A Moral Imperative for Nurse Leaders: *Addressing Incivility and Bullying in Health Care*

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BACKGROUND TO THE PROBLEM

A silent epidemic, a great threat to patient safety, an ugly secret in the most caring of professions,[1] these are just a few ways that incivility and bullying have been referred to in the literature over the last 10 years. Incivility and bullying have long existed in society and in health care, yet great strides have recently been made in moving the issue from the background to the forefront for discussion, leading to the beginnings of its prevention. It is known by many names—"eating our young," "toughening up," "getting a thick skin"—but at their core, they are the destructive and harming behaviors of disrespect and degradation. Edmonson and Allard[2] noted that some of the origins of bullying in nursing can be explained using oppression theory. They observed that most incivility in nursing is nurse to nurse, horizontal behaviors, a characteristic of an oppressed group. However, incivility and bullying also occurs within and among professions. They represent a continuum of behaviors that range from disrespect to workplace violence.[3] They can occur top down, bottom up, and horizontally within any team or organization. A hierarchal relationship is not required. Worst of all, they may occur between the health care provider and the patient and family. Bullying behaviors can be born out of conflict for resources, authority gradients, gender struggles, generational differences, value differences, power struggles, and learned patterns of behaviors. Health care is a dynamic, complex, and often stressful environment and is primed for bullying behaviors to occur.

Bullying is harmful to individuals, patients, professions, organizations, and communities. The long-term effects can lead to negative health impacts for its victims and human capital costs for organizations. In one study, up to 85% of nurses reported having experienced bullying in their careers, and 21% of turnover has been associated with the problem.[4] It has the capacity to reduce care provider productivity and employee engagement, which is easily translated into lost dollars for organizations.[5] What is not as easily measured is the cost to the individual experiencing bullying in terms of health and well-being from the impact of psychological and physical stressors. The highest cost may come to patients. Up to 70% of nurses have reported knowing of errors that were caused because of bullying behaviors among professionals.[6]

To name a thing is to take its power away.[7] In recent years, several national nursing organizations have done just this, producing position statements and focused conferences to address incivility and bullying in nursing.[3,8]

NURSE LEADER'S OBLIGATION TO THE MORAL IMPERATIVE

Bullies come in all shapes and sizes. It is often that one person who everyone else tends to steer clear of—the one nurses cringe from when they see that they are scheduled to work a shift with them. Or it could be the one who nurses dread handing off reports to because they fear that person is going to criticize their work or how they left their workspace. Or it is the one who makes condescending remarks about other nurses or team members in the presence of patients, families,

and visitors, causing them to lose trust and confidence in the team. Oftentimes, nurse leaders know exactly who the bully is in their department, but choose to look the other way. There are numerous reasons for this disregard. For example, the bully might be their most tenured and experienced nurse. They might be relied on by their leader to serve as a charge nurse, preceptor, or committee member. With rising patient acuity and a lack of experienced staff, removing the bully may lead to an open position and recruitment challenges that the leader may want to avoid.

What nurse leaders must realize is that no matter how valuable they believe that nurse is to the charge role, precepting, or staffing, in reality, bullies are toxic to the work environment. They, in fact, hold the team back from achieving its goals to provide the highest quality patient care. Although the nurse leader may view them as the irreplaceable clinical expert, the bully's expertise is much less effective when they have placed themselves in a position in which they are unapproachable and others are uncomfortable seeking their help and advice.

Understanding that there is a problem, and addressing and preventing it as a nurse leader are very different objectives. There is an interplay of complex systems and forces, best described in the socioecological model, that requires an organization's concerted effort to overcome.[9] How many nurse leaders have been approached by a care provider with a story regarding a disrespectful interchange between team members and gotten the reply, "Did you talk to that person about it?" Until recently, strategies to reduce incivility and bullying have focused on the perpetrators and the receivers as implied in our example, not the group phenomenon with its significant structural support. However, when applying the model, the complex interplay becomes clear. Strategies to build a culture of respect must be employed from the intrapersonal, interpersonal, institutional, environmental, and policy levels and not just between the perpetrators and receivers.

To build and sustain respectful cultures and prevent the negative effects of incivility takes nurse leaders committed to the moral imperative to uphold the principles and standards of right and wrong behaviors of conduct.

TOOLS FOR BUILDING RESPECTFUL CULTURES

So with that imperative, what can a nurse leader do to build and sustain a culture of respect? Respectful cultures are not always easy to build or sustain without expertise, commitment, tools, and policies that have been proven effective. Culture is really a collection of norms, beliefs, and values of the people in it. Work has been done on how to rebuild cultures where bullying has become normalized, but there is much left to do. Numerous informational websites have been developed to compile what has been done to support the work of nurses and nurse leaders to start the journey to respectful cultures. Among these are Civility Matters: Leading the Coalition for Change: Creating and Sustaining Communities of Civility; STOPBULLYINGNURSES: A call for an end to horizontal violence and relational aggression in nursing; and Civility Tool-Kit: resources to empower health care leaders to identify, intervene, and prevent bullying.[7,10,11]

Figure 1. Civility Moral Compass

Reprinted with permission from Adeniran et al.[11]

The Civility Tool-Kit is especially useful and is arranged in 4 "buckets" using a moral compass model of truth, wisdom, courage, and renewal (*Figure 1*). The materials in the buckets were selected and designed for leaders to use at varying stages in the journey to culture change. There is no beginning or end to the process, and users can start with the materials from any bucket; they are not discipline specific. To date, there have been more than 140,000 downloads from 25,000 users in 133 countries.

THE TRUTH BUCKET

Knowing where we are and where we want to be guides the work back to a moral and respectful workplace. Culture is transparent—everyone is part of it, and everyone contributes to it. At any time, each of us can be a perpetrator, a receiver, or a bystander to incidents of incivility and bullying.[12] For nurse leaders, creating a culture of respect begins with discovering and exposing incivility within a team. This requires close examination of the individuals who make up a given team.

In the Truth bucket are self-assessments for students, faculty, and the workplace providers and a dashboard to use to measure the civility in one's setting.[13-16] The dashboard is especially useful because it includes both easily retrievable organizational data and an additional assessment based on the feedback from the often "invisible" colleagues among us. How our invisible colleagues are treated and what they witness are important cultural measures for organizations. Measuring civility in health care can be challenging for nurse leaders without these types of surveys methods, because what is measured matters and gets attention. It can create a sense of urgency and promote change. The dashboard can be adapted to any setting and is scalable for the micro-, mezzo-, or macro-system.

The Wisdom Bucket

This bucket contains information and sample policies, and tools that can be modified for use in any organization. Links