PEOPLE MANAGEMENT

SIX INTENTIONAL WAYS TO BUILD TEAMS OF EVERYDAY CIVILITY (AND PROACTIVELY ERODE TOXIC BEHAVIORS)

By Mitchell Kusy, PhD

In this article ...

Explore the system that allows people to get away with bad behavior and learn what to do to improve individual, team, and organizational performance, and erode toxic behaviors.

AS I ENTERED AN ELEVATOR ABOUT 15 YEARS ago, I noticed a familiar perfume scent in the air. Although I couldn't immediately identify it, the scent made me sick to my stomach. After much pondering, I recalled that a former colleague wore this perfume. Then it hit me: She was one of the most toxic individuals with whom I have ever worked, and her toxic behaviors made me sick!

Toxic coworkers can have many deleterious effects on their colleagues. Most significantly in healthcare, they can negatively affect patient safety and the entire patient experience.

Why do some people get away with bad behavior and how can physician leaders improve individual, team, organizational performance by squashing toxic behavior?

TOXIC BEHAVIORS AND THE PATIENT EXPERIENCE

Several years ago, during a keynote address to a group of about 500 physician leaders, I shared some statistics about how toxic behaviors affect patient safety:

- **Increase in patient errors**: 51 percent of a sample of nurses reported an increase in patient errors as a result of verbal abuse.[1]
- **Decrease in critical thinking**: 57.6 percent of pediatric nurses surveyed reported a decreased ability to engage in critical thinking as a result of disruptive physicians.[2]
- **Circuitous medical interpretations**: In a survey conducted by the Institute for Safe Medication Practices,

75 percent of respondents reported going to a colleague to interpret an order rather than asking advice from the physician issuing the order due to feelings of intimidation.[3]

- **Avoidable medical errors**: 71 percent of survey respondents reported a link between disruptive behaviors and negative patient outcomes; 75 percent reported these outcomes could have been avoided.[4]
- **Increased surgical complications**: In a 2019 *JAMA* article, researchers reported that among 13,653 patients who underwent operations performed by 202 surgeons, those patients whose surgeons had more coworker complaints about unprofessional behaviors were significantly more likely to experience complications related to the surgery ($p<.001$).[5]
- **Increased financial cost**. 51 percent of people who are targets of toxic behaviors are likely to quit[6]; 12 percent do leave their jobs.[7] Further, human resource metrics demonstrated that the replacement costs for employees who quit are 30 percent, 150 percent, and 400 percent, respectively, in each of the three categories: entry-level, mid-level, and high-level.[8] Those who quit could be the highest performers.

During the keynote, a woman raised her hand and stated, "My husband is a nurse. Just last night he reported that he disagreed with the medication order. Rather than going to the intimidating physician who was on call, he went to two other individuals to interpret the order."

This circuitous routing to seek the advice of someone other than the provider can lead to error, because others may not know the patient's full history.

A second woman raised her hand and said, "Dr. Kusy, I am a surgeon. I need to be intimidating in the operating suite to make sure we have perfection. Would you want to go to a surgeon who is not perfect?"

My response: "Doctor, I want to go to surgeon who is open to feedback if they are about to make an error."

WHO ARE TOXIC COLLEAGUES?

My research colleagues and I found that 94 percent of the more than 400 leaders surveyed reported working with a toxic person[9] — someone who engages in disrespectful, uncivil behavior. Their behavior has wide-ranging effects on their colleagues' psyches, individual and team performance, *and* the bottom line. These employees often are bullies, narcissists, manipulators, and control freaks. They shame, humiliate, belittle, or take credit for the work of others.

The results of having toxic people in organizations often include good people quitting, commitment to the organization decreasing, and coworkers calling in sick.

Why not just fire the toxic person? These people are clever chameleons and their toxicity often goes undetected or excused, with leaders saying such things as, "I know she's a little tough, but she has a great track record." Someone who mentions having difficulty with the tough toxic individual may be labeled a complainer, a nuisance, a non-team player, or worse — someone who is not committed to the organization. Only 1 to 6 percent of the targets of these toxic individuals report incidents to human resource professionals.[10]

Based on a factor analysis, we grouped top toxic behaviors into three domains:

1. **Shaming** includes humiliating others face to face or in public, pointing out the mistakes of coworkers, dressing someone down, bullying, and giving condescending feedback for the sake of being overly righteous.
2. **Passive hostility** includes what is often referred to as "passive-aggressive" behavior: expressing anger in inappropriate ways by criticizing unfairly, being overly sarcastic, and spreading malicious rumors.
3. **Sabotage** includes seeking retaliation and meddling to interfere with a team or individual.

Some behaviors transcend all three domains: verbal abuse, rudeness, and teasing with the intent to hurt. Figure 1 summarizes some of the primary behaviors within each domain.[9]

FIGURE 1. THREE DOMAINS OF TOXIC BEHAVIOR

- **Shaming**: Humiliating, needlessly pointing out mistakes, giving condescending feedback for the sake of being righteous.
- **Passive hostility**: Exhibiting passive-aggressive behavior, taking "pot shots," being overly sarcastic with the intent of hurting, and spreading rumors.
- **Sabotage**: Seeking retaliation, meddling to interfere with the team or individual because of the person's own self interests.

A SYSTEMS APPROACH TO CHANGING BEHAVIORS

Coaching is the most *unsuccessful* strategy leaders use to turn toxic behaviors around.[9] Why? Without a systems approach in place that includes consequences, coaching is significantly less effective. Without consequences, coaching may simply be idle threats.

Does this mean physician leaders should not coach? Certainly not, but coaching should not be the first step. Start with the system that is allowing colleagues to get away with bad behavior.

Below (and summarized in Figure 2) are six strategies that will increase the probability of successfully erasing toxic behaviors from the healthcare system.

1. Engage hard data.

The first strategy is to help leaders understand the deleterious effects of toxic behaviors on patient care. A surprising amount of research has been done on the topic with consistent results: Patient care is compromised by disruptive behaviors.

FIGURE 2. TOP STRATEGIES FOR ERODING TOXIC BEHAVIORS

1. **Engage hard data**. Use hard data to help colleagues understand that toxic behaviors put a practice at risk.
2. **Design a zero tolerance policy**. Build a sequence of progressive discipline phases with consequences each step along the way.
3. **Co-create a compact of professional behaviors**. Integrate this into the fabric of daily work life.
4. **Build the desired culture one "baby step" at a time**. Sustain culture by keeping the professional compact alive.
5. **Assess the team based on established norms**. I use the Campbell-Hallam Team Development Survey for teams to have data by which to assess their effectiveness as a team.
6. **Introduce feedback using a unique formula**. Speak it = Intro + Behavior + Toss Back.

Obtain permission from various journals to distribute articles to leaders and suggest they integrate the information into team discussions. For example, periodically take 30 minutes at a team meeting and discuss as a team how its members might share these data with others, obstacles they might experience in trying some of these strategies, and how they could reinforce some of the key points from these articles with members of their team.

By sharing these data, the process of understanding disruptive behaviors becomes less threatening. The team discussion is more likely to result in behavior change over the long term than an order from the leader.

2. Design a zero tolerance policy.

Unless the behavior is highly egregious, zero tolerance does *not* mean the consequence is termination of employment. Rather, zero tolerance means that there are expected consequences for disruptive behaviors. If this consequence fails to change the behavior, you proceed to the next phase. Having consequences is key. Do not have a zero tolerance policy if you do not intend to have and enforce consequences. Figure 3 provides a sample zero tolerance policy.

3. Co-create a compact of professional behaviors.

One of the strategies that Renee Thompson, DNP, RN, CEO of the Healthy Workforce Institute, uses is a wonderfully easy strategy for all levels and disciplines: co-design a compact of professional behaviors.

I used this strategy recently, asking an entire department to brainstorm all the behaviors we should *not* do and all the things we should *not* say, as well as those behaviors and comments that we *should* do or say.

Each person received dozens of Post-It notes on which to jot down a *not* do/say or *should* do/say (one behavior per Post-It). This exercise was done within a two-hour window, such that staff came and went as their schedules would allow.

FIGURE 3. SAMPLE ZERO TOLERANCE POLICY

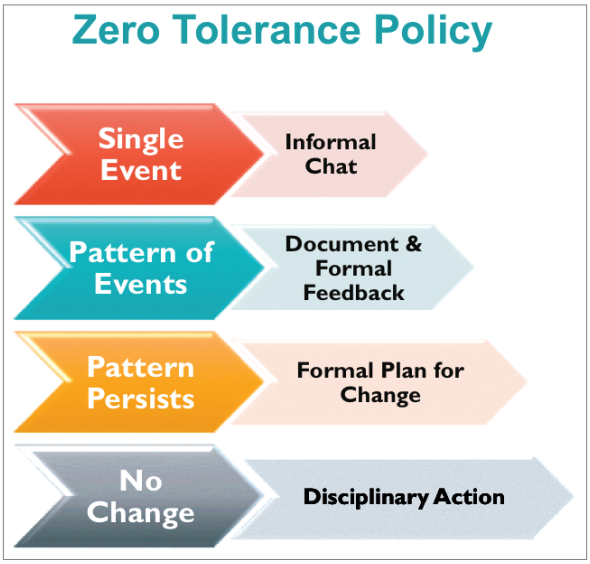

FIGURE 4. COMPACT OF PROFESSIONAL BEHAVIORS

Compact of Professional Behaviors

What we strive for:

A supportive environment in which all roles are valued for the service they provide — regardless of position or level. We extend our reach to others and do not have "territories."

How we make team decisions:

- Patients first.
- Team members second.

I commit to engaging in these positive behaviors:

- Acknowledging questions or comments without passive-aggressive intent.
- Providing feedback in a respectful way.
- Extracting myself from gossip circles.
- Going out of my way to support others.
- Disagreeing with respect and dignity.
- Extending appreciation to others even those who have been negative to us.
- Beginning with the premise of assuming positive intent.

I commit to *not* engaging in these behaviors:

- Gossiping about others.
- Belittling others at meetings (*e.g.*, rolling eyes, giving someone the cold shoulder).
- Taking credit for the work of others.

Interestingly, most staff members initially considered the activity a "flavor of the month"; however, within a short time they began talking with each other about the responses. People milled around just to see what was being posted.

Then the flipchart rotated throughout the department such that everyone had an opportunity to contribute — particularly those who had not been there for the initial activity. During a two-week period, the flipcharts were placed in the lounges, in the nurse's station, in the conference room, etc.

After the two-week flipchart rotations, I collected all the Post-It notes, digested them into themes, and worked with a multidisciplinary team to draft the behavior compact based on the themes. Figure 4 provides an example of this compact of professional behaviors.

This strategy helps build a culture that rejects incivility and promotes professional practice.[11] Staff (including physicians) appreciate being included in the process of developing this compact.

4. Build the desired culture gradually.

One way to build the desired organizational culture is with a template. Figure 5 is a sample completed template; Figure 6 is a blank template for the reader's use.

One team of physicians and nurses set up a large dry-erase board in their common work areas and divided the dry-erase board into four columns:

1. What we used to do or say.
2. What we do or say now.
3. Why change?
4. Obstacles to overcome.

As staff identify behaviors for each of the columns, they begin jotting them down on the dry-erase board, eventually completing all four columns. This kind of process spreads new norms beyond ivory tower perspectives to real-time perspectives.

5. Assess the team based on established norms.

The Campbell-Hallam Team Development Survey, or TDS, does not cull toxic individuals from the group; rather, it identifies how team members perceive the team performance

FIGURE 5. DEVELOPING NEW TEAM NORMS TO HONOR OUR PROFESSIONAL COMPACT

What we used to do or say:	What we do or say now:	Why change?	Obstacles to overcome:
"You've got to be kidding. I can't believe the way he talked to the charge nurse. What an idiot."	"I know I've been part of these conversations in the past. I don't feel good about myself when I do this. Why not talk with him directly?"	It increases team divisiveness.	You could be ostrasized for not contributing in this gossiping.
Someone rolls their eyes when you are speaking at a meeting.	"I noticed you rolled your eyes a couple times when I spoke today. Just checking with you if it was related to what I said? If so, it's OK to talk with me directly."	When nothing is said, anger can build up and increase resentment.	Getting the courage to say something.
You speak with others about how inappropriate the language was during today's surgery. You don't try to problem-solve but simply "vent."	"During the surgery, I noticed you were using a lot of language I have not heard you use before. Is everything OK? Tough day?"	If inappropriate language is used, people may be reluctant to speak up when there is a questionable error.	There is a tendency to view this as an isoloated incident, when actually it is not. And by gossiping about this to others, change in behavior is not likely to occur.
Someone doesn't share critical information with you that has been shared with others.	"I don't believe I have the most current information. Is there anything else you could share with me?"	If you say nothing, the situation could escalate, you could harbor resentment, and not support this person in the future.	If you are not used to talking with this person or if there is a power differential, it could be threatening.
The housekeeping staff has done a beautiful job of getting a room ready for a new patient. You tell others about how great this person is.	"Thank you for getting the room ready so quickly today. I really appreciate this." [And you share this with the charge nurse and head of housekeeping.]	The professional compact is not just about calling out disrerspectful behaviors. It's also about honoring respectful behaviors.	Time!
Someone who has "badmouthed" you in the past just praised you for a job well done. [You interpret this as just trying to get on your "good" side.]	"Thank you. This means so much to me. You just made my day."	Besides the professional compact being about respectful behavior, this change in attitude can be a "game changer."	Honing too much on your own perceptions and not giving someone the benefit of the doubt.

FIGURE 6. DEVELOPING NEW TEAM NORMS TO HONOR OUR PROFESSIONAL COMPACT

What we used to do or say:	What we do or say now:	Why change?	Obstacles to overcome:

and dynamics, including those related to toxic behaviors. The discussions associated with the data from this instrument likely will uncover ways to address toxic behaviors directly and clearly.

(Please note: I have no financial or vested interest in this instrument, which my clients purchase from Fifth Theory; I simply facilitate the process.)

Team members evaluate the team on 19 key dimensions related to best practices associated team effectiveness. The unique aspect of this instrument is that individuals who work with but are not part of the team anonymously assess the team on these same 19 dimensions. This provides objectivity to the assessment.

Another unique feature is that the team results are compared with those of other teams throughout the United States who have used the instrument; therefore, the team members see where they score on each of these 19 dimensions in comparison with the national average. Most physicians appreciate this as they now have hard data regarding what they need to do to affect professional behaviors.

This instrument provides a forum for team members to address a person's behavior in a safe venue. The data simply function as a catalyst to spur a rich discussion of areas of strength, challenges, and opportunities based on the team results.

With the data in hand, I engage the team in a discussion of how to share what they have learned from the external observers and their own internal team. At the end of the session, they move toward a proactive course of action.

Results from one team's process indicated the following:

- The toxic individual significantly reduced her shaming and condescending behaviors such that team members reported greater trust and confidence in the leader.
- Through an internally generated customer survey, key clients reported that the team improved their responsiveness to client issues, resolved problems more quickly, and were able to build their business so that they could serve their external customers more effectively.
- Customers further reported that the team had improved on four out of five best-in-class benchmarks associated with team performance.
- Service delivery with clients improved as demonstrated by results in follow-up focus groups and surveys.
- One team member volunteered to work with a coach to learn how to extinguish condescending feedback to team members; provide corrective and reinforcing feedback on a consistent and positive basis; and stop shaming individuals one-on-one and in public venues.

6. Introduce feedback using a unique formula.

Coaching professionals is a complex process. Most physician leaders get stuck in how to *initiate* the feedback process — essentially how to begin the conversation. Many times, leaders provide too much positive feedback and then hit the employee with a list of negative behaviors. At other times, physician leaders immediately go for the jugular. Both methods may be fraught with failure.

One formulaic process for introducing the conversation is a feedback model. It is simple, concrete, and elegant, and it

FIGURE 7. SPEAK IT = INTRO + BEHAVIOR + TOSS BACK

Intro: *"Help me understand this.* ***Behavior:*** *I just saw you roll your eyes at me.* ***Toss back:*** *Can we set up a time to talk about this?"*

Intro: *"I'm not sure you're aware of this.* ***Behavior:*** *The last few times we had a team meeting, you raised your voice at me in front of others.* ***Toss back:*** *Is everything OK?"*

Intro: *"I was offended by a comment of yours.* ***Behavior:*** *You said I don't know what I'm talking about.* ***Toss back:*** *I would appreciate talking about this. Is this a good time?"*

allays anxiety of initiating the conversation (which many find to be the most difficult part of the coaching process).

Figure 7 illustrates how this three-step process progresses. First, the "intro" is clear and respectful. Second, the behavior is stated in nonevaluative terms. For example, rather than "You shame others," the statement is, "You are rolling your eyes at meetings when some people speak." Third, the "toss back" provides an opportunity for a discussion.

This model can be applied to the formal coaching process or feedback ad hoc. Either way, physician leaders should make adjustments based on the context.

TAKING BABY STEPS

Organizational change is about baby steps. It's not bold strokes but, more importantly, the little things we do every day that make the biggest difference. Start small. For physician leaders to be successful in creating cultures of everyday civility, they should consider piloting these six strategies with a small sample. As they gain confidence, they should expand their reach and teach others what they are doing.

To be a leader is to teach. If you're not teaching, you're not leading. Share this learning with others!

Mitchell Kusy, PhD, is professor in the PhD Program in Leadership & Change at Antioch University, a consultant with the Healthy Workforce Institute, and Fulbright Scholar in organization development.
mitchellkusy@gmail.com

REFERENCES

1. Sofield L, Solmond SW. A Focus on Verbal Abuse and Intent to Leave the Organization. *Orthop Nurs*. 22(4):274-83.
2. Piper LE. Addressing the Phenomenon of Disruptive Physician Behavior. *Health Care Manag*. 22(4):335-39.
3. Intimidation: Practitioners speak up about this unresolved problem (Part 1). https://www.ismp.org/resources/intimidation-practitioners-speak-about-unresolved-problem-part-i. March 11, 2004.
4. Rosenstein AH, O'Daniel M. A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety. *Jt Comm J Qual Patient Saf*. 34(8):464-71.
5. Cooper WO, Spain, DA, Guillamondegui O, *et al*. Association of Coworker Complaints About Unprofessional Behavior by Surgeons with Surgical Complications in their Patients. *JAMA Surg*. 2019 Jun 19. doi:10.1001/jamasurg.2019.1738
6. Kusy M. *Why I Don't Work Here Anymore: A Leader's Guide to Offset the Financial and Emotional Costs of Toxic Employees*. Boca Raton, FL: CRC Press. 2017.
7. Pearson C, Porath C. *The Cost of Bad Behavior*. New York: Penguin Books. 2009
8. Borysenko K. What Was Management Thinking? The High Cost of Employee Turnover. April 22, 2015. *Talent Management and HR*. https://www.tlnt.com/what-was-leadership-thinking-the-shockingly-high-cost-of-employee-turnover.
9. Kusy M, Holloway E. *Toxic Workplace: Managing Toxic Personalities and Their Systems of Power*. San Francisco: Jossey-Bass. 2009.
10. Cortina LM, Magley VJ, Williams JH, Langhout RD. Incivility in the workplace: Incidence and Impact. *J Occup Health Psychol*. 6(1):64–80.
11. Sarik DA, Thompson R, Cordo J, Roldan IN, Gonzalez JL. Good for Nurses, Good for Patients: Creating a Healthy Work Environment in a Pediatric Acute Care Setting. *Nurse Leader*. 18(1):30-34.

> "I believe in the theory that the strongest motive, whether we are conscious of it or not, rules our conduct."
> *Ellen Glasgow*