

Incivility and disrespect as a workplace hazard: a new framework from occupational health and safety



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Disrespectful behaviour of physicians is increasingly recognized as a significant problem in health care, contributing to a dysfunctional culture, decreased staff well-being, and compromised patient safety. Regulatory approaches frequently focus on individual actions or conduct, treating such behaviour as isolated issues rather than hazards in the workplace. Such approaches are long and slow and fail to address the broader systemic impacts of incivility and disrespect. We advocate reframing incivility and disrespectful behaviours as workplace hazards, drawing heavily from the workplace-specific principles of occupational health and safety (OHS). This approach would encompass accurate detection of harmful behaviours; root cause analyses of workplace conditions that perpetuate incivility; and a hierarchy of interventions. Successful implementation of this paradigm shift would require few changes to regulatory statutes and would signify recognition of physician-oriented OHS concerns. Implementation would draw on existing foundational approaches, including just culture, patient safety, and continuous quality improvement. The Psychosocial Hazards Manifesto is a call to action for all of us to incorporate an OHS lens that recognizes the workplace context, as well as the obligations of both employers and physicians to address such hazards. It will also support effective assessment strategies and a robust tiered intervention approach.

KEY WORDS: disrespect, incivility, physician, psychosocial hazards, occupational health and safety

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Disrespectful physician behaviour is proposed as a core underlying factor in the dysfunctional culture in health care and a significant contributor to the limited progress in patient safety.¹ It is also linked to decreased well-being and increased stress and burnout among health care providers and physicians.^{2,3} Most interventions have failed to focus on systemic factors in addressing disrespectful behaviour in favour of individual skills-based interventions.⁴

We have overlooked an established approach to addressing incivility and disrespect — one that is simultaneously systems-driven and locally directed. Occupational health and safety (OHS) provides a unique conceptualization of incivility and disrespectful behaviours, which are regarded as *psychosocial hazards in the workplace*. An OHS perspective would enable more systematic approaches to prevent, address, and manage disrespectful behaviours in the local workplace of physicians. It would offer proactive bench-strength to complement disciplinary and regulatory measures through the inclusion of additional legislation, regulations, and policies.

Furthermore, we contend that physicians have a workplace, and disrespect and incivility are workplace hazards. Physicians are workers in need of protection and mitigation of such hazards. Our purpose is to change to a more nuanced consideration of interventions to address physician incivility and disrespectful behaviours.

How do existing regulatory and disciplinary solutions operate?

Ontario's *Public Hospitals Act* defines the governance role of the Board of Directors and the Medical Advisory Committee (MAC). The MAC is responsible for recommending to the Board of Directors the annual appointment of physicians' medical staff privileges. Where "incompetence, negligence or misconduct" is determined, the board has the authority to suspend or revoke privileges.⁵ Recent cases have documented how the MAC intervened because of a physician's documented use of fear and intimidation in interactions with colleagues; a physician's inability to



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collaborate with other staff, which presented a risk to the delivery of safe patient care; and a physician's inability to maintain civil interactions with other health care professionals.^{6,7}

In these cases, regulatory solutions took 15 years to achieve, and both physicians filed a series of false and inaccurate counter-complaints against their colleagues, including complaints to the College of Physicians and Surgeons of Ontario and the Human Rights Tribunal of Ontario.

An alternative regulatory approach involves the use of inspectors to bring about awareness and action. At one hospital, a group of anonymous physicians hired legal counsel to submit a claim of unprofessional behaviour by hospital administration, which prompted the Minister of Health to appoint an inspector to conduct a review. The subsequent report⁸ included recommendations, which the hospital's Board of Directors stated would require leadership to implement. At another hospital, inspections stemmed from the Ministry of Labour following staff safety incidents, which then linked staff safety and patient safety. In this case, hospital administration was compelled to address the safety issue from an organization-wide approach.⁹

Does this effectively address incivility and disrespect?

Such investigations result in physicians losing their licenses and reports being written. However, accountability often rests with the Board of Directors. Few are willing to nudge leaders (i.e., gently force compliance) to implement the recommendations. Also, given the lengthy timelines, aggrieved physicians have often left the organizations before resolution and likely do not experience any benefits.

We contend that there are three fundamental issues with these approaches. First, they fail to recognize the widespread impact of incivility and disrespect in a workplace. Often, the perpetrator or respondent is referred to as a "rotten apple." However, rotten apples spread problems and directly impact all those around them. A rotten apple emits a gas, which sets off a chain reaction that results in rotting the other apples.¹⁰ Just as one rotten apple can spoil a barrel, a workplace can be impacted by only a few people.



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Second, the approaches are ill-fitted to address disrespect and incivility; in fact, some might call them sledgehammer approaches. Sledgehammers are used for demolition, not reparations or improvements. A tiered approach to interventions is often described, but this has not truly been applied at the organizational level.⁴ Key suggestions for additional strategies have been cited in inspector reports following investigations.⁸ For example, addressing issues locally by minimizing formality and focusing on de-escalation; employing a third-party arbitrator to oversee individual complaints; and implementing “just culture,” a system-wide orientation based on the goal of optimizing safety through effective learning systems.¹¹

Third, the root causes of disrespect and incivility are not addressed. In cases reviewed previously, colleagues spoke of how the physician’s ongoing behaviour created a lack of trust and collegiality among their colleagues and adversely affected their ability to provide safe patient care.⁶ Nurses feared having to inform the physician of mistakes, because the physician would then make derogatory comments about staff.⁷ The two investigation case examples (both Ministry of Health and Ministry of Labour) revealed that fear of retaliation or punishment for speaking up was commonplace among physicians and staff.^{9,12} Essentially, there was a cited lack of psychological safety.¹³

Time for a paradigm shift: the Psychosocial Hazards Manifesto

We propose conceptualizing incivility and disrespectful actions as psychosocial hazards in the workplace. In doing so, we seek to highlight the role of the workplace in managing physician behaviours that impact patient safety, staff experience, and overall organizational culture. This approach incorporates fundamental aspects of OHS, including best practices listed in ISO45003: Occupational health and safety management — psychological health and safety at work — guidelines for managing psychosocial risks.¹⁴

Physicians as partners in OHS

According to the Public Services Health and Safety Association,¹⁵ physicians are workers (or independent contractors) when they provide services in a hospital or clinic. Thus, they are afforded the protection of the OHS act in the province or territory where they work. They are also afforded protection outlined in workplace safety bills. In Ontario, these include Bill 168 (*Occupational Health and Safety Amendment Act; Violence and Harassment*



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*in the Workplace*¹⁶) and Bill 132 (*Sexual Violence and Harassment Action Plan Act [Supporting Survivors and Challenging Sexual Violence and Harassment]*).¹⁷

Under the OHS act, physicians have an opportunity to be active members of the internal responsibility system, which guides safety in workplaces.¹⁸ Accordingly, Joint Health and Safety Committees (JHSC) would include physician contributions, thereby ensuring that their safety issues are identified and addressed (e.g., advocating an investigation of workplace harassment by the Ministry of Labour). An engagement strategy of JHSC would require incorporation of relevant physician-oriented items and MAC endorsement would be required via appropriate stipulation in professional staff by-laws.

Accurate detection of psychosocial hazards

Organizational culture must be an active process, whereby the implicit is stated as set expectations, where supposed “shared assumptions” are verified and corrected, and the protection and maintenance process of culture is active and negotiated on an iterative basis. Without set expectations, any change is hard to detect, and normalization of deviance (NoD) is inevitable. NoD occurs when individuals’ actions deviate from what is known to be acceptable behaviours (or performance) to such an extent that this “new way” becomes the norm.¹⁹

NoD as applied to patient safety culture underscores the benefits of placing organizational structures and culture as central driving factors that prevent the new way from emerging when faced with individual actions.²⁰

We contend that it is imperative to view the display of disrespect and unprofessional behaviour by a physician as an opportunity to restate and reinforce expected standards of behaviour. We believe that there are many missed opportunities to do so, in part because of reluctance and fear of retaliation. The opportunity for early, non-blaming interventions is underused. As well, the introduction of evidence-based systems that use “nudges” toward expected behaviour is recommended.^{21,22} Furthermore, tracking the implementation of early nudges and impact will ensure monitoring of any shifts overtime, ensuring identification of NoD. Building on the existing framework of continuous quality improvement that underpins the safety literature will ensure that detection and management of psychosocial hazards is a long-term, iterative process and not a passing phenomenon. In essence, disrespectful interaction could

be an opportunity for quality improvement, where nudges are used to protect organizational culture.

System lens for root cause analysis

Adopting an OHS lens necessitates a shift in the system's failures in prevention, recognition, and management of the psychosocial hazard. A big leap is required! This means individuals are not solely to blame for their disrespectful action, and, likewise, it is not solely an individual's responsibility to intervene to address it. We argue that denying the role of the workplace as a conduit for psychosocial hazards amounts to perpetuation of the careless work myth.²³

The careless work myth is a concept from OHS which suggests that some workers are accident prone, careless, or even reckless, which explains the injuries.

Root cause analysis shows that safety and care for patients is reduced in workplaces where unprofessional behaviours are present.²⁴ Such behaviours are fostered by harmful workplace processes (e.g., lack of role clarity, high job demands, managers' reluctance to address unprofessional behaviours).²⁵ It is necessary to underscore the links between civility and psychological safety.³ In fact, research in the United States has shown that physicians in strong protective systems report experiencing less mistreatment.²⁶

Apply a hierarchy of interventions

OHS interventions are designed according to a hierarchy of hazard controls,²⁷ constituting a five-tiered view of interventions, ranging from complete elimination of a hazard to personal protective gear to minimize impact. Australia has developed a guide managing psychosocial hazards, which specifically states that control measures (i.e., interventions) must predominantly be considered at an organizational, work, and system design level, instead of at an individual level.²⁸ This is consistent with recommendations from previous reviews and investigations, such as third-party dispute resolution⁸ and implementation of just culture to promote employee engagement.²⁹

Ombuds offices have recently been used in academic workplaces to address faculty-to-faculty conflict, including bullying and harassment.³⁰ The services are confidential, and staff are often skilled at coaching individuals and groups in conflict management, alternative dispute resolution,



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mediation, and restorative justice. Many are governed by a code of ethics from the International Ombuds Association.

Some of these services might be offered through hospitals. For example, the Ottawa Hospital recently posted positions in its Office of Conflict Resolution. Together, these early intervention approaches ensure that there is a focus on the organizational and systems designs, and not simply about training individuals to respond to incivility and disrespect.

Conclusion

We require a systemic and psychologically safe approach beyond “command and control” (e.g., sledgehammer) approaches, such as licence revocation.³¹ OHS offers a paradigm with relevant legislation and is premised on joint responsibility between physicians and employers. As well, the focus on detection of incidents through clear expectations and careful monitoring is central to this paradigm. Finally, the application of root-cause analysis and a hierarchy of interventions means that we can achieve a responsive approach that appropriately addresses the system issues that contribute to such psychosocial hazards. This is important given that group-oriented organizational culture has been found to enable the successful implementation of just culture training.³²

If we are to truly walk away from “name, shame, and blame” and other similar sledgehammer approaches that underlie the rotten apple verbiage, we must simultaneously acknowledge the widespread impact of disrespect and incivility, while uncovering what system characteristics tolerate (or even reinforce) such actions. The cost of incivility and disrespect is much more than we can imagine; it impacts individuals, teams, patients, organizations, and the entire health care system.³³

The Psychosocial Hazards Manifesto will enable all of us together to move toward the responsive obligation and regulation of incivility and disrespect as workplace hazards, consistent with international approaches and best practices in OHS.¹⁴

We hope you accept this call to action — to reframe incivility and disrespect as workplace issues, issues that are, in fact, occupational hazards. These hazards must be detected, in collaboration with physicians, and root-cause analyses are required to identify system issues. We envision interventions that are responsive and are drawn from a hierarchy of control for psychosocial hazards, with dedicated emphasis on prevention and early interventions offered at the organizational level.

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