Leadership Development

The silent organizational pathology of insidious intimidation

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While organizations are valiantly striving to address acts of disruption among physicians and nurses, a silent and yet equally disruptive pathology is spreading through the veins of the organization. This behavior is found among all ranks and responsibilities, from the C-suite to the housekeeping staff. It occurs daily and is rarely reported. It continues because its nature is such that it is difficult to measure, the victims often feel helpless, and the perpetrators are often those in positions that are not normally perceived to be as essential to the flow of patient care. Nonetheless, this insidious intimidation chills communication, reduces morale, and ultimately harms patients. Organizations that desire a culture of safety and comfort must address this behavior through individual coaching, education of all staff, a willingness to tackle system frustrations that amplify and perpetuate the behavior, and establish processes for dealing fairly and firmly with the behavior.

INTRODUCTION

Healthcare organizations spend significant energy, money, and time in initiatives addressing disruptive behavior and observable counterproductive behaviors. Although such efforts are necessary to attack obvious and ultimately more dangerous situations, smaller acts that slowly and consistently erode organizational culture generally go unaddressed. Those subtle, passive-aggressive breakdowns in communication and actions that may occur at any level and between any individuals delivering patient care are called “insidious workplace behavior.” (1) Leaders can change the direction of their organization’s journey by recognition, dedication, and fortitude in addressing this treacherous covert behavior.

How is insidious intimidation different from disruptive provider behavior? The professional disruptive behaviors that are generally addressed are overt acts of abuse and bad behavior that have a clear impact on the organization and patient care. The identified perpetrators are often the physicians and who are in visible positions. Those behaviors are being widely addressed by national professional organizations.

This article does not address physician disruptive behavior. Instead we focus on identifying, quantifying, and remediating actions or nonactions that slowly
invade an organization’s culture and are found at all levels of the organization: gossip, passive aggression, avoidance, and other negative, otherwise unremarkable behavior that tends to chill communication and reduce morale.

The identification of inconspicuous intimidation does not target any one individual or type of individual. Some people may refer to a person with a strong, assertive personality as “intimidating,” yet his or her behavior may be appropriate for a given situation and intended to be cooperative. Such individuals may be in actual or virtual leadership positions because of their knowledge, expertise, and experience. They may be overwhelming to certain personality types or to those with less experience.

Conversely, some individuals have a refined sensitivity to behavior they perceive as judgmental, overwhelming, or aggressive. Their overwrought calibration may lead them to conclude that individuals with strong personalities are intimidating.

Insidious behavior is just as important, if not more important, to address as overt disruptive behavior because of its impact on patient safety. While it may be true that 2% to 8% of physicians by specialty generate the greatest proportion of hospital claims and litigation,(2) there are many more perpetuators of silent disruptive behavior.

The frequency and subtlety of insidious behaviors result in continuous disruption to patient care and productive staff interactions at all levels of the system. Examples include the nurse who avoids speaking to the “grumpy” transporter to clarify handoff information; the housekeeper who notices a change in the patient’s condition but was once told sharply, “What are you? A nurse?” when she tried to communicate a concern in the past; the social worker in a receiving nursing home who resists calling for clarifying information on a newly admitted patient due to past perceived sarcasm from the hospital staff; the house supervisor who reports an event to the administrator on call in the middle of the night only to hear a chilly, “This could have waited until morning.”

None of these examples would rise to the level of provider disruptive behavior, yet each demonstrates the subtle way in which intimidation affects patient care at all levels of the organization.

Few organizations, and maybe none, have procedures for evaluating, documenting, quantifying, and proving these subtle behaviors. Therefore, they are unwilling to risk employment liability by asserting, investigating, and actively addressing these situations. These behaviors are low profile and grow slowly, and they are not usually obvious enough to require immediate intervention on a case-by-case basis. Consequently the organization frequently normalizes the behavior as “personality,” and what is subversive to patient care becomes dismissed as, “That’s just Joe.”

Nevertheless, simply working around insidious behavior creates a workplace culture that perpetuates it and short-circuits safe practices.(3)

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**How survival behavior fuels insidious behavior**

Efforts to change behavior in healthcare have been in place for many years. Risk managers bemoan how difficult it is to garner support for changes in policy or process that improve safety.

Although studies and stories dating back 10 years have demonstrated the value of transparency and disclosure, organizations still report difficulty getting buy-in from physicians, staff, and administrators. “Just Culture” has been a topic for nearly as long, yet despite workshops, organizational initiatives, and widespread discussion to improve communication at all levels of the healthcare process, employees still report fear of repercussion from human error and behavior.

So are our efforts to address these questions misguided? Is change beyond human implementation? Or does a need to protect our jobs trump all efforts to improve patient safety?

One thing is certain: biology plays a part in this destructive behavior. Human beings are similar to animals in basic ways. We are equipped with a neurosystem that is wired for survival. Like our animal counterparts, we are designed to remain alert for danger and to generate energy that will help us quickly and efficiently find safety from the danger. For many healthcare workers, avoiding potential conflict means making it through the day in a hectic system where the lives of people are at stake. For many, that means that they direct all of their psychological energy at performing daily tasks while inflicting as little harm on patients as possible.

In effect, such isolating behavior may produce the opposite result.

In healthcare organizations, the mix of individual psychologies and professional and cultural backgrounds creates a microcosm of society that is complex and difficult to navigate. The system is designed to assume that each staff participant is operating at 100% capacity psychologically and physically, but without recognition that each individual is striving to work and survive the system while coping with whatever stresses are going on in his or her life outside the workplace. Systems rarely consider the differences in human psychology and other human factors that will affect the implementation and actualization of system changes, particularly when a change of belief and behavior is required.

So often healthcare executives assume that people will behave rationally and that individual beliefs, regardless of culture, demographics, and training, will shift immediately in response to new programs, policies, and initiatives designed to improve the safety environment. The chain of command assumes that people will feel comfortable bringing less-than-optimal situations and issues to those in positions of authority. In fact, best efforts to create cultural change are difficult, and sometimes they result in frustration, if not failure.

To address this behavior effectively and definitively requires recognition that most behavior that appears subtle and amorphous to define or grasp is survival behavior gone awry. Survival may be based on purely physical or psychological needs. It may also be a reaction to system complexities that are creating the frustrations behind any employee’s action or inaction. Finally, characteristics of both the actor and the recipient of the behavior influence the behavior.

Regardless of the source, survival behavior can have a negative impact on the operation of the organization. Furthermore, if it is unaddressed, it can undermine staff morale, interfere with employee interactions, and ultimately jeopardize the safe care of patients.

Any behavior that influences the desire of staff to reduce, limit, or eliminate any patient safety interaction with a given individual because he or she expects the encounter to be unpleasant fits the definition of insidious intimidation.

**The primary behaviors behind insidious intimidation**

Most insidious intimidation falls into three major categories of behavior: passive-aggressive, verbal, and nonverbal.

**Passive-aggressive insidious intimidation**

Passive aggression is behavior in which an individual will make comments that appear cooperative and compliant yet they behave in ways that undermine those statements.

One of the toughest passive-aggressive behaviors to break through, ironically, is niceness. An employee may want to appear “nice” to coworkers, avoiding conflict or honest appraisals of a situation. The person’s activities may be benign—simply a desire to get along with others. He or she might not even recognize this behavior as subversive but detrimental to the organization. However, such people might use pleasantness to mask decisions, actions, and private comments to others that are 180 degrees from their outward statements. This may create avoidance behavior in others that can have a direct negative impact on patient safety. Simply put, someone who avoids negativity in discussing a patient situation might negatively affect patient safety.

Passive-aggressive behaviors go well beyond the “niceness” issue. They display in several forms. In one manifestation, the individual may agree to be compliant, may appear to be compliant, and say she is being compliant. Nonetheless, she may not quite do the actions required for compliance to the full extent required. She may procrastinate, which leads to a delay in the system; perhaps she does not deliver meds on time or is consistently late in passing on important information. She may be stubborn

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about doing things her own way despite system and process requirements that dictate other ways. *(There was never a problem doing it this way before, I don't see why we should change.)* She may willfully engage in a workaround of the process in order to save time or stress while not reporting systems issues up the chain of command *(It's too difficult to complete an incident report. The computer is always tied up.)* She may make negative comments about the process or the individuals involved in the process, perhaps even excluding them from important conversations. *(He is always so grumpy. Why should I tell him the status of his patient?)*

Passive-aggressive people may quietly sabotage individuals in the process by not completing their work to the level required for a safe hand-off *(I don't have time to complete that form. Let them figure it out.)* Their compliance may meet the letter of the law, but others may see it as resistant or perhaps even spiteful. If the person is a supervisor, he may regularly assign undesirable tasks to individuals he does not like.

Again, the challenge of passive-aggressive behavior is having evidence that is clear enough to pinpoint and change the behavior. This type of person may need to be monitored for a while before a clear pattern emerges. In most cases, this type of person often perceives himself as very easy-going and much maligned. He might even feel self-righteous in his behavior because of legitimate systems issues and frustrations.

**Nonverbal insidious intimidation**

Staring, sighing, glaring, gestures, making faces, and positioning the body to exclude others from a conversation may be forms of nonverbal intimidation. Others may see this, but again, it is difficult to document, and for many workers, it may be among the most powerful form of insidious intimidation filtered by gender, culture, training, and other factors. Although acceptable behaviors vary widely by culture, a consistent pattern of potentially damaging behavior by an individual or group against another individual or group should be addressed and explored. *(5)*

**Verbal insidious intimidation**

This variety of intimidation can go hand-in-hand with the other two types. At least it is direct, volitional, and, most important, potentially heard by others and therefore may more easily be documented as evidence.

The practitioner of verbal insidious intimidation frequently gossips, communicates with sarcasm, and in some cases even recognizes the deleterious effect of his behavior. Some may wield it like a weapon to ensure his position of authority or desired position of authority. Some may be experienced and may be burned out from years of service or from surviving years of changes. These people may overtly criticize colleagues, policies, changes, or administration while complaining that other parties are disregarding their own feelings or thoughts. They may complain to patients as well as other staff about staffing, administration, or policies. They may insult younger colleagues or make unkind comments about them. They may accuse people of being responsible for errors that occur. They may brag about their accomplishments or stonewall efforts to institute change by commenting that the process will “never work” or “has been tried before and it didn't work then, why would it work now?” Most important, managers and supervisors need to realize that their experience of these particular individuals gives their words weight and that younger and less experienced professionals may adopt their viewpoints and actions.

The challenge with this group of individuals is to separate their negativity from their worthwhile perspective that could bring positive change to the organization. They may have tremendous experience and expertise, yet lack the fortitude or interpersonal skills to improve patient safety. It is important to overcome resistance to listen to these individuals, determine whether they need help with the factors that are causing their undesirable behavior, and find out new ways to open a dialogue. As part of this process, it is particularly important to help these individuals realize the danger, intended or otherwise, that their actions have created for the organization they have served for many years.

**How organizational systems enable insidious intimidation**

Although any system issue can contribute to frustration and insidious intimidation, certain process failures are most likely to generate nuisance survival behavior. Those processes involve supplies, equipment, staffing, organizational reporting structures and feedback systems, and financial issues. Although disturbances within these processes do not excite insidious negative behavior, it is important to consider whether they create a tipping point by which an individual pushed to the edge of his or her survivor capability can be tipped into full-blown insidious behavior. Certainly the individual behavior and needs must be analyzed and addressed, but unless the system issues are similarly identified, the organization remains at risk for pervasive overt and insidious negative behavior, as well as exposure to risk and safety incidents.

Here are the main categories of institutional change that are catalysts for potentially insidious behavior:
• Changes in supply and equipment inventories and policies. Supply and equipment processes are tangible areas for patient safety concerns. Incorrect, inappropriate, or insufficient materials can lead to unacceptable levels of exposure risk for an organization, and changes are typically made by group decision or influenced by budgetary considerations that do not always include the individuals who actually use the materials. Those left out of the process may be frustrated, making it just as important to consider their feedback on how those purchasing decisions are affecting patient care.

• Changes in staffing. Departmental staffing is a leading area for frustration. Quality care demands that adequate numbers of appropriately and sufficiently trained workers are available to provide the services required. It is also important that staff be compatible with the culture and personality of the organization with hiring policies that conform to goals for diversity, skills, and performance. If an organization is a fast-moving and highly active facility, hiring individuals who can manage that pace while maintaining the customer service goals of the organization is important. Processes for ensuring adequate staffing should be reviewed regularly, including input from staff and all other affected parties on performance and safety implications.

• Changes in reporting structures. As the need to detail and document workplace activities expands in the healthcare arena, staff members report increasing frustration and confusion with the reporting processes that would best communicate their views about medical incidents, safety concerns, patient concerns, and administrative issues. Technology and organization are important issues, and staff members who feel these systems are difficult to access or navigate may hesitate to report problems or stop reporting completely. Unreported concerns often become stressful to workers and lead to negative behaviors. The same frustration holds for staff members who attempt to use the system but do not get timely feedback on their comments. They are likely to give up reporting altogether. When staff members are left without an outlet for suggestions and concerns, insidious and overt intimidation can take root.

• Financial and budget issues. Financial issues are a universal source of frustration at all levels of the healthcare system. Although higher-level staff may be involved in financial decisions, most employees are not. Budget cuts (some of them drastic), changes in payment and reimbursement structures, and real or perceived inequities in the distribution of resources are major stressors that have consequences inside and outside the institution. Staff usually blame the consequences of cuts on administration—otherwise known as the infamous “they”—closing the door on communication and information and allowing insidious negative behaviors to flourish.

• While it may be impossible to avoid financial constraints and diminishing resources, well-planned and detailed communication throughout the organization is essential. Such communication plans should be tied to workable feedback systems that can address patient safety issues directly tied to cuts in staff, resources, and money. It will be a crucial element in diffusing staff dissent and insidious and overt negative behaviors.

How systems perpetuate insidious intimidation

In a time of tight resources, it’s easy for professionals to blame external factors for dissension in their workplaces; eroding resources, growing regulation, and increasing patient demands certainly influence the level of stress in the healthcare workplace. Yet the most potent force in any ongoing culture of intimidation and negative staff behavior is the organization itself. In other words, organizations themselves contribute to that behavior and perpetuate it over time.

Organizations facing insidious intimidation issues typically have fed the problem for years and in two principal ways. First, they have a longstanding culture that discourages interpersonal communications. Second, they habitually ignore, and therefore tacitly accept, such behaviors.

In the first case, supervisors may caution staff not to speak up for fear of ramifications. Administrators may wish to maintain the status quo because of political or environmental constraints. Boards may fear community reprisal if evidence of dysfunction emerges in the organization. In these cases, insidious intimidation may be pervasive and may lead to widespread overt strategies for controlling the behavior of staff and even administrators. Although these situations are not the norm, they exist. We have experienced them both as staff members and as consultants. These are difficult situations, and the management of them goes beyond the scope of this article.

Despite these constraints, even in organizations where there is resolute control of behavior through subtle intimidation, there are pockets of behavior that can be affected and altered through appropriate systems improvement and staff coaching. It is important that the risk management leader not succumb to discouragement and instead maintain the course to address intimidation at whatever level possible.

In the second example, organizations employ the more common approach of passively ignoring intimidation that is not overt. Since individual cases of this behavior do not rise to the level of obvious reputational or physical harm to others, it is dismissed as the result of a particular worker’s “bad attitude” or “just the way things are” within that part of the organization. The danger in this approach is that unharvested insidious intimidation permeates the organization and poisons all staff interactions. Eventually that will filter down to patient care and safety, exposing the organization to liability and poor community relations. Insidious behavior cannot be passed off as insignificant merely because it is subtle and therefore tough to document and enforce.
Organizations need to teach appropriate communication, assertiveness, how to provide feedback, and how to address negative interactions to all staff. By not giving staff the permission and the tools to think and act when they see what they consider to be inappropriate interactions, the organization is tacitly giving the perpetrators permission to intimidate and control the organization.

Organizations must seek to create a culture of comfort where workers at all levels feel free to discuss negative behavior. They need to learn to properly evaluate whether an individual with a problem is overreacting or might be a target of insidious intimidation. Finally, the organization must be willing to address behaviors at the insidious level and have processes in place for doing so.

A model for eradicating insidious intimidation

Figure 1, which we developed, takes a two-track approach to addressing behavior by addressing both the individual and the system. It contends that every intimidation issue is the product of an individual employee situation as well as the entire employee system of an organization. It also assumes that all human behavior is responsive and may be symptomatic of individual or system disruptions. Because it is reactive, individual behavior may signal the need for a process improvement approach. Finally, this model assumes that the organization is committed to wiping out intimidation and disruptive behavior of all kinds and has worked out a systemic approach to dealing with symptomatic behavior. The figure suggests a pathway that managers can follow to intervene in situations of insidious intimidation before they escalate. The model proceeds in yes-or-no fashion. Diamonds in gray indicate a response to a yes answer at that stage; answers in red squares indicate the course if the answer is no.

The model begins with evaluation of a behavior in the reported instance as well as in habitual response behaviors. At each stage, however, a question is asked about the system factors that may have contributed to the behavior.

Essentially the model prods us to look at individuals and their habitual response patterns. Are there situation patterns or individuals who appear to be regularly associated with
this behavior? Is the pattern habitual or unique to an acute situation? Has the individual been given the opportunity to learn appropriate response patterns for various situations?

Simultaneously, it forces us to be looking at situations where this behavior emerges. Are there system triggers that contribute to frustration? Are these triggers easily remedied, or do they require process improvement? Regardless of the presence of system triggers, does the organization have a means to teach appropriate assertiveness skills and monitor and coach individuals for appropriate frustration responses? And finally, does the organization have a process in place to deal with individuals who do not respond to coaching or self-awareness efforts?

Start with the individual
Dealing with insidious intimidation starts with the individual (or individuals) at the center of the problem. Then the organization can widen its scope to see how culture, operations, and other administrative processes factor in.

Much like school bullies, insidious workplace intimidators behave in a way that puts distance between themselves and those they work with. Depending on how severe the problem becomes, they eventually put distance between themselves and their patients—a self-protective, defensive posture that has no place in patient care.

Whether the genesis of the behavior originates in the individual’s psyche or is the result of general workplace frustration, the individual must first understand which behavior is not acceptable and what makes it unacceptable. The individual must understand that the organization is willing to look at the systems issues that might be creating frustration, but that he or she has a responsibility for how that frustration is expressed in the workplace, particularly when people’s lives and safety are at stake. There should be no tolerance for divisive behavior, and this must be accompanied by recognition of the organization’s responsibility for behavior.

This coaching process needs to be matched to the type of insidious behavior. Following are some suggestions:

- Coaching passive-aggressive individuals. This can pose the greatest challenge because the individuals displaying this behavior are generally calm and pleasant; their damaging behavior has not been on wide public display. It is particularly important to document the behavior and the effect of the behavior, as well as to look for system frustrations with individuals who claim the best of intentions. It is also important to coach such individuals on the need to bring legitimate system concerns up the chain of command before they feel the need to act on their frustration.

Because these individuals are ostensibly calm and pleasant, coaching needs to be presented as a solution for the
behavior, not to address a character flaw. It is particularly important not to use pejorative words to describe the behavior; gossip, for example, is a word to avoid. Aim for objective wording instead, such as:

When you said you were supportive of this [process/coworker/initiative] and then took [this particular action], it had the effect of endangering patient safety.

An individual with a passive-aggressive personality is likely to respond in one of two ways. The first common response is an excessive apology accompanied by statements like, “Of course, I would never create a problem on purpose.” The second common response is for the individual to declare that he or she does not understand or believe the statement. Both responses can pose a challenge for the coach or manager. In each case, the individual stops just short of accepting his or her behavior. This person is in denial about the actions and the implications of those actions.

Therefore, the coach needs to come back with another attempt at buy-in. In this case, the coach must attempt to make a pact with the individual and say something like this:

I realize you may not know you have this behavior. It is very understandable. You are such a kind and caring person. Nonetheless, this is a repeated behavior, and it creates a problem for your coworkers. It endangers patient safety. How would you feel if the next time I see this behavior, I point it out to you so you can recognize it more quickly? Perhaps working together, we can help you see what happens so we can adjust it and take the best care of our patients.

This type of pact is kind. It works well with passive-aggressive individuals because it acknowledges their need to be perceived as nice. It also stands firm on the recognition that the behavior is negative and affects patients and coworkers negatively. It is important, in addition, that a coach provides these individuals with other acceptable behaviors. Because they want to be thought of as “nice people,” they may have a limited repertoire for dealing with situations or people who bother them. By noticing the pattern of situations where the individual intimidates, the coach can provide alternative behaviors:

Mary, rather than say you support a policy and then belittle it and the people who worked on it, it would be much better if you spoke up at the meeting. If you are unable to do that, then come to me afterward to work out a way to communicate your feelings effectively to the appropriate parties. When you continue the behavior of talking about people outside the committee, you sabotage the work of the committee and make it more difficult for us to find solutions to real problems. I’m sure you don’t intend to do that.

If the individual does not respond to two or three confrontations of this type, it is time to up the stakes. At this point the coach might say:

We have been working on this together. I have given you feedback several times about this type of behavior. We can no longer tolerate this type of reaction. Next time you do not try a different approach to dealing with this person [or situation], we will have to take formal action. This is not acceptable behavior on our team.

• Coaching nonverbal insidious intimidators. Again, start with documentation. This individual may or may not be aware of the way his or her body language is interpreted. However, this intimidator, like the verbal intimidator, may be very much like the school bully and may select prey based on the ability to intimidate that person.(6) Since much nonverbal intimidation is cultural communication differences, a simple education about cultural norms may suffice in many cases. In other situations, the behavior may be a direct reflection of feelings about others in the organization and constitute intimidation. Where it is evident that nonverbal intimidation is being concentrated on a specific individual or group of individuals, the organization may wish to coach the victims on how to respond and the perpetrators.

• Coaching verbal intimidators. It can be easy to collect data on intimidators, although they may allege that the words were misunderstood or misinterpreted. It is important that verbal intimidators understand that intimidation frequently has a nonverbal component. The words that are spoken in a tone of aggression or barrier setting will have a different effect from words spoken in a spirit of cooperation. With these individuals, awareness may be the most effective approach in the long term. If they receive regular and immediate feedback over time about statements and actions that others interpret as intimidating, these individuals can learn to recognize and modify habitual patterns of interaction.

Assemble a behavior change team to create a nonintimidating organization

Insidious behavior underlies the smooth surface of most organizations and tends to rise at critical times—during periods of demand or stress or during simpler functions like handoffs. The very nature of this obstinate behavior requires a long-term and determined commitment on the part of the organization to address it. It is also the type of issue that lends itself perfectly to a multidisciplinary project improvement team approach.

Here are some critical factors in executing this process:

• Collecting the data. Before convening a project improvement team, consideration should be given to using surveys or other quantitative or qualitative methods of measuring the levels of insidious behavior within an organization. Industrial and organizational psychologists and other professionals working in the area of organizational culture and performance can recommend appropriate methods of measurement for the healthcare organization. Case reviews continued on next page
and interviews with personnel involved in near-miss or actual patient safety incidents where insidious behavior was a factor are invaluable resources. Review of prior root cause analyses and incident reports readily provides additional sources of data for establishing baseline metrics. Using multiple methods to objectively identify the breadth of the problem for an organization can be a powerful tool for garnering organizational and leadership support.

• **Getting buy-in from the top.** Success depends on having subject matter expertise, adequate resources, and leadership and governance support in place before beginning the actual improvement work. Once the scope of the problem is identified and its impact on the organization explored through interviews and surveys, senior leadership or governance support, or both, must be obtained. Without the full and continuing support of the organization’s leadership, cultural change work often fails.

• **Building the roster.** Attacking the problem of insidious intimidation means assembling a leadership team to direct and supervise what will likely be a multiyear project. Removing barriers, having crucial conversations, and using multifaceted and creative problem-solving approaches will work best with a diverse team that represents voices from the top to the bottom of the organization. It is important to have a senior officer or board member as a project sponsor to reflect the top-down importance of the project’s mission while naming a project champion to keep the day-to-day functions of the project on schedule.

Once the project sponsor and project manager are chosen, careful consideration should be given to naming significant stakeholders as active team members. These names should come from every part of the organization: physicians, department heads, communications staff, key support staff, volunteers, and top officers. The group should be only large enough to accomplish tasks within the assigned time frames. Each member of the team should be given the ability to convene a work group to accomplish specific deliverables on deadline.

**Facilitating discussion of the problem**

The first meeting should be used to validate the breadth and scope of the problem that the organization is attempting to address. The project champion should be prepared to facilitate a discussion that defines the problem of insidious intimidation with the organization’s collected research, what the negative impact is on the organization, and any positive financial or other organizational gains that can be achieved by remediating the negative behaviors. Some suggested goals for the first meeting are introducing new team members, reviewing the team membership to ensure that all appropriate parties are represented at the table, and determining the level of commitment and resources available to the team. Rules of team engagement should be established and the first draft of project time lines over-viewed. (These are under constant modification as additional issues and work are being identified and initiated.)

Identification of barriers should be discussed at the beginning of the project. Ways to remove or achieve success in spite of certain barriers need to be discussed and addressed during the early planning stage. Frank and honest discussion needs to be part of the game plan from the beginning as well. If an outside facilitator (project specialist) would be better able to ensure that takes place, the champion should consider this as a viable option.

As the first and subsequent meetings take place, various teams will need to be formed to take on individual or highly related topics. Examples are a human resource team to deal with organizational awareness and assessments, developing methods of identifying new personnel who would fit with the desired organizational culture, and developing methods of addressing insidious behaviors identified in existing personnel.

Another example of an improvement team is a marketing and public relations team. This team’s function is to ensure that organizational awareness, education, and information sharing are taking place throughout the project and that any success in problem remediation is being widely celebrated and published.

During the initial and all subsequent meetings, concrete goals and deadlines need to be established, measured, and completed. Taking on a huge organizational issue such as insidious behavior requires that this team maintains its energy and avoids being labeled a flavor-of-the-month issue. Building in accountability and constant communication ensures that projects stay on track. Monitoring success helps to ensure that the team feels that it is making a difference if even in small amounts.

In the beginning stages, completing basic tasks and identifying measurement tools and percentage of attendance at meetings would meet early goals. Later, repeat surveys or case studies could be used to validate the level of the organization’s awareness of insidious intimidation and whether there has been any progress in remediating the issue.

**Keep the eyes on the prize**

When even the most talented people tackle a tough issue over a period of months and years, energy can wane. So can resources. Understanding this at the onset is critical to ensuring the success of this enormously important project.
The communications professional can have an important role here. Through newsletters, e-mail blasts, and other key communications tools, the team can keep an ongoing dialogue going with the rest of the organization that not only keeps the discussion alive but measures the effectiveness of solutions as they evolve. The commitment to creative strategies to spread the news about tough issues assures team members that this is not a fleeting initiative and the entire organization that important, game-changing work is being done.

**Ask the big strategic questions**

As the team develops the overall goals for the project, issues such as the following must be addressed:

- How to hire people who fit with the organization’s desired culture
- How to identify insidious acts and repeat offenders
- How to objectively, consistently, and justly respond to the events and the people who do not have appropriate communication styles, personalities, or characteristics needed for creating the desired level of communication for maintaining relationships and, ultimately, environments of safety
- The metrics that will be used to monitor the work of the team
- Which body will be responsible for reviewing the measurements of the project over time and ensuring that progress is consistently being made (this may be the board, various quality committees, or senior leadership)
- The resources that will be dedicated to remediating the insidious behaviors (personal coaching, group work, education, or something else)
- The strategies that will be implemented to separate repeat offenders from the organization so constant and steady progress can be maintained without creating organizational backlashes

**CONCLUSION**

Insidious intimidation is a serious behavioral problem within healthcare organizations that can have a long-term detrimental impact on patient safety, quality of care, and organizational reputation. It happens when an employee at any level of an organization chooses to engage in subtle acts of workplace hostility or avoidance that disrupt critical communications at the clinical, staff, and leadership levels. Causes for this problem are varied and a challenge to quantify, and they can be personal as well as systemic. The stubborn strength of this problem lies in its quiet ability to undermine morale and deter important communication surrounding patient care.

Organizations that are committed to a culture of safety must recognize that human behavior does not happen in a vacuum. Attention must be paid to behaviors that chill communication, and efforts must be made to determine if the behavior is precipitated by personal or systems frustrations. Where personal issues impede the ability of the individual to function cooperatively in the organization, active measures must be taken to educate, coach, and mentor the individual while holding the person to the standard of the organization. Where systems issues dominate, the organization must take action to recognize the impact of system frustrations on the behavior and ability of staff to provide safe care.

Much as for a culture of safety, a just culture, or a learning culture, the organization must form a team that identifies, defines, and supports efforts to eradicate insidious intimidation in the organization.

Taking an intersecting two-pronged approach to addressing such behaviors, the organization can develop a culture that supports patient safety and provides an environment where staff feel free to express concerns about systems and individuals who impede the efforts of the organization to serve their community safely.

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