Kindness in Health Center

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The healthcare workplace is a high-stress environment. All stakeholders, including patients and providers, display evidence of that stress. High stress has several effects. Even acutely, stress can negatively affect cognitive function, worsening diagnostic acumen, decision-making, and problem-solving. It decreases helpfulness. As stress increases, it can progress to burnout and more severe mental health consequences, including depression and suicide. One of the consequences (and causes) of stress is incivility. Both patients and staff can manifest these unkind behaviors, which in turn have been shown to cause medical errors. The human cost of errors is enormous, reflected in thousands of lives impacted every year. The economic cost is also enormous, costing at least several billion dollars annually in the US alone. The warrant for promoting kindness, therefore, is enormous. Kindness creates positive interpersonal connections, which, in turn, buffers stress and fosters resilience. Kindness, therefore, is not just a nice thing to do: it is critically important in the workplace. Ways to promote kindness, including leadership modeling positive behaviors as well as the deterrence of negative behaviors, are essential.

Keywords: stress ; incivility ; disruptive behavior ; medical error ; kindness ; safety ; quality of care ; malpractice ; patients ; providers

1. Disruptive Behaviors in the Health Care Workplace

Incivility and related undesirable (and unkind) behaviors are a natural outcome of stress as well as a cause of stress. High-quality care requires strong, positive relationships among team members. Communication is key—taking the time to articulate information clearly coupled with active and empathetic listening to others is absolutely essential. The simplest team, of course, is the provider and the patient. They form a partnership in which quality communication is mandatory. Ultimately, they need to trust one another [1]; the cornerstone of trust, particularly for patients to caregivers, is that they listen. It is the tangible mark of caring.

In more complex teams that require multiple expertise (such as surgical teams comprised of physicians, nurses, aids, pharmacists, therapists, etc.), quality communication becomes even more essential [2]. That is, to minimize hand-off errors, have a shared understanding of the care plan, and coordinate its execution, effective, consistent, and compassionate communication is required. As with the simpler relationship between a patient and provider, a central component of multi-disciplinary teams is that team members need to trust one another [3][4].

Yet, in a stressful environment, quality communication can suffer. Both the person speaking, as well as the listener can be affected [5]. As a substantial portion of communication is non-verbal [6][7], and stress can affect both the content as well as the tone and prosody of speech and facial expressions [5][8], it is critical to recognize how important this “soft” aspect of interaction can be in the health care workplace. In addition, as even mild stressors affect cognitive processing (see below), it is easy to see how stress will disrupt the quality of communication and, therefore, care.

Beyond heavy workloads, restricted agency, and the responsibility for someone else’s health, another major class of stressors in health care is disruptive behavior. Disruptive behaviors include more blatant and active types, such as bullying, physical violence, discrimination, harassment, anger [9][10], as well as incivility, which is less directed.

In a seminal paper on the subject of workplace incivility, Andersson and Pearson define incivility as “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others” [11]. With regard to healthcare, there are two important facets of incivility to consider: between and among staff members and between the patient and provider.

It has been known for quite some time that incivility and other disruptive behaviors were commonplace in health care. They occur between patients (and their families) and staff, as well as between and among staff [12]. They are too often experienced by medical and nursing students and those in training after graduation [13][14].

Multiple studies have documented disruptive behaviors and examined their relevance to outcomes. Lucian Leape described the process as follows: "*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. 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*" [15].

Rosenstein and O'Daniel [16] surveyed hospitals in the western US of Voluntary Hospitals of America (VHA). A total of 4530 staff responded, approximately a 3:1 ratio of nurses to physicians. In that early study, the vast majority of respondents reported having ever witnessed disruptive behavior by physicians (77%) as well as by nurses (65%). The respondents also clearly linked the disruptive behaviors to negative outcomes for staff, such as stress (94%), reduced team collaboration (89%), reduced communication (91%), and impaired RNs and MDs (99%). A significant majority (67%) thought that there was a link between these behaviors and significant adverse events, which included death. Finally, 18% were aware of a specific adverse event that occurred because of disruptive behavior.

Westbrook and colleagues surveyed staff in seven tertiary care metropolitan hospitals in Australia using the Negative Acts Questionnaire [17] focused on disruptive behaviors among staff [18]. A total of 5178 staff responded (out of an invited 15,213). Of these, over 4600 (>89%) reported experiencing incivility of bullying within the past year; in 2009, staff members (39%) who reported experiencing disruptive behaviors at least weekly, a comparable number also reported that it negatively affected their well-being to a moderate or major extent.

Teamwork also suffered—55% responded that it had a moderate or major negative effect. Similarly, almost 50% of respondents stated that disruptive behavior decreased the quality of care to a moderate or major degree. Respondents who also reported (having) "speaking up skills" experienced a less deleterious effect on both teamwork and quality of care.

Lim and colleagues adopted Rosenstein and O'Daniel's survey instrument to assess the incidence of disruptive behavior in Singaporean health care [19]. A total of 500 nurses and physicians responded, yielding an ~40% response rate. Approximately 95% of respondents had witnessed at least one form of disruptive behavior, which included rudeness, condescending remarks, facial expressions, outbursts (yelling), harassment, throwing objects, etc. Of the respondents, 34% witnessed these behaviors on a weekly or more frequent basis. These behaviors were reported to commonly result in negative employee outcomes as well as negative patient outcomes. Similar results have been observed by Oppel and colleagues in the US [20].

Cooper and colleagues examined how patient complaints about surgeons' disruptive behaviors would predict later errors [21]. They examined how two years of prior complaints related to postoperative surgical and medical complications within 30 days after the surgery. They reported that surgeons with a greater number of complaints had a significantly increased risk of later errors. Separated into quartiles of complaints, the authors estimated that if the surgeon were in the three highest quartiles of patient complaints, compared to those in the lowest quartile, then 426 complications of surgery would have been avoided. A similar observation has also been made by Lagoo and colleagues [22].

These studies have largely focused on incivility that was displayed by a provider staff member. Yet disruptive behaviors from patients, families, and other visitors are another major source of stress for staff. In a large survey undertaken in a single academic medical center, ~23% of physicians reported experiencing "mistreatment" (including verbal abuse, physical violence or threats of violence, or sexual harassment) from patients and/or family members during the previous year, a finding that was linked to increased risk of burnout and intention to leave the profession [23][24][25]. Women and members of minorities, in general, are at greater risk of experiencing mistreatment.

Hatfield and colleagues recently documented that, at an academic medical center, verbal threats from patients or families were reported by 70% of healthcare practitioners within the previous year, with threats of physical harm or actual physical harm relayed by 23% and 12% of HCPs [26]. In another survey study at a large academic medical center, Meese and colleagues reported that approximately 10% of all clinical staff reported patient mistreatment as a major stressor, which was experienced most by nurses (19%). This problem is not isolated—in a meta-analysis that encompassed reports from 30 countries, it was found that ~20% of staff experienced workplace violence on an annual basis [27]. As expected, with a reported increase in errors, incivility decreases organizational efficiency in the healthcare workplace [24].

It should be emphasized that the problem of incivility is societal. It is considered a major problem by most Americans that is increasingly becoming worse [28]. It is not an American phenomenon—it is seen in the UK and elsewhere [29]. Incivility

(disruptive behaviors) often begets retaliatory behavior by the recipient [30][31]. Negative behaviors spread, creating more stress and perpetuating diminished teamwork, communication, cognitive function, and work satisfaction.

2. Kindness Is Not Just about Being Nice

Thus, kindness is not just about being nice. It has very practical implications for interpersonal relationships, upon which many different outcomes depend. For patients, this includes satisfaction, trust, and engagement in the providers and their organization. For providers, it affects their own satisfaction as well as their cognitive function and hence decision-making, creative problem-solving, and ability to show compassion and caring. It will affect burnout and turnover. All of this has financial implications on multiple levels.

A simple(r) way to view this process is that kindness creates a positive interpersonal connection, which is well-known to buffer stress and promote resilience [32]. As the effects of stressors are lessened, better mental and physical health ensues. Happiness is a natural outcome of all of this, and happier people are kinder, completing a virtuous cycle [33]. Thus, the promotion of kindness has manifold implications for quality of life. This cycle is depicted in **Figure 1**.

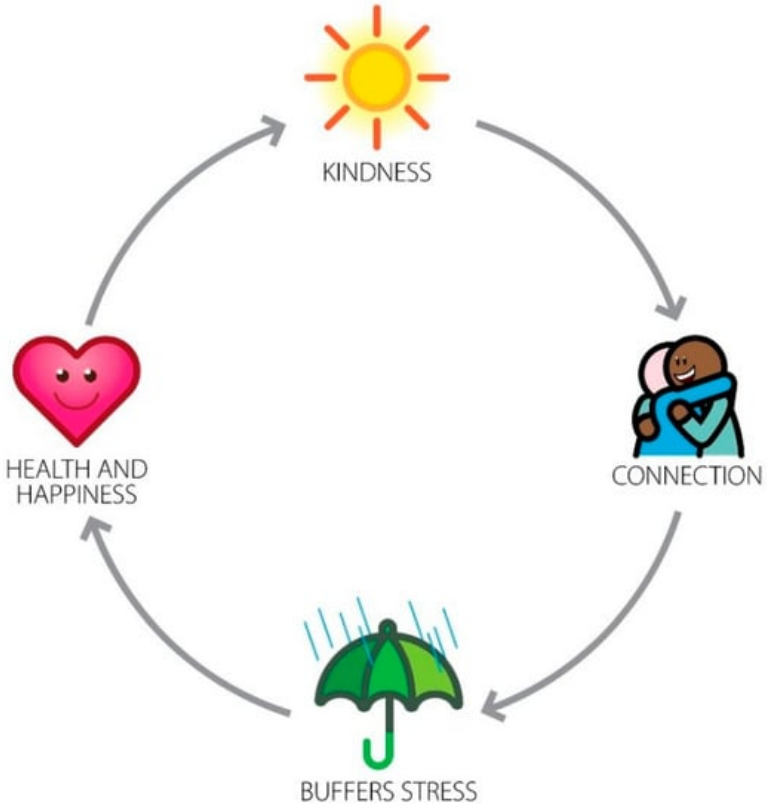

Figure 1. Kindness creates connection, which in turn, buffers stress and promotes resilience. As stress is attenuated, health and happiness become more manifest, which, in turn, creates more kindness. This is a virtuous cycle. Not shown in the figure is that simply seeing kindness, either in-person or in media, can trigger this cycle.

Some may raise reservations about promoting kindness for a variety of reasons. One might be the misconception that the intrinsic nature of human beings is selfishness and that kindness is a distant priority or one that is externally imposed by a moral code or religion. Although all living beings have a drive for self-preservation (and selfishness), it is not the exclusive drive. The willingness to help others is present in many species and has been referenced by Darwin in his second book, *The Descent of Man*. That is, although self-interest is necessary for a single organism to survive, other-interest or preservation and the willingness to sacrifice for others, is necessary for the species to survive [34][35]. Nature has instilled that quality in all of us and is discussed extensively elsewhere [36]. Researchers should look at human behavior as a modulation of these two drives and create the circumstances to allow for a greater manifestation of kindness and caring.

Another objection might be that medicine is about the focused application of science to help patients. That is how it is taught in graduate health care education. Invoking an entity as “soft” as kindness is antithetical to a data-driven, unemotional “just-the-facts,” and entirely rational approach to health care. It must be emphasized that fact-driven care is absolutely necessary. However, as discussed above, having just the facts is not enough. *Emotions clearly impact clinical decision-making*—the accession and interpretation of facts—in multiple ways. In addition to affecting cognitive function, they also affect the quality of the interaction between the patient and provider or healthcare team members who elicits and interprets those facts [37]. Facts alone, therefore, are insufficient for good care [38][39]. Given that health care is really about

communication and trust, which are highly dependent on a connection, it is inescapable that kindness and caring are indispensable parts of health care.

Finally, kindness, in general, is relatively amorphous; it has many manifestations. Moreover, there may be less familiarity with the science surrounding it, including immunity, inflammation, vagal nerve activation, mortality, etc. These are detailed elsewhere [36] as well as described by Trzeciak and Mazzarelli [40]. One only needs to look at the literature on loneliness, volunteerism, and Blue Zones to know how positive interpersonal connection, a major outcome of kindness, is critical to health.

3. Promoting Kindness and Connection in the Health Care Workplace

Thus, there is a substantial warrant to foster kindness in the healthcare workplace actively. Many specific efforts have been developed to address this complex situation. They can be divided into three major categories, including: 1. Addressing the systemic issues that induce stress and cause burnout, depression, and suicide; 2. Supporting personal issues for staff regarding stress and the accompanying burnout; 3. Focusing on elements of the patient experience to enhance them.

Shanafelt and Noseworthy wrote an insightful overview of what healthcare leaders should consider for reducing stress and burnout for staff [41]. Specific initiatives have been shown to have promise, such as medical scribes to reduce administrative burdens for clinicians, among others [42][43][44], as well as broad recommendations [44].

Although specific initiatives can be quite impactful and foster kindness and lower stress in specific ways, prior to undertaking them, leaders should assess the culture first. Maslow recognized many years ago that beyond the achievement of basic needs (food, income, etc.), humans seek meaning, purpose, and belonging. That is, how do they matter? How do they have value and respect? As these are central to the human experience in promoting life satisfaction, then every aspect of work needs to be considered through this lens. Shanafelt and Noseworthy placed meaning at the center of the path to greater joy and engagement for staff [41].

Belonging, or feeling connected at work, is critical to performance and productivity and, ultimately, meaning. A Gallup poll of the general workplace has consistently shown the significance of having a “best friend at work” [45]. Those that had a best friend produced higher quality work, had greater well-being, and were seven times more likely to be engaged in their work [46]. What the best friend concept suggests is that people are connected to someone(s) else at work that cares about them. Imagine teams that are experiencing recurrent disruptive behaviors. On an individual contributor basis, their performance falls. As each affects the other, it is entirely anticipatable that their collective performance also falls. Conversely, teams that have positive interpersonal relationships and are in psychologically safe environments can flourish. When the team flourishes, everyone, especially the patient, benefits.

One way to create a more connected culture is kindness (prosocial behavior). There are recommendations that often start with leaders creating standards for expected behavior [47] and modeling behavior, including compliments, acknowledging others’ work publicly (and thanking them), practicing gratitude and appreciation, etc. What underpins making this easier to foster is the understanding that everyone needs to be respected [47]. They need to be seen and listened to, and treated honestly, including telling (and hearing) the truth even when it is uncomfortable. Psychological safety is critical.

On a day-to-day basis, those relationships and a sense of safety can be challenging to maintain as new events and stressors occur, and communication may be delayed. An entirely different way to complement the efforts above is to promote kindness and connection through kindness (prosocial) media. Studied in academic settings for many years, kindness media (such as a clip from Oprah) works rapidly (within 2 min) to “elevate” or uplift viewers. People experience a transcendent sense of being connected to others [48][49]. These studies have also shown that the decrease in the self–other gap is associated with the willingness to contribute to a charity supportive of members of another race [50] or express attitudes of greater acceptance of others.

A specific, novel portfolio of kindness media has been studied in different healthcare settings. It is intended for both patients and staff. The foundations of this portfolio are crowd-sourced images of kindness and caring from many cultures and countries that have been incorporated into short-form videos along with other types of media covering related concepts (gratitude, empathy, forgiveness) as well as quotes, etc. When streamed into the waiting room of a pediatric healthcare setting, this media rapidly uplifted both parents and staff and increased happiness, gratitude, and feeling calm. It increased generosity as measured by a donation to a needy family [51]. In other studies and settings, kindness media decreases irritation, stress, anxiety, and sadness and increases feeling connected to others as well as positively affects how hospital nursing and medical staff treat one another (unpublished results).

The media works well in all of these studies simply because researchers are “wired” to respond to it, similarly to how images of food or drink induce hunger or thirst. As media can stir this innate drive to want to connect with others and care for them, no training or significant time is needed in a stressed and time-constrained environment. As media work rapidly and can be streamed almost anywhere, it creates the possibility to help people reconnect quickly and on a regular basis with their own humanity and the humanity of others.

One aspect of the use of media in health care is that it is meant for both patients and staff. That is, as both patients and staff have stress, the intent is to create a better emotional and spiritual environment for both. Having both of these major stakeholder groups involved enhances the likelihood that a more positive and productive interaction will occur. Each party benefits from the improved countenance of the other and predicts a higher quality, more satisfying interaction. Eventually, it is anticipated this will translate to better clinical outcomes for patients (greater patient engagement, fewer errors) and happier and more satisfied staff. The next steps for testing the effects of these media include determining the impact on patient satisfaction, patient-provider communication, provider satisfaction, and teamwork.

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