment for talking about race, hence propagating the culture of under-reporting. Workplace incivility can have devastating consequences for the individual, team morale and result in poor performance for the victim and the surrounding

team. The adverse impact on patient care is significant. By means of specific impacts resulting from bullying and harassment to staff health, sickness absence costs to the employer, employee turnover, diminished productivity, sickness presenteeism, compensation, litigation and industrial relations costs; conservative estimate of the cost to the taxpayer was £2.281 billion per annum in 2016-17. [4]

The causes of such incivility are manifold and include personal characteristics of the target or perpetrator but more often than not, there are institutional/ environmental factors that propagate such behaviours [5,6.] Particularly relevant to the healthcare sector are; "Boiler room" environments- typically in emergency departments, operating theatres and labour rooms; competitive, hard-driving cultural image of leaders as "movers and shakers' tend to under value employees opinions while driving 'targets', inspiring terror by abusing/ridiculing employees—a misguided but common notion of how to motivate trainees, disorganised, exploitive work environments. In addition where involvement is not facilitated, morale is low, teamwork is not encouraged, supervision is poor, worker role-conflict and strain; Although often difficult to quantify, most organisations where incivility is rife recognise 'cultures' that accept bullying as an aspect of doing business and authoritarian rather than participatory leadership styles as important factors.

How then should one tackle this in-civil behaviour in healthcare?

There is an increasing suite of policies and guidance for employers (line managers)[7] and confidential support offered to targets. Strict policies are implemented when in a small proportion of cases bullying is reported by human resource processes.

Most NHS Chief Executives would happily rally around a zero tolerance policy. However, there seems to be little improvement noted in recent surveys. There is a missing link and the answer perhaps is in organisational proactiveness to change a 'culture of bullying at a system level'. In a recent initiative undertaken jointly by Health Education England (HEE) and NHS Improvement, a series of confidential interviews with affected staff in a few pilot sites in England, found that a stressful, disorganised working environment, lack of mutual respect born of segregated working practices, fractious interactions, power imbalance, lack of social interactions or knowledge of each other's cultural differences, unmanageable work pressures due to rota gaps, culture of blame and fear of retaliation were some of the common themes.

The intervention included a facilitated Change Laboratory® methodology 8 for developing work practices by the practitioners. It facilitated both intensive, deep transformations and continuous incremental improvement. The team organised on the shop-floor, a room or space for analysing disturbances and for constructing new models for the work practice. The team worked closely with the participants to develop a charter of excellence and a journey of defined 'smart actions' to implement change. The change was led by internal champions who were entrusted to model excellent behaviours and call out deviations. More importantly, the members identified simple measures such as being referred to by first names, daily

introduction to the team, multi-professional shared responsibility, regular shared learning events, multi- professional handovers, daily safety huddles and reform of archaic working rotas to effect improvement.

Interestingly, none of the members identified individual perpetrators as the sole cause of the incivil working environment. For such a scheme to be successful a strong commitment was necessary from the senior leadership. It is important to acknowledge that it is more likely that organisational culture is responsible for supporting and propagating workforce incivility and therefore to be successful, institutions must invest in change from within. For success, one requires a true commitment from leaders and a safe space to develop charter for change.

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