Barbers of Civility

In 1540, with the support and encouragement of King Henry VIII, the Worshipful Company of Barbers and the Fellowship of Surgeons merged to form the Company of Barber-Surgeons.[1] For centuries, relative strangers confronted by serious injuries and ill health have placed their trust in the lineage that arose from these barber-surgeons. In many significant ways, that trust and the responsibility that surgeons assume in accepting that trust have not changed for nearly 500 years. However, what has clearly evolved is the civility quotient applied to surgical practice, the level of courtesy modeled by senior surgeons as reflected in the means by which new surgeons are trained, and an appreciation of the consequences of rude behavior on ourselves, our coworkers, and our patients. Only recently has the qualitative belief that civility can tangibly affect the surgical workplace enjoyed confirmation by quantitative analysis. Consequently, medical organizations have begun to appreciate that disruptive behavior is a problem deserving of serious attention.

Uncivil behavior is so present in society at large that we should not be surprised to find it among health care workers. This article is meant to raise the awareness of the costs—both in dollars and in human misery—of incivility in the practice of medicine by looking in particular at the case of surgeons. This article will (1) explore important factors that determine civility in surgical practice, (2) highlight evidence that supports a direct link between civil behavior and both clinical outcomes for patients and measures of health and quality of life for medical professionals, and (3) offer a framework for fostering civility in the surgical workplace.

WHAT IS CIVILITY AND WHERE HAS IT GONE?

For many people, the term *civility* conjures up images of an exquisitely set dinner table with multiple forks, spoons, knives, and wine glasses at each place setting. Men in 3-piece suits with starched collars rise to hold chairs for women wearing evening gowns and gloves. Synonyms like etiquette, politeness, courtesy, and good manners come to mind. It is reasonable to ask whether these antiquated rituals are irrelevant in the 21st century. Does it really matter which fork I select for the salad, whether I walk through a door in front of my spouse, or whether I give up my seat on the bus for a senior citizen? The answer, according to P. M. Forni, professor of Italian literature at Johns Hopkins University (Baltimore, Maryland) and founder of the Johns Hopkins Civility Project, is a resounding yes. Manners, he says, do the everyday busywork of goodness. Holding doors for companions, chewing with your mouth closed, and passing both the salt and the pepper when you are asked only to pass the salt demonstrate a willingness to consider the feelings and needs of others. Mastery of this essential social skill is a powerful attractant to others. By doing these things, we become likeable and, to paraphrase Forni, "The world is the oyster of the likeable."

So all of this sounds like common sense. The fact is that self-interest, stress, anxiety, unhappiness, and the desire for power and control conspire to undermine civility and to foster rudeness. The framework for an increasingly rude society may have its origins in the expectations placed on the current generation of young adults during their formative years. Twenge[2] writes about Generation Me—people born in the 70s, 80s, and 90s. Generation Me'ers, she suggests, grew up in an era in which every child was told repeatedly how special he or she was. Regardless of how an individual child performed in a competitive environment, everyone was a winner. When children violated expected codes of politeness and courtesy, they were not reprimanded, they were encouraged to do their own thing. Not surprisingly, children grew up to believe their own press. In 2006, two-thirds of US college students had elevated scores on the Narcissistic Personality Inventory (NPI).[3] This was a 30% increase from 1982, when the NPI was first given. In its extreme form, narcissism can be viewed as a gateway personality disorder in which cheating, lack of empathy, insensitivity, and egocentric behavior are dominant attributes. It is not surprising that Twenge[2] also observed a persistent rise in the percentage of high school students who admitted to cheating—from 34% in 1969, to 61% in 1992, and to 74% in 2002. So it is not just the conventions of politeness that have been eroded during the past few decades. The concern is that basic rules of social behavior have been abandoned or at least suppressed.

CIVILITY IN THE OPERATING ROOM

Picture yourself in the operating room (OR). You are a surgeon well into a complicated 4-hour liver resection, you have not eaten all day, and your bladder is reminding you that you are on the wrong side of 50 years old. You are working with a scrub nurse whom you think you may have met before, but you are not sure because the cap, mask, and scrubs are terrific camouflage. You ask for a clamp but are handed a clip applier. Your response could be one of the following:

A. "[Expletive], pay attention! [Expletive], I said clamp not clip."
B. "[Expletive]!" Throw clip applier on floor.
C. "[Expletive]!" Throw clip applier at anesthesiologist.
D. In a calm and polite voice, say "Sorry, clamp please."

This is certainly a moment in which stress and anonymity could en-

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able the situation to get out of control. However, if you knew the scrub nurse better, perhaps if you had chatted with her over coffee about your families or if you at least remembered her name, would your response have been the same? Most experts say no. Familiarity allows you to fill the well of good will so that when things go wrong you are much more likely to react with understanding.

Waisel,[4] an anesthesiologist, makes the analogy that interactions between physicians and nurses in the ORs are similar to what game theorists refer to as "the prisoner's dilemma." In the prisoner's dilemma, 2 participants can independently choose to cooperate with or to defect from each other. If both cooperate, they both gain; but if one cooperates and one defects, the one who cooperates becomes what is referred to in game theory as the "sucker." When individuals in the stressful environment of the OR must decide whether to cooperate or to defect, there is a powerful and perhaps logical incentive to defect so as to avoid becoming the sucker . . . *unless* a culture of trust exists that assumes individuals will make respectful choices that consider the needs of others. According to Waisel, the pathway to promulgation of such a culture is through the development of "social capital" by defining expected behaviors, consistently applying the rules of engagement and the penalties for disregarding those rules to *all* participants, and having an organization-wide commitment to monitor compliance.

SELECTING A TEAM: FOUNDATION OF CIVILITY IN SURGERY

The success of any effort to rebuild or to strengthen a culture of civility in the surgical workplace is ultimately dependent on the members who constitute the group. One obvious way to stack the deck for success is to use interpersonal skills, or lack thereof, as a factor in selecting surgical residents, faculty, and nurses. Dan Wilford, former chief executive officer of Memorial Hermann Healthcare System in Houston, Texas, is a proponent of the "no jerks" rule.[5] He would not hire jerks, and if hired individuals were subsequently discovered to be jerks, they were dismissed.

A human resources consultant to Southwest Airlines once remarked that their low-fare business model relied heavily on worker efficiency and productivity to make a profit. More important, they recruited new hires primarily on the basis of their attitude and *then* they taught them the skills they would need at Southwest. Unfortunately, in academic surgery we often do just the opposite. We hire on the basis of accomplishments, knowledge, training, and productivity and often have no idea how the applicant functions in a social environment. Even worse, despite obvious red flags that a person will be difficult to work with, big clinical practices and National Institutes of Health funding can be seductively persuasive. It takes only 1 toxic employee to poison the workplace. If we hope to promote civility in surgery, there appears to be wisdom in applying the no jerks rule no matter how many R01 grants a person has.

What skills should we be recruiting for in surgeons? Technical skills and knowledge are necessary but not sufficient. Increased emphasis should be placed on nontechnical skills such as leadership, communication, teamwork, and situational awareness. Among our medical colleagues and administrators, we are not often thought of as model consensus builders who work well in groups. I have yet to be at the OR table and to hear a fellow surgeon ask, "Who thinks we should use 6-0 prolene for this anastomosis, who's in favor of 5-0 prolene, anybody for staples?" And yet once we step out of the OR, we need to understand the power of relinquishing authority. This may sound counterintuitive, but by not insisting that we make all the decisions and by empowering others to lead, we gain immeasurable respect among our peers and subordinates. More important, we create a culture of loyalty. Top-down management, which was so prevalent among surgical leaders 2 or 3 decades ago, is out of style.

BEGINNING EARLY: TRAINING SURGEONS TO BE RUDE

Health care would appear to be a hot zone for the incivility epidemic. A survey of 50 hospitals and more than 1500 nurses and physicians revealed that 86% of the nurses said they had witnessed disruptive behavior by physicians, whereas 47% of the physicians made the same claim against nurses.[6] Apparently, exposure to incivility among physicians begins in their formative years. A recent article in *BMJ* evaluated belittlement and harassment of more than 1500 medical students at 16 US medical schools. By their senior year, 42% of students claimed to have been harassed and 84% thought they had been belittled.[7] The most frequent perpetrators of the belittlement or harassment were residents, fellows, and clinical professors, the role models for the next generation of physicians. This is not just a US phenomenon. In Canada, psychological abuse was reported by 93% of the residents in training.[8] Sexual harassment was also reported by 93% of the residents, but this number is difficult to interpret because the events that were catalogued ran the gamut from sexist jokes or complimenting someone on his or her figure to flirtation or unwanted sexual contact. Less ambiguous but quite worrisome was that nearly 20% of the residents experienced physical assault during their training.

When carried to its extreme form in the workplace, incivility is referred to as bullying. Examples include social isolation or exclusion, devaluation of someone's work, verbal threats, or even physical confrontations. Nine of 10 trainee physicians in southern India believed they had been a victim of bullying.[9] It has been suggested that the overuse of the Socratic method in surgical training to the point of humiliation, "pimping" for the purpose of one-upmanship or demonstrating dominance, teaches disruptive behavior to young surgeons. If this is valid, are we, the supervising surgeons, in large measure responsible for the incivility of the next generation of surgeons? Today's victims are tomorrow's bullies. The challenge to each of us entrusted to teach the next generation of surgeons is to nurture important surgical traits of ego strength, confidence, focus, work ethic, and dedication without abandoning the commitment to civil behavior.

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INCIVILITY IS BAD FOR YOUR HEALTH

There is a growing body of evidence to support the contention that civility affects a person's physical as well as mental health. When people engage in rude behaviors, the stress response is activated. However, this activation is not without a price. Epinephrine, norepinephrine, and cortisol levels climb; blood pressure increases sometimes to dangerously high levels; blood glucose, cholesterol, and triglyceride levels rise; macrophage activity is impaired; and the body's innate immune system is weakened.[10] This is not to mention constipation, anorexia, and erectile dysfunction. Incivility and lack of a supportive working environment have been associated with obesity, increased number of sick days, low back pain, and back pain–related sick leave.[11-13] At least 1 study has shown that if the incivility is severe and persistent, as is the case with bullying, there is an association with new onset of cardiovascular disease and newly diagnosed depression.[14] The fact is that rude behavior is bad for your health. On the other hand, civil behavior has been associated with what Luks and Payne[15] have termed a "helper's high." Luks and Payne studied more than 3000 volunteers, many of whom testified to feeling a rush of euphoria and increased energy, followed by a longer period of calm, after performing a kind act. Dopamine and serotonin have been invoked as mediators for the helper's high, which has been associated with decreased incidences of insomnia, depression, diabetes mellitus, and pain perception and increased lifespan. It is like the runner's high without the running.

A DIRECT EFFECT ON PATIENT OUTCOMES

The point at which civility really starts to get the attention of senior hospital management is when you show a correlation with health care outcomes. In the intensive care unit, positive caregiver interactions that encompass leadership, communication, conflict management, and culture are associated with decreased lengths of stay, lower nurse turnover, and elevated perceptions regarding technical quality of care.[16] It is very difficult to quantify the effects of civility in the OR. However, Mazzocco and colleagues[17] conducted a study to determine whether behavioral markers of teamwork in the OR predicted postsurgical outcomes. They studied 300 surgical cases, during which trained observers graded the surgical teams on the OR briefing, information sharing, asking of input from all team members, and vigilance and awareness. From the observed behaviors, they were able to calculate a Behavioral Marker Risk Index from 0.0 to 1.0. The higher the index, the "riskier" the team behavior. The 30-day outcome of each patient was then determined by a medical records reviewer masked to the Behavioral Marker Risk Index of the case. There was a direct correlation between high-risk behavior in the OR and postoperative death and complications.

Many would agree that because of the surgeons' relative position of power, rude behavior on their part can be particularly disruptive. A primary consequence is the effect on nursing turnover, which itself has been shown to be a causative factor for poor clinical outcomes and increased number of medical errors. In a 2002 study of Veterans Administration hospitals,[18] 96% of nurses witnessed disruptive physician behavior. A decade earlier, Diaz and McMillin[19] reported that 64% of nurses claimed to have been verbally abused by physicians at least once every 2 to 3 months, and 23% of nurses had been physically threatened by a physician. One solution to rudeness is to avoid the perpetrator. In the hospital, that response can prove to be injurious if not lethal to the patients. A survey of nurses and pharmacists conducted by the Institute for Safe Medication Practices revealed that nearly half of the respondents altered the way in which they handled order clarifications on the basis of past experiences with intimidation.[20] Of those surveyed, 75% asked a coworker to help them interpret a confusing order or to validate its safety to avoid interacting with intimidating physicians; 64% of pharmacists and 34% of nurses assumed a medication order was correct and safe to avoid interacting with a particular physician; and 7% of those interviewed believed that during the past year they had been involved in a medication error in which intimidation played a role.

OFFERING A TEST OF CHANGE

The surgical community has an incredible opportunity to lead a civility initiative in health care. The first step is to recognize the power that civility has to improve the surgical workplace, the patient outcomes, and the workers' quality of life. Organizations should commit to developing a universal code of conduct that is identical for surgeons, nurses, staff, administrators, and patients. This code must have clearly defined expectations as well as consequences for violations. More important, the code should be applied fairly and consistently, without modification or special allowances based on an individual's actual or perceived status in the group.

Second, the criteria for recruiting staff, trainees, and faculty should include an assessment of social skills and personality traits that will nurture a culture of civility. In other words, apply the no jerks rule for recruitment and retention. Many books on management skills emphasize the importance of the manager's getting to know the team to promote loyalty and to generate a positive working environment. However, to foster civility within the organization, the *staff needs to know each other*. The rewards likely to accrue from the investment of time required to become acquainted with coworkers are substantial. The loss of anonymity coupled with a better appreciation of coworkers' lives decreases the likelihood that rude behavior will be initiated or accepted or that minor disagreements will escalate into damaging conflicts.

Finally, the surgical leadership must model behavior for the team. The training methods we use to shape the next generation of surgeons should encourage the acquisition of knowledge and the development of sound surgical judgment

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without sacrificing a commitment to civility.

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