Perspective: A Culture of Respect, Part 2: Creating a Culture of Respect

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Perspective: **A Culture of Respect, Part 2: Creating a Culture of Respect**

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Abstract

Creating a culture of respect is the essential first step in a health care organization's journey to becoming a safe, high-reliability organization that provides a supportive and nurturing environment and a workplace that enables staff to engage wholeheartedly in their work. A culture of respect requires that the institution develop effective methods for responding to episodes of disrespectful behavior while also initiating the cultural changes needed to prevent such episodes from occurring. Both responding to and preventing disrespect are major challenges for the organization's leader, who must create the preconditions for change, lead in establishing and enforcing policies, enable frontline worker engagement, and facilitate the creation of a safe learning environment.

When disrespectful behavior occurs, it must be addressed consistently and transparently. Central to an effective response is a code of conduct that establishes unequivocally the expectation that everyone is entitled to be treated with courtesy, honesty, respect, and dignity. The code must be enforced fairly through a clear and explicit process and applied consistently regardless of rank or station.

Creating a culture of respect requires action on many fronts: modeling respectful conduct; educating students, physicians, and nonphysicians on appropriate behavior; conducting performance evaluations to identify those in need of help; providing counseling and training when needed; and supporting frontline changes that increase the sense of fairness, transparency, collaboration, and individual responsibility.

Previously,[1] we called attention to the pervasiveness of disrespect in health care and identified six types of disrespectful behavior that constitute threats to the safety and well-being of patients and health care workers. At one extreme of disrespectful behavior is disruptive conduct, which is rare, but unfortunately all too familiar to doctors and nurses in most hospitals. At the other extreme, lesser forms of disrespectful treatment are so common and so intimately woven into the health care environment and everyday work that they are accepted as normal and often are not recognized as disrespect, per se. This systemic disrespect is manifest in long work hours, high workloads, physical hazards, and psychological intimidation that affect doctors, nurses, and all health care workers, increasing the likelihood that they will make errors that harm patients or themselves, and diminishing meaning and satisfaction in their daily work. For patients, systemic disrespectful treatment includes being made to wait for appointments, receiving patronizing and dismissive answers to questions, not being given full and honest disclosure when things go wrong, and not receiving the information they need to make informed decisions.

Although the origins of disrespectful behavior may reside in the personality characteristics of individuals and their responses to stressful environments, its expression is learned behavior, and it thrives in a culture that tolerates and supports disrespect. Eliminating disrespectful behavior in an organization thus requires transforming that organization's culture.

Cultural Transformation

Creating a culture of respect in health care is part of the larger challenge of creating a culture of safety. Studies of safe organizations reveal certain common cultural characteristics[2-4]: shared core values of transparency, accountability, and mutual respect. In these organizations, safety is an organizational priority shared by all. Safe organizations are "learning organizations"[5] that build shared visions, use systems thinking, and respond to untoward events as opportunities for improvement rather than with denial and cover-up. They achieve high levels of mutual trust, collaboration, and accountability, both personal and institutional.

Respect is core to all of these behaviors. A culture of respect is a "precondition" for the changes needed to make health care safe. As noted, collaboration and teamwork are at the heart of successful implementation of safe practices. Without mutual respect and a sense of common purpose, people cannot and will not work effectively together.

Many of these characteristics are embodied in so-called "high-reliability organizations" (HROs), which have been proposed as a model for health care.[4,6,7] These are organizations that have succeeded in becoming extremely safe despite working in highly hazardous industries, such as aviation and nuclear power. Recently, Chassin and Loeb[8] reinforced earlier calls for health care organizations to adopt this model and identified three distinctive features of an HRO: "collective mindfulness," powerful tools to eliminate unsafe processes, and presence of a safety culture. Collective mindfulness is described by Weick et al[7]

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as the condition in which everyone understands that even small failures can lead to catastrophic outcomes and accepts both individual and group responsibility for identifying hazards early and correcting them before harm occurs.

One of the leading students of HROs, Karlene Roberts, emphasizes that relational aspects of organizational cultures account for HROs' successes: interpersonal responsibility, person-centeredness, being supportive of coworkers, friendliness, openness in personal relations, creativity, credibility, interpersonal trust, and resiliency.[4,9] Respect is at the heart of these relationships.

We propose that creating a culture of respect is the essential first step in the journey to becoming a safe, high-reliability organization and will require transformation on several fronts. It should begin in medical school. Students need to learn about respect as a cornerstone of ethical professional behavior, and they should practice respect by working in teams with other professionals, such as nurses and pharmacists.[10] Both preclinical and clinical faculty must be held to standards of respectful treatment of students, trainees, and colleagues. Evidence of respectful behavior should be a job requirement for all leadership positions.

Because they are responsible for the continuum of undergraduate and graduate medical education, medical school deans have a vital interest in the learning environment in the hospitals and clinics where clinical medical education takes place. Therefore, ensuring safe and humane hospital working conditions and respectful treatment of students and residents by faculty are legitimate concerns of deans and their leadership teams.

However, the major responsibility for addressing these problems in the clinical environment belongs to the hospital chief executive officer (CEO). Creating a culture of respect requires that the institution develop effective means of responding to episodes of disrespectful behavior while simultaneously developing a supportive, mindful, and responsible culture that prevents such episodes from occurring. Both are substantial challenges to leadership.

A Leadership Challenge

The responsibility for creating a culture of respect falls on the organization's leader because only he or she can set the tone and initiate the processes that will lead to change. We believe the CEO has five major tasks: (1) to motivate and inspire, (2) to establish preconditions for a culture of respect, (3) to lead the establishment of policies regarding disrespectful behavior, (4) to facilitate frontline worker engagement, and (5) to create a learning environment for residents and students.

Motivate and inspire

The initial task in changing culture is to create awareness of the problem to motivate others to take action, and to create a sense of urgency around doing so.[11] As behavioral theorists point out, a prerequisite for changing behavior is perceiving the need to change.[12] Our previous article[1] marshals arguments that can be used as a resource for that purpose. Even more powerful are local data, such as an institutional survey of nurses, residents, and others, which can reveal the extent of disrespectful treatment in a specific setting and which, in turn, can command immediate attention from all.

Next, the CEO must communicate the vision that mutual respect must become a core value for the institution and articulate his or her commitment to achieving it. All leaders, including department heads, division chiefs, and unit managers, will need to commit to this vision. A leader's commitment and enthusiasm are infectious, set the tone for the institution, and serve as powerful motivators. An end point of the process of motivating change might be reformulation of the institution's vision and mission statements.

Establish preconditions for a culture of respect

Staff are more likely to treat others with respect if they are treated with respect. Leaders must demonstrate concern for the safety and well-being of faculty and staff. Early on, the CEO should initiate a process of assessing and revising the policies and practices affecting work hours and workloads for residents, physicians, nurses, and all workers. Attention should also be directed to mitigating physical hazards, such as needlesticks and back strain. Leaders' actions in these areas send a powerful message of respect that enhances employee morale and engagement.

During this phase, top leadership may engage in early discussions about how to implement former Alcoa CEO Paul O'Neill's preconditions for a culture of respect: enabling every worker to feel he or she is treated with respect, has the support he or she needs to do his or her job, and is appreciated.[13] Just putting these issues on the agenda sets the proper tone and demonstrates commitment to the stated vision.

Lead the establishment of policies regarding disrespectful behavior

In addition to articulating respect as a core value that supports the institutional mission, setting expectations for behavior is important in effecting change. This usually takes the form of a code of conduct, which should apply to all members of the community, not just professionals. Intrinsic to such a code is an individual's assumption of responsibility for his or her actions and interactions with others. Mutual respect, regardless of rank, station, or status, must be the explicit expectation. Because of the importance of a code of conduct in documenting expected behaviors, we provide recommendations for developing and implementing such a document in some detail below.

Facilitate engagement of frontline workers

Although a code of conduct and well-thought-out mechanisms for enforcement are essential first steps, creating a culture of respect requires much more. Organizational leaders need to address the systemic issues that cause and promote disrespectful behavior—a hierarchical system of control and a host of clinical and environmental stressors, among others. They need to prevent disrespectful behavior by eliminating its causes. We offer recommendations for approaching these issues below. The CEO's responsibility is to support these activities, remove barriers to achieving them, and maintain a sense of urgency and progress toward the stated mission.

Create a learning environment

Medical students too often suffer demeaning experiences at the hands of supervising faculty and residents. Because students and residents learn by emulating their teachers, disrespectful behavior of the faculty not only creates but also perpetuates a hostile environment. This must change. Both the CEO of the teaching hospital and the dean of the medical school have a responsibility to motivate their department chairs and other leaders to

> create learning cultures that emphasize patient safety, model professionalism, enhance collaborative behavior, encourage transparency, and value the individual learner. They should work to eliminate hierarchical authority gradients that intimidate others, emphasize that professionalism means, among other things, demonstrating mutual respect and non-tolerance for abusive or demeaning behaviors … (they) should declare and enforce a zero tolerance policy for confirmed egregious disrespectful or abusive behaviors…. Every teacher must be the kind of physician we want our students to become.[10]

Because many clinical faculty have not been trained in or exposed to these concepts, hospital and medical school leaders need to develop training programs for their faculty in basic safety skills: systems thinking, systems redesign, collaboration, and respectful conduct.

Responding to Disrespectful Behavior: Codes of Conduct

At its founding, in 1847, the American Medical Association (AMA) established a code of ethics, exhorting physicians, among other things "to be temperate in all things."[14] Subsequently, it has specifically recommended that medical staff by-laws include a code of conduct to address disruptive conduct.[15] The AMA defines disruptive conduct as "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care."[16] The code-of-conduct recommendation includes details of an appropriate process for managing disruptive behavior.[15] In addition, the Joint Commission requires hospitals to have a process for managing disruptive behavior.[17] Since these recommendations and requirements have been issued, essentially all hospitals have developed codes of conduct.

Unfortunately, the quality of these codes and their enforcement vary considerably. Hospitals that are serious about creating a culture of respect must ensure that their codes are explicit and consistently enforced. A proper code reflects the organization's vision and values and is, therefore, a powerful statement of "who we are." The whole community must be involved in the development process: both those who will be affected by the code and those who will be responsible for its implementation. Successful codes are usually the product of an iterative and transparent process, championed by leaders throughout the organization.

Codes are not just about preventing disruptive conduct. The purpose of a code is to establish the expectations of the institution and its community in the whole realm of personal interactions. It is the standard against which behavior will be judged; therefore, the language must be clear and unambiguous. The core institutional value is that everyone is entitled to be treated with courtesy, honesty, respect, and dignity.

Some institutions have framed behavioral expectations as a compact, articulating what it is that each party—institution and participant—expects from the other.[18] These expectations include the responsibility of the institution to provide an environment that facilitates courtesy and respect.

Appropriate conduct should be defined explicitly—both in terms of expected behaviors (a credo) and unacceptable behaviors (boundaries). Defining activities that violate the institution's core values provides clarification and avoids ambiguity. When such clear guidelines are publicized widely, violators cannot hide under the cover of ignorance (e.g., "nobody told me"). An example of such guidelines is shown in List 1.[19]

List 1
Examples of Disruptive Behavior

Inappropriate words

- Profane, disrespectful, insulting, demeaning, or abusive language
- Shaming others for negative outcomes
- Demeaning comments or intimidation
- Inappropriate arguments with patients, family members, staff, or other care providers
- Rudeness
- Boundary violations with patients, family members, staff, or other care providers
- Gratuitous negative comments about another physician's care
- Passing severe judgment or censuring colleagues or staff in front of patients, visitors, or other staff
- Outbursts of anger
- Behavior that others would describe as bullying
- Insensitive comments about the patient's medical condition, appearance, situation
- Jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance, or socioeconomic or educational status

Inappropriate actions/inaction

- Throwing or breaking things
- Refusal to comply with known and generally accepted practice standards such that the refusal inhibits staff or other care providers from delivering quality care
- Use or threat of unwarranted physical force with patients, family members, staff, or other care providers
- Repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available
- Repeated and unjustified complaints about a colleague
- Not working collaboratively or cooperatively with others
- Creating rigid or inflexible barriers to requests for assistance/cooperation

Source: College of Physicians and Surgeons of Ontario, Ontario Hospital Association. Guidebook for Managing Disruptive Physician Behavior. Toronto, Ontario, Canada: College of Physicians and Surgeons of Ontario; 2008. Reprinted with permission.

In addition to a general code of conduct that applies to everyone, hospitals often find it advantageous to have specific codes for particular populations, such as physicians, nurses, and students. A professional code for physicians, for example, might specify in some detail unacceptable words and types of conduct—for example, profanity, demeaning comments or intimidation, boundary violations, outbursts of anger, bullying, throwing or breaking things, and using threats of physical force, as well as failing to respond to calls for help or refusal to follow required safe practices.

Once developed, the code should be disseminated widely through required educational programs to ensure universal understanding and support of the code's details. A key point is that every individual is responsible for his or her own respectful conduct and for confronting or reporting others who violate the code. Acceptance of the code—by written attestation—should be part of the hiring, credentialing, and recredentialing process for all professionals and employees.

Implementation

A code is only effective if it is supported at the highest levels of the institution,[20] which requires that leaders not only publicly endorse and enforce the code but also model recommended behaviors. A code of conduct from which some are exempt, or which leadership is unwilling to enforce, undermines the sense of shared responsibility. As long as the faculty member who brings in the most grant dollars, the surgeon with the largest volume, or the resident who is the relative of a senior faculty member is excused from responsibility for his or her actions, no statement of values or code of conduct will have credibility for the community at large or have much effect on conduct.

The best way to avoid these issues is to have a clear, explicit, well-understood mechanism for processing complaints and to respond consistently when violations occur. Fairness requires an official, transparent response that offers the accused the opportunity to explore the facts and the various elements that underlie the behavior. Such a process also opens up the possibility of exoneration, without which the innocent may be convicted by the rumor mill that exists in every organization.

The importance of a prompt, predictable, and appropriate response to an alleged violation cannot be overemphasized. The Ontario Guidebook includes the caution, "Intolerance of unprofessional behavior does not mean that punitive action is required. It does mean that some action is required."[19]

Guidelines for managing disruptive physician behavior have been published by various organizations. Guidelines from the AMA,[15] Vanderbilt University School of Medicine[20], and the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association[19] are worthy of emulation. Box 1 shows common essential characteristics of effective policies that we have identified in these guidelines.

Reporting

As with all other safety reporting systems, to be successful, the process for reporting behavioral complaints must be safe, simple, and productive.[21] Reporting has to be easy for victims, who must be protected from personal or professional repercussions. The major barrier to reporting is the fear of retaliation. Therefore, the process and the safeguards must be widely known and respected; confidentiality is essential. Including an ombudsperson in the process may be useful.

The process for reporting should be specified in detail, including the items to be reported and to whom the report should be made. Reports should include the name of the reporter, the name of the person whose conduct is in question, the date and time of the incident, a description of the incident, and the names of any witnesses. If incidents are to be pursued and addressed and if disciplinary action is contemplated, providing anonymity to the reporter may not be possible, because the person being reported is entitled to know the details of any charge, and the person doing the investigation needs to be able to consult both sides.

How the institution responds to complaints is exceedingly important. Reporting systems work only if personnel perceive that complaints are taken seriously. The complainant should receive a report about follow-up action. More important, the hospital must

Box 1
Characteristics of Effective Policies for Managing Disruptive Behavior

Fairness: The process for responding to breaches of the code of conduct must be perceived by all parties to be fair. Achieving fairness requires first that in the code development process all parties who will be affected are represented. Next, the process for responding to violations should be spelled out clearly and explicitly and disseminated to all. The policy should include a clear plan for progression of the review and disciplinary policy, if needed, as well as the consequences for failure to adhere. The document should include a clear statement that the policy applies to all, regardless of seniority or position. Notifying all to whom the code will apply that it has been adopted is important.

Consistency: The program of enforcement must be responsive to all complaints, large or small. Serious complaints must be investigated, and the subject must be informed of the complaint. Leadership commitment is required to overcome natural tendencies not to report or take action against a high-status individual or one whose departure, if necessary, would be damaging to the institution's reputation or income.

Graded response: The response to a complaint must be proportional to the nature of the incident. For a single, relatively minor infraction, an informal conversation initiated by a trusted peer may suffice. More egregious episodes or patterns of offensive conduct require a more formal approach. The policy must clearly define the process: Who is responsible for a contingency of actions for each level of staff? Under which circumstances and when is an investigation indicated? What are the criteria for advancing the response to a higher level?

Restorative process: The goal of the process should be to enable the individual to change his or her behavior and continue as a member of the health care community. Plans for remediation must be explicit, with clear markers, deadlines, and methods of monitoring. Disciplinary action should be reserved for those who are refractory to improvement or whose behavior is so outrageous as to constitute a threat to patient or worker safety. There are national programs to treat individuals who exhibit repeated disruptive behavior. Some of these are residential and are used by health institutions across the country.

Surveillance mechanisms: Without effective mechanisms for identifying individuals with problems, policies are meaningless. In addition to safe reporting of inappropriate behavior, surveillance should be proactive, such as the use of "360-degree" evaluations, to identify problems early.

publicize the response to the institutional community (while protecting privacy by referring to the case in the abstract without mentioning names). By making these actions known, the institution demonstrates its commitment and accountability and draws a clear line between acceptable behavior and behavior that is not tolerated.

The Guidebook for Managing Disruptive Physician Behavior of the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association provides an example of a complaints procedure.[19] (Appendix C)

Prevention of disrespect

Although having effective policies and procedures to deal with disruptive behavior is essential, the goal is to prevent such conduct. In its behavioral guidelines, the Joint Commission suggests that hospitals not just develop and implement codes of conduct but also take other actions to reduce intimidating behavior.[17] These include educating physicians and nonphysicians on appropriate professional behavior and holding everyone accountable for modeling desirable behaviors. In an HRO, every individual feels personally accountable for his or her own and colleagues' behavior, collaborates to anticipate and prevent errors, and commits to not tolerate disrespectful conduct.

Performance evaluations. A principle of medical professionalism is that physicians take responsibility for their peers.[22] However, in practice, physicians rarely do so spontaneously. Instead of relying on peers or complaints to identify those in need of help, routine evaluation for professional behavior as part of an annual, formal process (e.g., "360-degree" evaluations) can effectively identify individuals who exhibit disrespectful behavior. Evaluating everyone—not just suspected "bad apples"—ensures fairness and frames the evaluation as a tool for quality improvement rather than discipline. Appropriately performed, these "early warning" systems can provide valuable information about interaction and communication problems, enabling leaders to address them before they escalate to disruptive or disagreeable conduct that requires disciplinary action. Behaviors that may be uncovered are listed in the Ontario Guidebook.[19] Examples include failing to be on time for meetings and attend to duties, inappropriate dress or conduct, failure to show respect for coworkers or patients, blaming others for work or personal problems, and emotional reference to personal upset over recent events in the workplace or personal life.

Culture change. The work of prevention requires much more than early detection of problems—It requires a change in the institution's culture, which requires numerous individual changes made in daily routines by frontline workers. These workers need support and encouragement. The challenges are formidable: creating transparency, breaking down authoritarianism while maintaining accountability, learning to work in teams, creating an environment in which change is safe, cultivating a "just culture" in which individuals are not punished for making errors but are held accountable for following safe practices,[23] and making respect the core of everyone's identity ("who we are").

Changes of this magnitude in our complex health care systems require receptivity to a wide range of approaches. Most powerful are interventions that build on inherent strengths, such as appreciative inquiry (AI), which is based on the understanding that "organizations are socially constructed and generate the contexts in which people act and interact to create new realities through learning and innovation."[24] Interaction among clinicians is critical to how they respond to new policies and to how they are adopted. Instead of fixating on what is wrong and how to fix it—which stimulates fear, shame, defensiveness, and false expectations—AI focuses on what is right, what is working, and how to have more of it. Thus, expectations and behavior organize around a core perception of capability and hopefulness rather than deficit.[25] AI has also been used successfully for teaching professionalism to medical students.[25,26]

The pairing of positive and negative approaches is crucial. An official response to disruptive behavior affirms the commitment of the organization to respect, transparency, and fairness. An organization that offers no official and transparent response to disruptive behavior quickly loses its moral authority, degrading any opportunity for emphasizing strengths and positive features to bring about culture change.

Cultivating a Culture of Respect

Disrespectful behavior is at the core of the dysfunctional culture prevalent in health care systems. It is a "root cause" of the difficulties encountered in developing team-based approaches to improving patient safety and implementing safe practices. The most extreme forms of disrespect—disruptive and humiliating behaviors—induce errors. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfillment in work for many types of health care workers. Being treated disrespectfully is devastating for patients. The time has come for health care organizations to do something about this invidious problem and cultivate a culture of respect.

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