Perspective: **A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians**

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Abstract

A substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect. The authors identify a broad range of disrespectful conduct, suggesting six categories for classifying disrespectful behavior in the health care setting: disruptive behavior; humiliating, demeaning treatment of nurses, residents, and students; passive-aggressive behavior; passive disrespect; dismissive treatment of patients; and systemic disrespect.

At one end of the spectrum, a single disruptive physician can poison the atmosphere of an entire unit. More common are everyday humiliations of nurses and physicians in training, as well as passive resistance to collaboration and change. Even more common are lesser degrees of disrespectful conduct toward patients that are taken for granted and not recognized by health workers as disrespectful.

Disrespect is a threat to patient safety because it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices. Nurses and students are particularly at risk, but disrespectful treatment is also devastating for patients. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfillment in work for all health care workers and contributes to turnover of highly qualified staff. Disrespectful behavior is rooted, in part, in characteristics of the individual, such as insecurity or aggressiveness, but it is also learned, tolerated, and reinforced in the hierarchical hospital culture. A major contributor to disrespectful behavior is the stressful health care environment, particularly the presence of "production pressure," such as the requirement to see a high volume of patients.

The slow pace of improvement in patient safety has been a source of widespread dissatisfaction for policy makers and the public, but even more to the health professions. Despite extensive efforts by many institutions and individuals, recent studies show little improvement in the rate of preventable patient harm since the Institute of Medicine's (IOM's) "To Err Is Human"[1] sounded the alarm and issued its call for a nationwide safety improvement effort 12 years ago.[1–4]

One explanation for this poor record is that the problem is so large and its causes are so varied. For example, the Centers for Disease Control and Prevention estimates that 5,000 people acquire an infection in our hospitals every day,[5] and the IOM estimates that 1.5 million patients are injured by medication errors every year.[6] Other reasons include our lack of knowledge of how to prevent most complications of treatment, inadequate government investment in patient safety initiatives, and insufficient preventive and remedial measures.[7]

We believe, however, that the fundamental cause of our slow progress is not lack of know-how or resources but a dysfunctional culture that resists change. Central to this culture is a physician ethos that favors individual privilege and autonomy—values that can lead to disrespectful behavior. We propose that disrespectful behavior is the "root cause" of the dysfunctional culture that permeates health care and stymies progress in safety and that it is also a product of that culture.

Disrespectful behavior threatens organizational culture and patient safety in multiple ways. A sense of privilege and status can lead physicians to treat nurses with disrespect, creating a barrier to the open communication and feedback that are essential for safe care. A sense of autonomy can underlie resistance to following safe practices, resulting in patient harm. Absence of respect undermines the teamwork needed to improve practice. Dismissive treatment of patients impairs communication and their engagement as partners in safe care.

In addition to its toxic impact on patient safety, disrespectful behavior affects many other aspects of health care. Quality suffers when caregivers do not work in teams. Disrespect saps meaning and satisfaction from daily work and is one reason nurses experience burnout, resign from hospitals, or leave nursing altogether.[8] Lack of respect poisons the well of collegiality and cooperation, undermines morale, and inhibits transparency and feedback. It is a major barrier to health care organizations becoming collaborative, integrated, supportive centers of patient-centered care.

Students and residents suffer from disrespectful treatment. "Education by humiliation" has long been a tradition in medical education and still persists. Patients suffer when physicians do not listen, show disdain for their questions, or fail to explain alternative approaches and fully involve them in the decision-making process.[9,10] Failure to provide full and honest disclosure when things go wrong

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is the epitome of disrespect and is a major reason patients file malpractice suits.[11]

Respectful behavior is a moral value esteemed in its own right. Respect is also a foundational element of professionalism that forms the core of the self-image of most physicians. Professionalism is a critical element of the six competencies that form the foundation of medical education and practice espoused by the Accreditation Council on Graduate Medical Education, the standard-setter for graduate medical education, and by the American Board of Medical Specialties (ABMS), the standard-setter for all medical specialties.[12] Although professionalism embraces a number of other behaviors and attitudes, showing respect for others is central to all aspects of professionalism.

The vast majority of physicians treat others respectfully most of the time; however, some do not. In a recent national survey, two out of three physicians reported witnessing other physicians disrupting patient care or collegial relationships at least once a month. One in nine physicians reported seeing disruptive behavior every day.[13]

A culture of disrespect is harmful for many reasons, but it is its effect on the safety and well-being of our patients that makes it a matter of urgency. In simple terms, we believe that a health care organization that supports and tolerates disrespectful behavior is unsafe for its patients and hostile for its workers. Although disrespectful behavior permeates all of health care, physicians dominate the culture and set the tone; therefore, in this discussion we focus on physicians.

Here, we present a call to action. Our intent is to motivate individuals at all levels in health care institutions to take action toward creating a culture of respect and to provide them with the evidence they need to support improvements in the cultures of their institutions.

The Scope of the Problem

Disrespectful behavior takes many forms, ranging from outbursts of outrageous, aggressive behavior to subtle patterns that are so firmly embedded in our culture as to seem normal. On the basis of our collective personal experience, we suggest the following as a useful classification of disrespectful behaviors in the health care setting.

Disruptive behavior

At one end of the spectrum of disrespect are physicians whose behavior has been characterized as disruptive, defined by the Ontario College of Physicians and Surgeons as "inappropriate conduct, whether in words or action, that interferes with, or has the potential to interfere with, quality health care delivery."[14] Hickson and Pichert[15] define disruptive behavior as "any behavior that impairs the medical team's ability to achieve intended outcomes." Disruptive physicians are found in almost all hospitals. Although most observers agree that only 5% or 6% of physicians fall into this category,[16] the detrimental influence of this small minority far outweighs their numbers.

Disruptive actions include angry outbursts, verbal threats, shouting, swearing, and the threat or actual infliction of unwarranted physical force that legally would be considered battery. Having a temper tantrum, throwing objects, and breaking things are other forms of disruptive behavior, as is any unwanted physical contact of a sexual nature. Disruptive conduct may be directed at anyone—nurses, colleagues, residents, medical students, ward staff, hospital administrators, and even patients and their family members.

Disruptive behavior includes profane, disrespectful, insulting, or abusive language; loud or inappropriate arguments; demeaning comments or intimidation; shaming others for negative outcomes; and simple rudeness. Violations of physical boundaries and sexual harassment are in this category, as are gratuitous negative comments about other physicians' care and passing severe judgment or censuring colleagues or staff in front of patients, visitors, or other staff. Also included are bullying; insensitive comments about a patient's medical condition, appearance, or situation; and jokes or nonclinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance, or socioeconomic or educational status.

Humiliating, demeaning treatment of nurses, residents, and students

Much more common than egregious forms of disruptive behavior are patterns of demeaning or humiliating treatment of subordinates, particularly nurses, residents, and medical students.

Abuse of nurses by physicians has a long history. Twenty years ago, Cox[17,18] reported on the high rate of verbal abuse of nurses and its negative effects. A recent review of the literature yielded 10 U.S. studies since 2000 of abusive treatment of nurses.[19] A large percentage of nurses reported being subjected to abuse or disruptive behavior, and in four of the studies, more than 90% of nurses reported that they had experienced such abuse. In one large study, 31% of nurses reported knowing a nurse who had left the hospital because of disruptive physician behavior.[19]

Medical students, at the bottom of the patient care team hierarchy, are very vulnerable to disrespect from faculty, house staff, nurses, and others through verbal or physical abuse, belittlement, humiliation, harassment, intimidation and exploitation, or simply by being ignored. Nurses and residents may make them feel insignificant or "in the way." Annual surveys by the Association of American Medical Colleges show that 14% to 17% of graduating students report having been subjected to or witnessing some form of mistreatment.[20] However, other studies and informal discussions with students suggest that the prevalence of student mistreatment is much higher.[20,21] Recent reports that 53% of medical students experience "burnout"[22] and that 14% suffer clinically significant depression[23] provide further evidence that the environment in many of our academic medical centers and medical schools is sometimes hostile and quite toxic.

In our experience, students indicate that they seldom report disrespectful acts because they are concerned about being seen as troublemakers and fear reprisal or vindictive retaliation, such as a lower grade, a critical evaluation, or a poor recommendation for residency applications. Disrespect can also occur in the preclinical classroom or laboratory, but it is more common in clinical settings like hospital wards or clinics. Women

students are more vulnerable than men.[21,24] Anecdotally, students report that barbs related to gender, race, or sexual orientation are heard more commonly in high-stress areas, such as the operating room and the emergency department. Often, students relate that when such disrespectful behavior is reported, corrective measures are not apparent, sending the message that disrespectful behavior is tolerated, if not celebrated.

Examples of serious disrespectful behavior toward medical students reported in one academic year are presented in Box 1.[20]

Passive-aggressive behavior

Passive-aggressive behavior is defined as a pattern of negativistic attitudes and passive resistance to demands for adequate performance.[25] Unable to express anger in a healthy way, passive-aggressive individuals harm others through actions that seem normal on the surface. They tend to be unreasonably critical of authority and blame others for their failures. They frequently complain of being misunderstood and treated unfairly.

Passive-aggressive behavior includes refusing to do tasks or doing them in a way intended to annoy others. Passive-aggressive individuals go out of their way to make others look bad while pretending innocence, fail to follow through on agreements, and deliberately delay responding to calls, covering the delays with excuses. They often make negative comments about their institution, hospital, group, or colleagues. The defining characteristics of passive aggression are concealed anger, negativism, and intent to cause psychological harm.

We know of no studies undertaken to quantify these types of behaviors, but we have encountered widespread agreement among clinicians that such behaviors are not rare.

Passive disrespect

By contrast, passive disrespect is common; it consists of a range of uncooperative behaviors that are not malevolent or rooted in suppressed anger. Whether because of apathy, burnout, situational frustration, or other reasons, passively disrespectful individuals are chronically late to meetings, respond sluggishly to calls, fail to dictate charts or operating notes in a timely fashion, and do not work collaboratively or cooperatively with others. They resist following safe practices, such as hand disinfection, checklists, and "time-outs," even when the rationale has been sufficiently described. They may decline to participate in quality improvement efforts, or, if they do, they are indifferent or poor team players. All of these behaviors are manifestations of disrespect—for others, for the institution, and for expert opinions.

Although this type of behavior would be included in Hickson's definition of disruptive behavior,[14] it is usually not perceived as such by colleagues, who tend to accept it as a fact of life that some people are "difficult."

Dismissive treatment of patients

Again, incidence data are lacking, but anecdotal evidence abounds in the form of patient stories regarding demeaning, disrespectful, and dismissive treatment by physicians. Patients may describe this treatment in a number of ways: "He treats me like an idiot," "He makes me feel like I'm wasting his time," "She won't return my calls," "They ignore me on rounds. They talk about me but not to me," or, "It was clear he doesn't like people who ask questions."

Not only does such behavior violate the fundamental obligation of the

Box 1

Examples of Disrespectful or Abusive Behavior Experienced by Medical Students

1. Two second-year medical students spent an afternoon observing surgery in the operating room (OR) as part of a medical school course. The chief surgical resident assigned the students to a corner of the room with instructions to be quiet and not touch anything. After the students washed their hands and moved to their assigned place, the attending surgeon noticed the students and yelled, "Who are you? What are you doing in this OR? When you come into an OR you introduce yourself to the surgeon. And why are you standing there? Go stand in that [pointing to a different] corner."*
2. One third-year medical student was scrubbed-in for a case, observing and occasionally assisting the surgeon. At one point, she noticed the surgeon pulling a retractor in a way that seemed to indicate that the surgeon wanted her to take over retracting. As she reached to grab the retractor, the surgeon, who apparently did not want her assistance, slapped her hand out of the field instead of verbally instructing her to remove her hand.*
3. S.N., a third-year student, was distressed with the behavior of the young attending physician and the senior resident on the last month of her medical clerkship. Constant references to "the yellow fat whale in Room 506" or that "dumb drunk" by the attending shocked S.N., and when she spoke to both the attending and resident about their constant disparagement of patients, she was told, "When you grow up you'll do the same thing." S.N. was heartbroken to hear these comments from physicians she had respected.
4. *A third-year medical student on an OB/GYN rotation related the following:* I was instructed to observe a hysterectomy, but when I arrived to the OR, the doctor looked at me with disdain and told me to stand in the far corner and not mess anything up. So, I perched myself atop a small stepstool in the back corner of the room, and I spent the next three hours squinting from across the room, completely unable to see anything except for blue-gowned backs. Suddenly, the doctor called out, "You, over there!" I looked over in surprise—me? Apparently, there was no one available to pull out the catheter, and they beckoned for me to approach the table. I cautiously approached, and before I could even begin, the doctor sharply barked, "DON'T mess this up for me!" Shaking, I followed her instructions, and managed to remove the catheter without contaminating the sterile field. "Now, GET OUT of the way!" she yelled. I couldn't see behind me, and in a small tremulous voice, I asked, "Is it ok to move backwards, I can't see anything behind me…?" Raising her voice up a notch, she yelled, "Just GET OUT!" I took several hasty steps backwards, and my arm grazed lightly against the side of a table holding sterile instruments—mind you, nowhere NEAR the table-top, where the instruments lay, but just on the side curtain—and a nurse shrieked, "She contaminated the whole sterile field!" With fury, the doctor looked up and spat, "F___ you!" I blinked and stared right back at her—really, did she just actually say that? Although I didn't feel sad at all—only mad as hell—tears rushed to my eyes in a visceral response to all of the shouting. The instant that the curse left her lips, I could tell that she regretted it, but you can't take back something like that, so the words hung awkwardly in the air, hovering over all of our heads for the rest of the procedure. She tried to make up for it, sending arbitrary, irrelevant compliments in my direction, and the nurse patted me on the shoulder several times and tried to appear motherly and compassionate. But, what I remember most strongly from the experience—what I STILL cannot believe—is the fact, despite their palpable remorse, no one ever said, "I'm sorry."*

*Source: Cases 1, 2, and 4 are reprinted with permission from Unmet Needs: Teaching Physicians to Provide Safe Patient Care. Boston, Mass: National Patient Safety Foundation; 2008.[20]

physician to provide support and healing, it can be devastating for the already-apprehensive patient. Patients seldom file formal complaints to the hospital about dismissive behavior, but as more hospitals implement the Consumer Assessment of Health Plans Survey as part of Center for Medicare and Medicaid Services Hospital Compare reporting,[26] these sentiments are now beginning to be captured in a systematic fashion.

Dismissive treatment and put-downs are not limited to patients. Some physicians treat nurses, students, residents, and even peers with disdain, making easy communication and collaboration impossible. However, because they are so dependent on the doctor for their well-being, patients are especially vulnerable to dismissive treatment.

Systemic disrespect

Many features of our health care system are so firmly entrenched that they are taken as givens and not recognized for the disrespect they represent. A classic example is waiting. Everyone—patients, doctors, nurses, clerks, and administrators—seems to accept the fact that patients should wait for services. There is a reason we label our reception areas as "waiting rooms"! Making a person wait, however, sends the unambiguous message that the physician considers his or her time more valuable than the patient's.

Physicians are also victimized by a scheduling system that doesn't respect their time. The productivity demands of the short appointment times characteristic of present-day ambulatory medicine mean that to have necessary additional time with one patient requires the physician to make the next (and all subsequent) patients wait. This type of scheduling is institutional disrespect of both the physician and the patient, ignoring the physician's need to have enough time to do a professional job.

The unnecessary nature of waiting is apparent from the success that increasing numbers of institutions—offices, clinics, hospitals, operating rooms, and even emergency rooms—have had in streamlining flow, with marked reductions in and sometimes elimination of waiting.[27–29] But even when systems fail and emergencies create delays, apologizing for waiting demonstrates respect.

A more serious example of systemic disrespect is the hostile working conditions that are so universally ingrained that we take them for granted as "normal." Unduly long hours, sleep deprivation, and excessive workloads are well-known causes of errors and patient harm.[30–36] Requiring residents or nurses to work under these conditions not only is disrespectful of their well-being and potentially harmful for them (residents who have been on continuous duty for 24 hours or more are more likely to have a fatal automobile accident when driving home)[35] but also violates their right to work under conditions that do not increase the likelihood that they will harm their patients. And, of course, it is disrespectful to patients to knowingly put them at increased risk of injury.

Hospitals also demonstrate lack of respect for nurses and other workers when they fail to ensure their physical safety by taking appropriate measures to prevent injury, such as needlesticks and back strain. The fact that these are often accepted as risks of the job illustrates the extent to which disrespect is institutionalized in hospitals.

At the patient level, a serious form of covert systemic disrespect is the failure to engage and inform patients fully about their care. Failure to provide the reasons for tests, the meaning of test results, the options for diagnosis and treatment choices, and, most important, thorough explanations of the risks and benefits of each option, are failures of respect of the patient's right to information and of his or her ability to understand and make decisions. Shared decision making is not just a good idea, it is showing respect.

Minor forms of systemic disrespect of patients abound. One is the ubiquitous clipboard questionnaire about demographic and medical history information that patients fill out for every doctor, even when the physicians are in the same institution and have access to a common electronic medical record that already contains this information. Another is the simple failure of health care workers to greet patients, introduce themselves, and say "please" and "thank you." Addressing patients by their first names without seeking permission for this level of familiarity may be interpreted as disrespect. Calling a patient by terms of endearment, such as "honey" or "dear," infantilizes the patient and enforces a power differential with the clinician.

Perhaps the most serious form of systemic patient disrespect is the failure to admit and explain fully what happened when things go wrong and to apologize when we or our system has failed. Honoring the patient's right and need to know everything that is relevant to his or her well-being is fundamental to doctoring and reflects respect for the "doctored."

The Effects of Disrespectful Behavior: Why Is It a Concern?

Humiliating, degrading, or shaming behavior is a threat to patient safety because it can have both immediate and long-term negative effects on the recipient. In the immediate aftermath of an episode of humiliation, the recipient experiences a mixture of intense feelings: fear, anger, shame, confusion, uncertainty, isolation, self-doubt, frustration, and depression. These feelings affect significantly a person's ability to think clearly, making an error in decision making or performance more likely. In addition, intimidation may stimulate a person to commit an unsafe act.[37]

Long-term consequences of humiliating and intimidating behavior stem from the recipient's very rational response: Avoid the person inflicting the hurtful behavior. For a nurse or resident, this may be expressed by reluctance to call a disrespectful attending physician with questions for clarification of an order, or for clinical concerns that are not clear-cut. In such cases, caregivers may divert their attention from the patient to self-protection. When communication on the health care team is limited to that which is absolutely necessary, the loser is the patient, who may suffer from delayed or erroneous diagnoses or treatment.

Everyone suffers in an atmosphere of intimidation. A hostile work environment lowers morale, creates self-doubt, and is a cause of burnout.[38–40] Not surprisingly, some health care professionals choose to leave rather than endure such an environment.[41]

Malpractice suits are more common against physicians who intimidate or insult patients.[42]

Teamwork is another casualty of disrespect because it requires mutual trust and respect among all its members. Even less severe forms of disrespect, such as not learning individuals' names, habitual tardiness for meetings, and expecting deferential treatment, are detrimental to teamwork.[43] Teamwork is essential for the management of patients with multiple or complicated diseases. It is also the cornerstone of safe practice. The most effective safe practices, such as prevention of central line infections by adherence to proper insertion technique and prevention of surgical complications through "time-outs" and checklists, require smoothly functioning teams to succeed.[44,45] If the physician is not a constructive team player, team efforts fail, and patients suffer the consequences. For these reasons, teamwork has been identified as a critical element of systems-based practice, one of the six competencies deemed essential for all physicians by the ABMS.[46]

As noted, disrespect underlies failure of physician compliance with safe practices. Lack of respect for the organization and the expert opinions of others leads some physicians to disobey rules with which they do not agree, such as the requirement to disinfect hands before touching a patient or to perform a "time-out" before surgery.

Disrespectful behavior is also a barrier to *improving* safety. The major safety efforts have focused on implementing new safe practices. Both implementing standard practices and developing new practices require collaboration among all members of the care team. If the physician fails to participate constructively in such efforts, progress is virtually impossible.

Students are especially vulnerable to degrading or humiliating treatment by their teachers. In addition to the anger, humiliation, shame, and frustration that anyone feels as a result of humiliating treatment, students may experience feelings of self-doubt and loss of self-esteem. A harshly negative judgment from a respected senior physician carries great weight and sometimes leads a student to question his or her fitness to be a physician. Students are also vulnerable because they are subject to faculty evaluation. A negative assessment can make a student less competitive for residency positions.

But the most serious effect on students comes from within. Disrespect is learned behavior, and students learn it from their role models, the faculty. The power of role models is strong, particularly in the clinical years. Although some students will encounter disrespectful behavior and draw the opposite lesson, many students will emulate the behavior they see, ensuring a never-ending cycle of disrespect.

Disrespectful behavior can also be very harmful to patients. Insulting and stifling comments from physicians render patients reluctant to be forthcoming and volunteer information, cutting the physician off from important information that only the patient can provide about symptoms or complications of therapy and observed failures of the care system. Even when they have minor ailments, virtually all patients have some fear and anxiety when interacting with the health care system. Doctors and nurses have the power to reduce this distress substantially by being sympathetic and understanding. Conversely, they have the power to increase distress substantially by ignoring patients' concerns or treating them with scorn or indifference. Such fears are magnified many-fold in the aftermath of a medical complication, whether or not it is caused by an error. Patients can be devastated if caregivers are not open, honest, and understanding in these situations. Dismissive or dissembling treatment undermines the trust that is the cornerstone of the doctor–patient relationship.

The Causes of Disrespectful Behavior

Disrespectful behavior results from multiple factors related both to the individual (endogenous) and to the environment in which he or she works (exogenous).

Endogenous factors

Certain personality characteristics are associated with disrespectful behavior. Many are associated with threats to self-esteem. Self-esteem is especially important to physicians. It is closely linked to their perception of their own competence and reputation. Because they invest a substantial amount of time and energy to achieve competence and professional success, doctors may be sensitive to any threats to self-esteem. When their self-esteem is threatened, physicians may react with destructive interpersonal behavior as a way of reestablishing professional dominance. These reactions may be manifest in several ways.

Insecurity and anxiety. Some physicians are particularly prone to insecurity and anxiety stemming from concern about whether they are up to the challenges of practicing medicine. Especially when they are overworked or stressed, doctors who are not confident about their skills may react to stress by blaming others when things go wrong or by making demeaning or hypercritical comments.

Depression. Surveys show that physicians have higher levels of depression—and higher suicide rates—than the public at large.[47] These individuals become depressed by threats to their professional competence, blaming themselves for real or fancied inadequacy. In addition to being hypercritical of themselves, depressed individuals may cope by being hypercritical of others.

Narcissism. The investment of time and energy necessary to succeed professionally in medicine requires a high degree of self-involvement, which in some individuals may accentuate narcissistic character traits. Highly narcissistic individuals believe that they and their ideas are special. They have difficulty tolerating people they view as ordinary, have a sense of entitlement to favorable treatment by others, and are insensitive to the feelings and needs of other people. Banja[48] has coined the term "medical narcissism" to reflect the observation that some aspects of narcissism, such as high self-esteem and feelings of superiority, authority, perfectionism, and self-absorption, are often found in physicians. For some, these characteristics may be essential to mastering the highly complex demands of practice and achieving self-preservation in a stressful environment.

Although few physicians exhibit these characteristics to the degree that would be classified as pathological narcissism, Banja[48] notes that

> many physicians and other health professionals nevertheless demonstrate a kind of muted or closeted narcissism whose associated behaviors serve as a form of self-protection when their feelings of adequacy, control, or competency are threatened.

He believes that these feelings are a common cause of the difficulty many physicians have in disclosing and apologizing after adverse events.

Aggressiveness. Highly aggressive people enjoy combat and confrontation, have hair-trigger tempers, and find reassurance in being able to bully others as a defense against helplessness. Professional setbacks may be experienced as helplessness, triggering an aggressive response. Highly aggressive people may find that their behavior is better tolerated in the health care environment than in others and that, in some hospitals, it is even rewarded.[49]

Prior victimization. Doctors who have suffered bad experiences, such as bullying, during their formative years may be so traumatized that imitative behavior becomes engrained in their unconscious. Their reaction to stress is to bully, reflecting their earlier experiences.

Exogenous factors

Exogenous factors are characteristics of the workplace that facilitate disrespectful behavior. The culture of an institution—"the way we do things here"—defines acceptable and unacceptable behavior. That culture, in turn, is influenced heavily by the customs and mores of society at large. In the United States, a culture of aggressive crudity has taken hold in the past 10 to 20 years, sparked originally by the "let it all hang out" and assertiveness-training era.[50–52] The result is that civility is regarded as weakness and as an invitation to exploitation. This trend is obvious in the media, in literature, and in conversation; a certain degree of demeaning disrespect has been elevated to a normal style of communication that is tolerated and that elicits little comment.[53–55] The rise of "social media" has greatly expanded the reach of insulting and derogatory speech that, in earlier times, would have fallen on few ears. Not unexpectedly, some of this society-wide tolerance for disrespect spills over into health care.

In addition to this societal acceptance of disrespect, contemporary health care culture is characterized by features that foster disrespectful behavior. One such feature is its hierarchical nature. Disrespect, which is closely tied to status, usually flows down, not up. Medical students rarely are outwardly disrespectful toward their professors, house officers toward their seniors or their attending physicians, or nurses to their supervisors because of the likelihood of repercussions. On the other hand, students and residents often make disrespectful and derogatory comments about their superiors when out of earshot.

Disrespectful behavior may actually affirm status by rewarding the person behaving disrespectfully, who is typically highly sensitive to the hierarchy and keenly aware of the consequences of disrespect directed up the status gradient. In a hierarchical environment, the ability to disrespect others with impunity is a measure of status. The department chair or world-class cardiac surgeon can often "get away with" conduct that is not tolerated among those lower down the ladder.

But the major exogenous factor leading to disrespectful behavior is the stressful environment of modern hospitals, in particular large academic teaching centers, where many people work unduly long hours, have unreasonably heavy work loads, and experience multiple conflicting demands on their time and psyche. Burnout is common not only among staff doctors and nurses but even among medical students and residents.[22,56] Workplace stress creates anxiety and depression and leads individuals to focus inwardly, accentuating self-absorption and decreasing empathy and the willingness to cooperate. A person looks naturally for others to blame for what appears to be an unsolvable situation.

The stressful environment of health care organizations has multiple causes, but primary among them is production pressure. The U.S. business model of health care places enormous pressure on health care organizations and physicians to increase output; income for both the group and the individual depends on the number of patients treated. Short outpatient appointments, shortened hospital stays, and increasingly complicated, sometimes dangerous procedures mean that pressured staff are often performing at the edge of their comfort and competence. As a result, there can be loss of continuity of care, and too little time is left for the courtesy and respect that are essential for good patient care and a work environment that is comfortable and humane.

In addition to production pressure, physicians face complex documentation requirements and increasing demands to improve quality and safety—with no increase in time or compensation—as well as the frustrations that come from trying to make a clumsy system work to meet patients' needs. This situation is a prescription for anger and exasperation that, not surprisingly, results sometimes in outbursts or disrespectful behavior.

Many other industries, however, have succeeded in creating supportive and satisfying work environments in spite of production pressures and complex regulatory and documentation requirements. For example, commercial aviation firms pay substantial attention to duty hours and workloads. Former Alcoa CEO Paul O'Neill[57] emphasizes the importance of treating employees with respect and dignity, of providing them with the resources necessary to carry out their work, and of showing appreciation for their contributions. A first principle is to guarantee the workers' physical safety and psychological safety. Such focus on and concern for the workforce are conspicuously absent at all levels in many, perhaps most, health care organizations.

For example, physical safety in health care settings lags far behind safety in industry. The average number of days lost because of injury per worker per year in health care is 2.8; for Alcoa, the number is 0.15.[57] Psychological safety, which includes feeling safe about reporting an error and being supported when things go wrong, is also often lacking. A recent report by the Agency for Healthcare Research and Quality on culture surveys conducted in 1,052 hospitals showed that more than half (56%) of responders did

not feel safe to report an error.[58] In large hospitals (which include most teaching hospitals), the rate was even higher: 60%.[58]

Summary

Disrespectful behavior is pervasive in health care and takes many forms. The six types we identify are associated with different, sometimes unique, threats to the safety and well-being of patients and health care workers. Although disruptive behavior has drawn increasing attention in recent years, other types of disrespect are far more common and potentially more harmful overall. "Institutionalized" disrespect, such as unduly long work hours, burdensome high work loads, physical hazards, and psychological intimidation, is so common in health care that it is often accepted as normal.

Although personality characteristics predispose some individuals to disrespectful behavior, for the most part, disrespect is learned behavior that is supported and reinforced by the authoritarian, status-based culture found in most hospitals. We address these cultural and educational issues elsewhere,[59] but we hope the definitions and discussion of disrespectful behavior we have provided in this article will enhance awareness and understanding of the harm that such behavior causes for everyone on the health care team and the patients they serve.

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