By Melissa A. Madden and Barbara S. McAlister

A Time to Speak: When Incivility Injures Patients

ABSTRACT: *Incivility continues to create challenging work environments for healthcare workers. Nurses who experience incivility related to patient concerns or treatment often must confront power differentials and the fear of consequences if they speak up on behalf of the patient. This case report of a family's labor and delivery experience demonstrates the potential of harm to patients and long-term consequences of workplace incivility for the patient and the nurse. Moral courage and biblical insights to strengthen nurses' commitment to speak up for patients are discussed.*

KEY WORDS: *conflict management, incivility, nursing, patient safety, work environment*

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The authors declare no conflict of interest.

* Names changed to protect privacy.

Accepted by peer review 11/16/2020.

DOI:10.1097/CNJ.0000000000000971

A seasoned nurse faculty co-worker once advised me to stop focusing on the concept of incivility because "incivility is just part of the job." Left to ponder that advice, I realized I could not recall one nursing job in my 30 years of experience where I had not encountered co-worker incivility.

Unfortunately, my experience is not unique; incivility remains a pervasive societal challenge and the healthcare professions are not immune to its deleterious effects. Decades of research on workplace incivility have produced few evidence-based interventions to curtail the rampant problem (Gillen et al., 2017). The issue has become dire enough for professional organizations to call for evidence-based teaching strategies that prepare nurses to speak up when faced with behaviors of incivility (American Nurses Association, 2015); however, research suggests that new nurses are more likely to leave their position than to exercise their right to express their viewpoint (Çaylak & Altuntas, 2017).

The purpose of this article is to expand the dialogue regarding the impact of healthcare worker incivility on patient safety and to elaborate on the nurse's duty to intervene through patient advocacy. Wisdom from the Old Testament book of Ecclesiastes serves as a reminder that "for everything there is a season, and a time for every matter under heaven" (Ecclesiastes 3:1, NIV) and "…there is a time to keep silent and a time to speak" (verse 7). But when does the Christian nurse recognize the time to speak up in relation to co-worker incivility? An episode of incivility witnessed during one couple's labor and delivery experience illustrates the long-term effects on patient outcomes. Their heartbreaking case highlights the need for Christian nurses to embrace their faith, stand firmly on their spiritual foundations, and "speak up for those who cannot speak for themselves" (Proverbs 31:8, NIV).

BACKGROUND

According to Dang et al. (2016), workplace incivility can be defined as "low-intensity deviant behavior that violates workplace norms of mutual respect" (p. 115). Clark and Kenski (2017) described incivility as the display of "a range of rude or disruptive behaviors and failing to take action when action is warranted or justified" (p. 60). Incivility in healthcare is symptomatic of conflicting professional relationships that alter the work environment and affect the quality and safety of patient care. Although physician perspectives of healthcare worker incivility suggest a link between unprofessional clinician interactions and diagnostic errors (Giardina et al., 2018), nursing perspectives suggest the potential for unfavorable outcomes, such as patient harm and near misses (Dang et al., 2016). These views merely relate to the perceived immediate ramifications of incivility, however, and do not consider the weeks, months, or even years that follow.

What is known is that healthcare systems that foster a culture of safety and promote teamwork have decreases in patient harm and hospital mortality (Berry et al., 2020). To date, research has focused primarily on healthcare team members'

perceptions of co-worker incivility; however, this approach seems myopic. Patients are the reason the healthcare industry exists. Thus, patients' impressions after having witnessed healthcare workplace incivility provide a unique perspective upon which nurses may reflect.

LITERATURE REVIEW

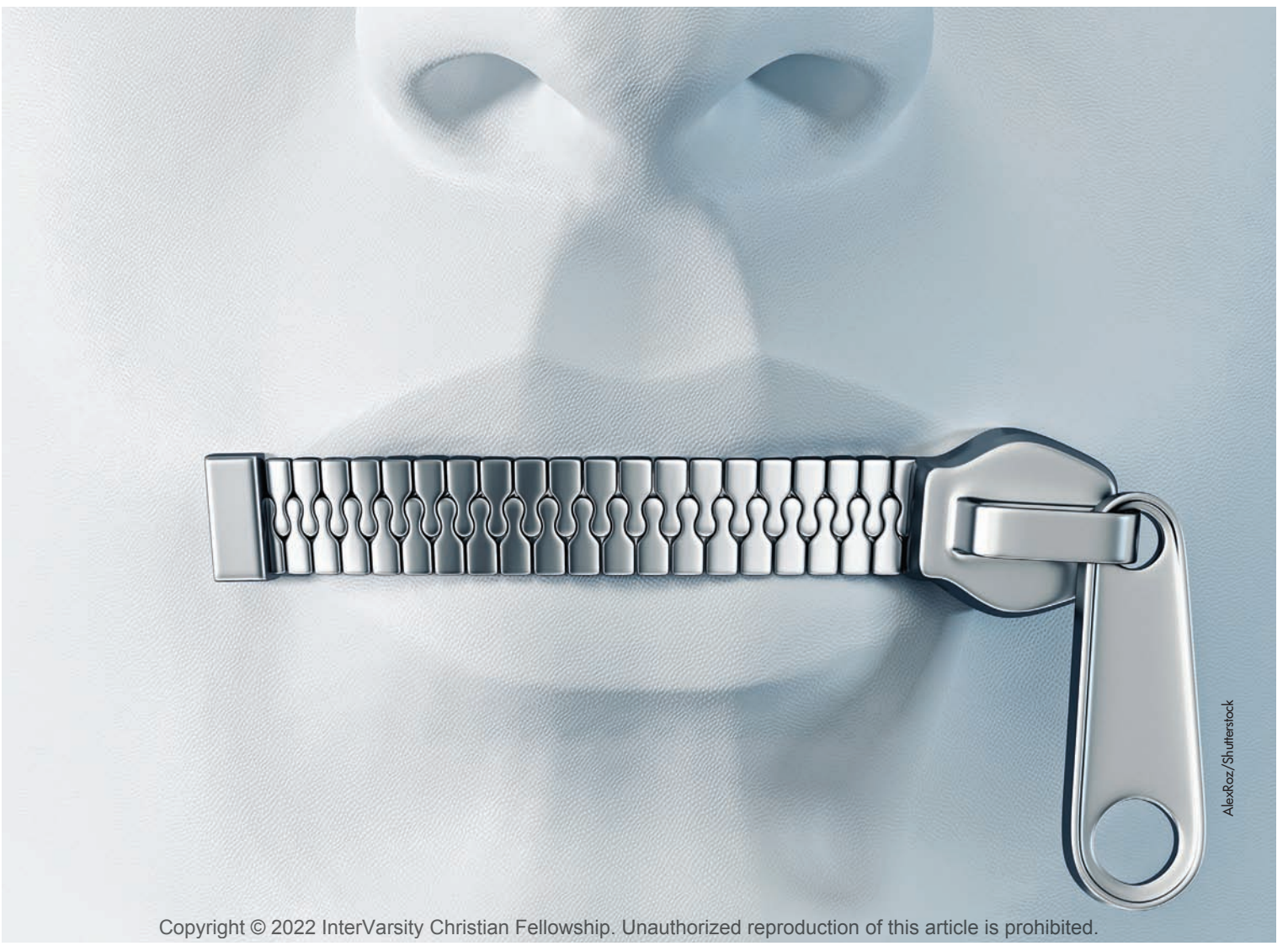
Numerous studies have explored factors associated with barriers and predictors for the nurse's ability to speak up. Barriers to speaking up include nurses' reports of insubordination, fear, anger, and lack of confidence (Fagan et al., 2016; Kirrane et al., 2017). Power differentials can result in nurses remaining silent as they conform to practices in the clinical environment which could negatively impact quality of patient care (Bickhoff et al., 2017; Houck & Colbert, 2017). This type of silence is considered "defensive silence," which is associated with the emotion of fear and is the act of the nurse "protecting self" (Kirrane et al., 2017, p. 355). The role and position of subservience also influences nurses' self-perception and the value of their contribution and their confidence to assertively speak up (Fagan et al., 2016). Kirrane et al. (2017) identify this as a form of "acquiescence silence" (p. 356) in which the individual becomes resigned and disengaged, believing his/her opinion is not valued. Additionally, nurses report concern for looking foolish as a barrier to speaking up (Bickhoff et al., 2017). This lack of confidence is related to generational differences and lack of knowledge concerning regulations, policies, and organizational systems (Bickhoff et al., 2017).

Common to all themes identified in the literature is the role of emotions as a primary factor for nurses choosing not to speak up (Bickhoff et al., 2017; Fagan et al., 2016; Kirrane et al., 2017). Emotions act as the motivational conduit between thoughts and actions, and different emotions lead to different types of action tendencies (Kirrane et al., 2017). Edwards et al. (2009) explain that anger and guilt predict speaking up following an observed transgression, whereas anticipatory fear and shame predict decisions to remain silent. Kirrane et al. (2017) suggest "fostering approaches that eliminate fear are key to improving constructive voice and engagement" (p. 373).

The following case report demonstrates the barriers to speaking up as identified in this review. Following the example, a discussion of Scripture is offered to help direct Christian nurses' decision-making process of knowing when they should speak up.

METHOD

Institutional Review Board approval was obtained from the researcher's doctoral university, and the participant provided written informed consent.



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The participant was known to the researcher through a previous professional affiliation. The participant was purposefully chosen because he had offered to share his experience of witnessing physician-to-nurse incivility during his wife's hospitalization for childbirth. The participant hoped that his family's story would promote incivility awareness and education for nurses.

The story was recounted during an audiotaped interview that lasted approximately 90 minutes and a private follow-up clarification phone call that lasted approximately 20 minutes. The interview was conducted solely between the researcher and the participant during nonbusiness hours at a private location. Interviews were transcribed verbatim immediately following the interview appointment. The participant's story was analyzed for themes and implications for educating nurses on the impact of healthcare worker incivility and their duty to speak up.

Healthcare systems that foster a culture of safety and promote teamwork have decreases in patient harm and hospital mortality.

CASE REPORT

Mr. and Mrs. Adams* never expected their third pregnancy would be different than their prior ones. They were reassured throughout the pregnancy that everything was going well, until late in the third trimester when Mrs. Adams became concerned about high blood pressure. Fortunately, she was scheduled for her 38-week prenatal visit during which her concerns were affirmed. She was immediately admitted to the hospital where labor was induced.

The synthetic oxytocin was effective in stimulating uterine contractions; Mrs. Adams' labor began to progress, and an epidural was placed. The labor induction continued with Mrs. Adams' pain relieved by the epidural. Mr. Adams recalled that, at one point during labor, without warning, his wife's "blood pressure dropped, and she turned white as a sheet." Mr. Adams called the nurse, who in turn alerted the obstetrician of the drop in blood pressure from 146/90 to 96/60. The nurse summoned the physician to come and assess the patient. Mr. Adams vividly recalled the physician–nurse interaction that followed at the bedside.

> The nurse openly questioned him regarding the similarity of my wife's and baby's heart rates displayed on the monitor. The nurse even requested a bedside ultrasound, but the OB literally stiff-armed her and said, "No, you don't know what you're talking about; it's just the effects of anesthesia."

The nurse cowered in response to the physician and ceased further attempts for advocacy.

Several hours passed as Mrs. Adams' blood pressure continued to drop. Finally, the fetal heart monitor began alarming, marking a defining moment that would change the couple's lives. Mr. Adams recalled, "We trusted our nurses and still do, but it was obvious something disturbed the nurse about the alarm." Evidently, that alarm was the catalyst that finally caused the nurse to bring in the bedside ultrasound, "on her own gumption." Mr. Adams elaborated, "I'll never forget the look the doctor gave the nurse when she did this; it was not a look of thankfulness."

Five hours had passed since the nurse had initially made her request for the ultrasound to verify the accuracy of the maternal and fetal heart rates visible on the monitors. Ultimately, the ultrasound revealed a fetal heart rate of 50 beats per minute. Mr. Adams explained, "It was discovered that the internal fetal monitor had been misplaced on my wife's cervix and not our baby's head. This is when we had an 'Oh my gosh!' moment and immediately began to pray." Their child's heart rate had not been monitored during that entire time interval.

An emergency cesarean section ensued, leading to the delivery of a neonate with poor Apgar scores and severe brain damage. The parents later learned that there were over 1.5 liters of blood in Mrs. Adams' uterus at the time of delivery; about one-third of the blood was already coagulated, suggesting that an undetected placental abruption had occurred.

Their child required extensive care during her lifetime. In their 10 years of providing for her, there was never one smile or touch from her to connect

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with and encourage them; only their faith sustained them. In the months and years that followed, Mr. and Mrs. Adams could not help but ponder about how differently their lives might have been if only their nurse had not succumbed to their doctor's incivility, and instead had courageously taken her concerns up the chain of command.

ANALYSIS

Identified Themes

Based on Mr. Adams' perception of healthcare worker incivility, four themes emerge. Three of the four themes have been discussed previously in the literature through nurse and physician perceptions of co-worker incivility including defining incivility, power differentials, and fear to speak up. The fourth theme of long-term consequences is unique to the patients' perspective and emphasizes the nurse's duty to speak up.

The following statements demonstrate Mr. Adams' definition of healthcare worker incivility, which aligns with Clark and Kenski's (2017) description of insolent behavior and "failing to take appropriate action when action is justified" (p. 60). Although the nurse took initial action by notifying the healthcare provider of her concerns when Mrs. Adams turned "white as a sheet," the physician discredited her in the presence of the patient. This led to defensive acquiescent silence and further inaction by the nurse.

> I think incivility is just open unprofessionalism and really using power to manipulate a standard of care. It is the opposite of collaboration. Creativity is stifled. It really has to do with a cruel, unprofessional act that everyone in the room knows what it is when they see it. This is when I first saw the incivility. The doctor literally stiff-armed the nurse by telling her there was nothing wrong. The nurse was completely discredited.

Power differentials may alter one's ability to make ethical decisions. "Those in lower roles within organizational hierarchies are often those who experience the negative effects of power relationships such as bullying and oppressiveness" (Gibson et al., 2014, p. 2).

The second theme of power differential can be seen through the following statements provided by Mr. Adams' observation of the uncivil encounter between the nurse and the physician.

> It was like the doctor was saying, "I know this; who are you to tell me what to do?" But what I think that stood out that night was that in all the stuff going on, was that the doctor would not listen to the nurse and he was disrespectful. Had the doctor listened to the nurse, we wouldn't be talking right now.

The third theme of fear to speak up can also be seen through Mr. Adams' perspective of the uncivil encounter. The Adams's realized "the nurse knew something was wrong," and that she chose not to engage in conflict with the healthcare provider nor take further action through the proper channels.

> In retrospect, we realized this was the moment we were in trouble, and the fetal monitor strip later confirmed our thoughts. I think the nurse knew hours before that the cuff reading and the internal monitor should never match. It was like there was no collaboration; it seemed like the nurse was having to work against the doctor. If the nurse had spoken up the chain of command earlier, our child would be 12 years old now.

The fourth theme identified from the interview with Mr. Adams emphasized the importance of including the patient's perspective of healthcare worker incivility and serves as a reminder that nurses need to consider the long-term consequences of their silence. Currently, there are no policy or practice initiatives to supplement patient safety data using patient-reported experiences or feedback that capture long-term effects of hospital experiences (Giardina et al., 2018). The following statements identify long-term effects felt by Mr. and Mrs. Adams due to healthcare worker incivility behaviors that occurred during their labor and delivery experience.

> So, our child lived for a little over 10 years as a spastic quadriplegic with optic nerve blindness and seizure disorder. There was never any sign of a connection or communication. We just want other nurses to learn from this. We love and forgive those involved, but just want others to learn to speak up and to follow the chain of command with the power given them through Christ.

DISCUSSION

This case report demonstrates the associated barriers to speaking up as identified in the literature, including power differentials and fear. Although the nurse attempted to speak up to the physician at the first sign of trouble, the power differential was clearly observed by the patient. According to Scripture, the nurse can find strength when faced with the issue of power differentials by remembering for whom he/she is working. The Christian nurse knows that his/her work is a labor of love for God, as Colossians 3:23-24 (NIV) reminds us: "Whatever you do, work heartily as for the Lord and not for men, knowing that from the Lord you will receive the inheritance as your reward." New nurses often view their role as following physicians' orders. Certainly, that is their role in part. However, their role also requires their own assessment, communication, and advocacy skills. Christian nurses know through God's Word who they ultimately are responsible to; this can strengthen them to intervene on behalf of their patients. The apostle Paul also reminds us, "Stand firm. Let nothing

Web Resources

- **American Association of Critical-Care Nurses: AACN Standards for Establishing and Sustaining Healthy Work Environments** https://www.aacn.org/wd/hwe/docs/hwestandards.pdf
- **Healthy Workforce Institute** https://healthyworkforceinstitute.com/
- **Nurse.com: How to recognize and prevent bullying in nursing** https://resources.nurse.com/workplace-violence-recognize-and-prevent-bullying
- **The Joint Commission** https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/american-nurses-association/

move you. Always give yourself to the work of the Lord, because you know that your labor in the Lord is not in vain" (1 Corinthians 15:58, NIV). Remembering that the true power differential is between God and the perpetrator of incivility, the nurse can pray for the individual while advocating for the patient.

Facing fear to invoke the chain of command in response to a healthcare provider's actions or behaviors takes moral courage. God's Word is steeped with the concept of moral courage through examples of people (Daniel; Esther; David being persecuted by King Saul; apostle Paul) facing fear and acting on the strength given to them by God. Christian nurses can draw on Scripture to inform their need to intervene on behalf of their patients as they follow through with the godly principles of moral courage. Although Christian nurses may fear repercussions, they should not conform to poor practices that may affect the safety of the patient.

In this case example, the nurse did not take her concerns through the proper channels when she knew something was wrong. Instead, hours passed before she brought the ultrasound to the bedside of her own accord. Learning from this example, Christian nurses should remember God's presence by recalling Scripture that reminds us to "fear not." Joshua 1:9 is one example: "Have I not commanded you? Be strong and courageous. Do not be frightened, and do not be dismayed, for the Lord your God is with you wherever you go" (NIV). Another can be found in Isaiah 41:10: "Fear not, for I am with you; do not be dismayed, for I am your God; I will strengthen you and help you; I will uphold you with my righteous right hand" (NIV).

When Christian nurses hesitate to speak up due to the fear of consequences of their actions, remember that fear is not derived from God, as 2 Timothy 1:7 reminds us: "The Lord does not give us a spirit of fear, but of power, love and a sound mind" (NKJV). This spirit is the same spirit given to Old Testament leaders Moses and Joshua, and to Jesus' own disciples in the New Testament. Christian nurses faced with power differentials and fear in the face of healthcare worker incivility need to recall what God has said to help them communicate and advocate for their patients. In doing so, Christian nurses exercise moral courage to speak up in love, while following God's command to be fearless and courageous, knowing that he is with them, strengthens them, and upholds them through the power of the sound mind he has given them.

CONCLUSION

Although the outcomes of this case report had negative long-term consequences, the participant felt his family's loss should not be in vain. This family's Christian love is evidenced by their passion to help current and future nurses overcome the barriers to speaking up. The painful and potentially convicting insights gleaned from this case report remind us that the right time to speak is most often at the moment of initial concern or shortly thereafter. A family member's vivid memories of having witnessed healthcare worker incivility remind us that incivility can cause more than embarrassment and hurt feelings. Patients' health and well-being are at risk of suffering collateral damage. In some instances, patients' lives hang in the balance.

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