Workplace Culture and the Ethics of Interpersonal Interactions

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Objectives

1. Identify issues that arise during interpersonal interactions in the workplace

2. Apply different ethical frameworks to analyze interpersonal interactions in the workplace

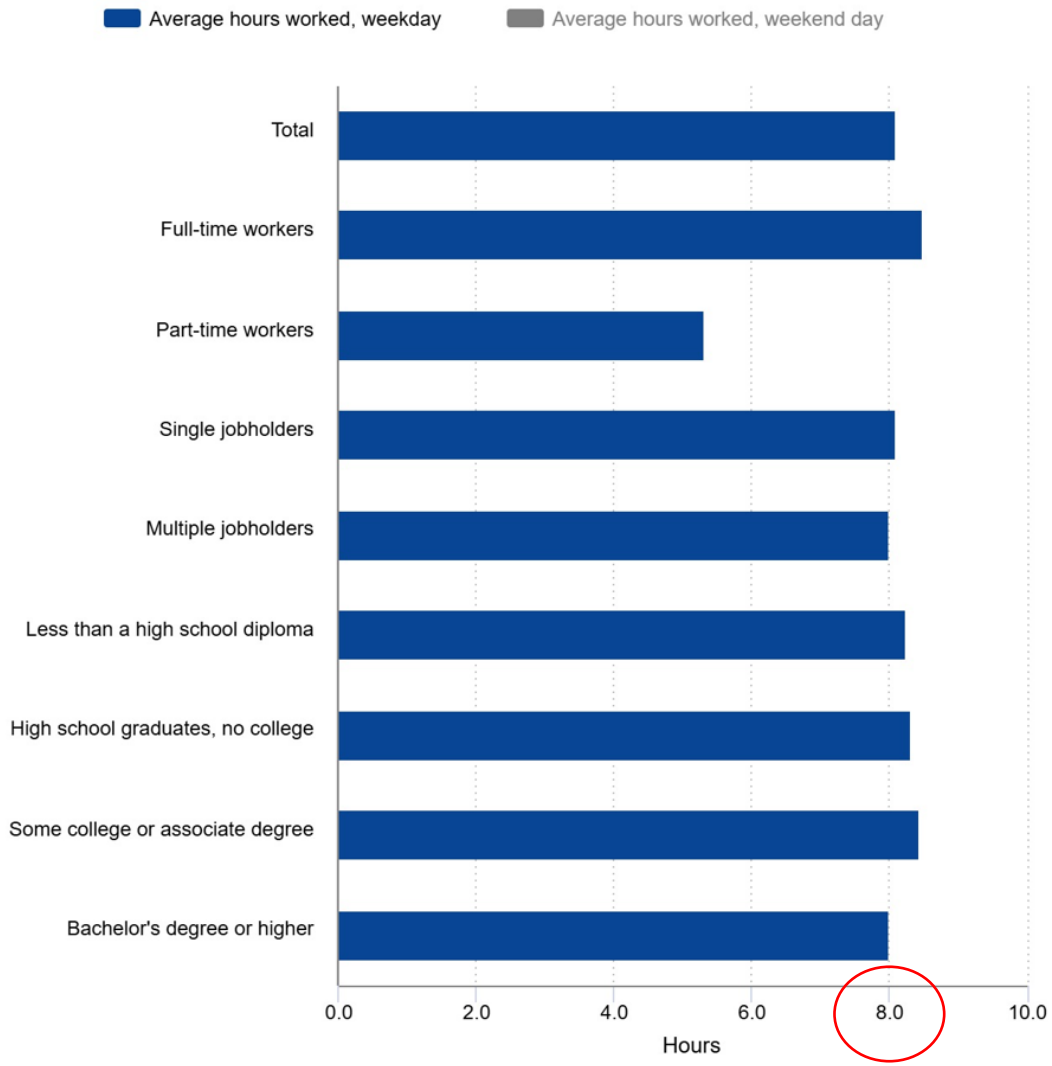
3. Explore tools and systems designed to facilitate ethical interactions in the workplace

Annual Time Use Survey

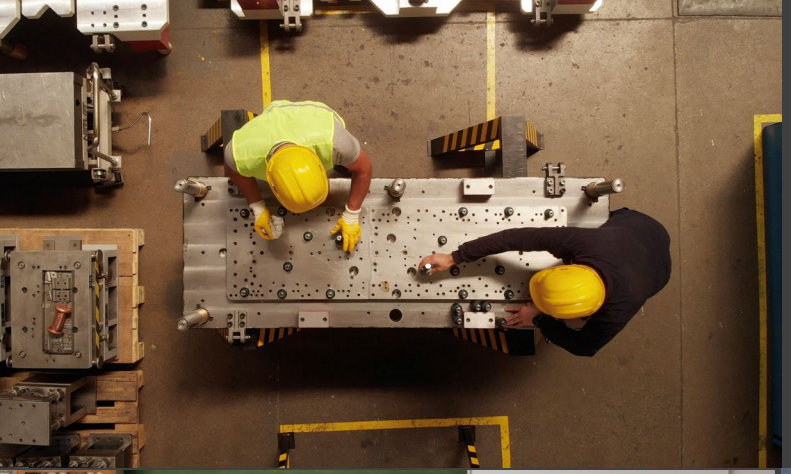
U.S. BUREAU OF LABOR STATISTICS

- Average person works 8h/day
- 40h/week
- With 2 weeks of vacation: 2000h/yr

We work a lot…



Source: U.S. Bureau of Labor Statistics.



How we work may vary…

We spend a significant amount of time with our co-workers

These interactions are impactful

Impacts can be favorable and unfavorable

What is Disruptive Behavior?

What *is* Disruptive Behavior?

- Behavior that is:
  - Interpersonal (directed toward others or occurring in the presence of others)
  - Results in a perceived threat to victims and/or witnesses
  - Violates a reasonable person's standard of respectful behavior

Villafranca A, Hamlin C, Enns S, et al. Disruptive behaviour in the perioperative setting: a contemporary review. Can J Anaesth 2017; 64:128–140.

What *Causes* Disruptive Behavior?

- Intrapersonal (within a person)
- Interpersonal (between people)
- Institutional

- Resource shortage (Institutional) → Frustration/stress (Intrapersonal) → Disruptive Behavior (Interpersonal)
- Workplace relationships can increase disruptive behavior
  - personality conflicts, different values, miscommunications, hierarchies, profession-related tribalism
- Workplace logistics can increase disruptive behavior
  - OR= small space, long hours, few breaks, stressful tasks
- Contextual factors can increase disruptive behavior
  - individual life experiences, relationships outside of work, societal values

- Walrath JM, Dang D, Nyberg D. An organizational assessment of disruptive clinician behavior findings and implications. J Nurs Care Qual 2013; 28:110–121. 8.
- Bae S-H, Dang D, Karlowicz KA, et al. Triggers contributing to healthcare clinicians' disruptive behaviors. J Patient Saf 2016; 12

One workplace microcosm…

The OR is a tough place to work…

- International survey of 8000 OR employees (anesthesiologists, surgeons, nurses, CRNAs, OR technicians)
- 98% reported experiencing or witnessing at least one incident of disruptive behavior in the prior year
- Average employee exposed to disruptive behavior 64 times/year

- Villafranca A, Hamlin C, Rodebaugh T, et al. Development of survey scales for measuring exposure and behavioral responses to disruptive intraoperative behavior. J Patient Saf 2017; Villafranca, Fast, Jacobsohn. 2018. Disruptive behavior in the operating room prevalence, consequences, prevention, and management. Curr Opin Anesthesio 31(3): 366-374

The OR is a tough place to work…

- Ethnographic Investigation of OR communication patterns
- Researchers observed 128 hours of OR interactions during 35 procedures from 4 surgical divisions (Gen Surg, Urology, ENT, Cardiac) at a teaching hospital and interviewed staff.
- Tense communication was a regular occurrence, with each procedure having 1-4 high-tension events.
- These events led to tension in other participants/contexts in the OR.
- High tension events occurred most often between surgeons and nursing staff
- 2.8% of OR communications are tense

- Team communications in the operating room: talk patterns, sites of tension, and implications for novices. Acad Med 77: 232–237;
- Time as a Catalyst for Tension in Nurse-Surgeon Communication. AORN Journal, 2.8% of OR communications are tense Ethological observations of social behavior in the operating room. Proc Natl Acad Sci U S A 115: 7575–7580

What is disruptive behavior *in the OR*

- Unprofessional behavior: incivility, transgressions, disruptive behavior, physical and verbal aggression, bullying
- Poor communication, passive aggression, lack of responsiveness, public criticism of colleagues, humor at others expense
- Causal and generalized or highly targeted with intention to harm.

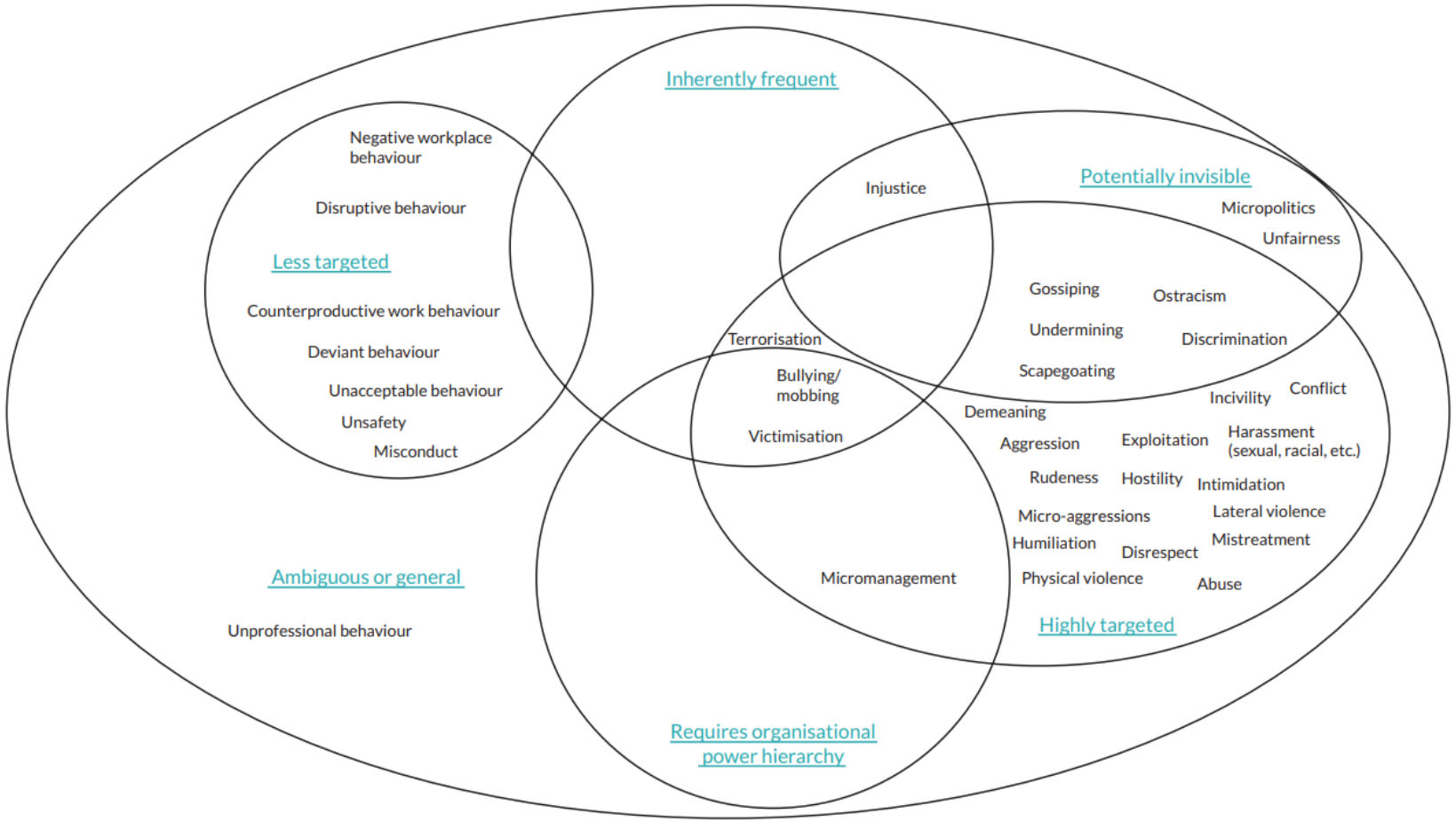
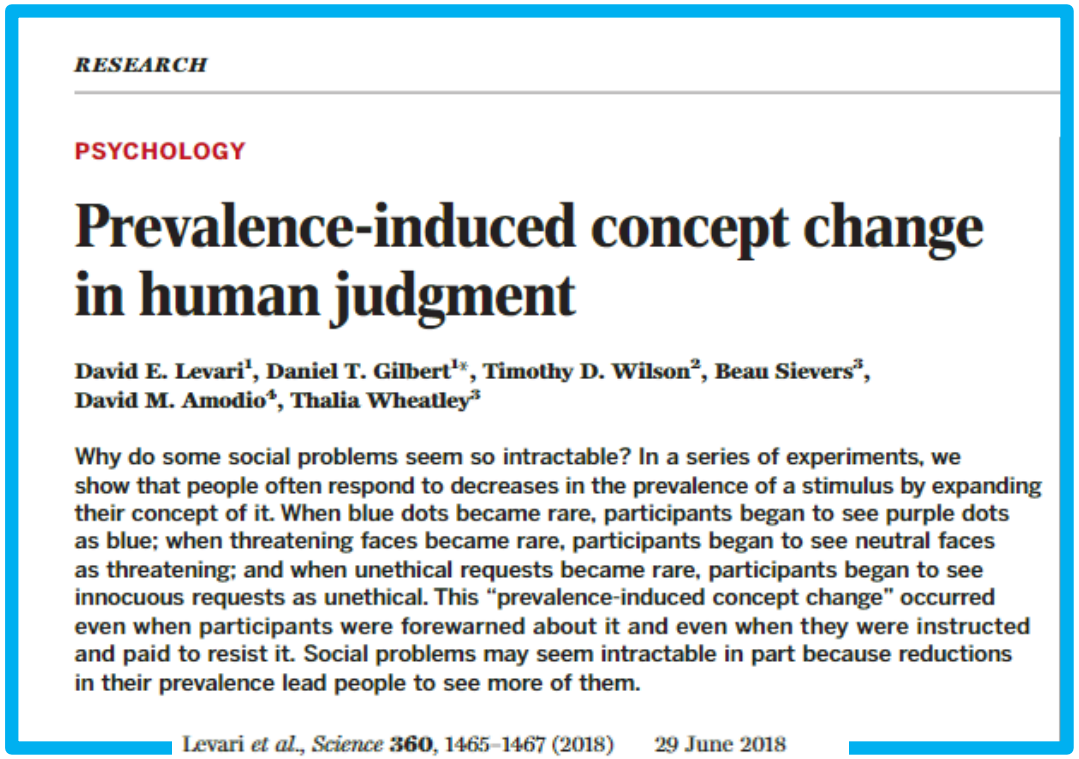


FIGURE 6 Typology of UB terms and their dimensions.

Aunger JA, Abrams R, Westbrook JI, Wright JM, Pearson M, Jones A, et al. Why do acute healthcare staff behave unprofessionally towards each other and how can these behaviours be reduced? A realist review. Health Soc Care Deliv Res 2024;12(25).

Evolving Definition of Disruptive OR behavior?



RESEARCH

PSYCHOLOGY

Prevalence-induced concept change in human judgment

David E. Levari[1], Daniel T. Gilbert[1]*, Timothy D. Wilson[2], Beau Sievers[3], David M. Amodio[4], Thalia Wheatley[3]

Why do some social problems seem so intractable? In a series of experiments, we show that people often respond to decreases in the prevalence of a stimulus by expanding their concept of it. When blue dots became rare, participants began to see purple dots as blue; when threatening faces became rare, participants began to see neutral faces as threatening; and when unethical requests became rare, participants began to see innocuous requests as unethical. This "prevalence-induced concept change" occurred even when participants were forewarned about it and even when they were instructed and paid to resist it. Social problems may seem intractable in part because reductions in their prevalence lead people to see more of them.

Levari *et al.*, *Science* **360**, 1465–1467 (2018) 29 June 2018

CREEP: a material science word→ deformation of a solid under load

Recently "creep" has been used to describe any unintended expansion of a boundary.

Authors developed a study to understand ***why concepts creep***

Stimuli are judged in the context of other relevant stimuli that surround them in space or precede them in time…so the perceived aggressiveness of a particular behavior will depend on the aggressiveness of the other behaviors the observer is seeing or has seen.

Idea- if most behaviors are less aggressive than they once were, then some behaviors will seem more aggressive than they once did → may lead observers to mistakenly conclude that the prevalence of aggression has not declined.

i.e.: ***"Prevalence induced concept change"-*** when instances of a concept become less prevalent, the concept may expand to include instances that it previously excluded.

Evolving Definition of Disruptive OR behavior?

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Participants viewed 1000 dots ranging from very blue to very purple- when blue dots became rare, participants started to see purple dots as blue- change resulted even when participants were told that they would see fewer blue dots or were specifically warned not to let their knowledge of the lower number of blue dots affect their responses

Changed blue dots to threatening to not threatening faces and asked participants to tell whether the person's face was/was not a threat. When the prevalence of threating faces decreased, participants concept of threat expanded to include faces that they had not previously considered threatening

Same finding when asked participants to review IRB proposals that ranged from obviously ethical to obviously unethical.

Reducing the prevalence of problems (disruptive behavior in the OR) may not be appreciated because with decreased incidents, people may just broaden what they consider to be disruptive behavior???

Consequences of disruptive OR behavior

Effect on Patients: impact communication (avoidance, misleading, lying, less frequent) and teamwork between clinicians, reduce technical performance (stress has been shown to impact performance in the OR, difficulty focusing, attention, impair decision making (placating, avoid conflict)

Effect on Clinicians: increased occupational stress, decrease in wellbeing and career satisfaction, depression, decreased self esteem, negative coping mechanisms

Effect on Institutions: decrease employee productivity, increased turnover/sick days/medication and procedural errors, physicians who behave disruptively have increased lawsuits

Effect on Trainees: medical students report loss of interest and loss of respect when members of a surgical subspeciality act disruptively, and they are less likely to consider surgery as a potential career

Cochran A, Elder WB. Effects of disruptive surgeon behavior in the operating room. Am J Surg 2015; Villafranca A, Benoit P, Jacobsohn E. Medical student exposure to negative intraoperative behaviors and post clerkship interest in anesthesiology and surgery. Anesthesiology 2014; Villafranca A, Hamlin C, Benoit P, et al. Exposure to negative intraoperative behaviors alters the residency application of some student. Anesth Analg 2016; 123(Suppl 2):108–109. PR079

Effects of Unprofessional Behavior on OR Safety

Research

JAMA Surgery | Original Investigation

Association of Coworker Reports About Unprofessional Behavior by Surgeons With Surgical Complications in Their Patients

William O. Cooper, MD, MPH; David A. Spain, MD; Oscar Guillamondegui, MD, MPH; Rachel R. Kelz, MD, MSCE, MBA; Henry J. Domenico, MS; Joseph Hopkins, MD, MMM; Patricia Sullivan, PhD; Ilene N. Moore, MD, JD; James W. Pichert, PhD; Thomas F. Catron, PhD; Lynn E. Webb, PhD; Roger R. Dmochowski, MD; Gerald B. Hickson, MD

Invited Commentary page 835

- Retrospective cohort study from 2 academic medical centers that participated in the National Surgical Quality Improvement Program (NSQIP)
- Recorded electronic reports of unprofessional behavior by surgeons
- Identified post-operative complications within 30d of operation
- 13,653 patients underwent surgery by 202 surgeons; 1,583 complications
- Patients whose surgeons had more coworker reports were significantly more likely to experience any complication
- Complication rate 14.3% higher for pt whose surgeons had 1-3 reports and 11.9% higher for surgeons with 4+ reports as compared to surgeons with no reports
- Authors interpret that “organizations interested in ensuring optimal patient outcomes should focus on addressing surgeons whose behavior toward other medical professionals may increase patient’s risk for adverse outcomes”

Is it the individual or the system?

Can we simply remove or remediate disruptive OR team members?

Situational Triggers

PLOS ONE

RESEARCH ARTICLE

"Disruptive behavior" in the operating room: A prospective observational study of triggers and effects of tense communication episodes in surgical teams

Sandra Keller[1,2*], Franziska Tschan[1], Norbert K. Semmer[3], Eliane Timm-Holzer[1], Jasmin Zimmermann[1], Daniel Candinas[4], Nicolas Demartines[5], Martin Hübner[5], Guido Beldi[4*]

1 Institute of Work and Organizational Psychology, University of Neuchâtel, Neuchâtel, Switzerland, 2 Virginia Tech, Blacksburg, VA, United States of America, 3 Institute of Work Psychology, University of Bern, Bern, Switzerland, 4 Department of Visceral Surgery and Medicine, University Hospital of Bern, Bern, Switzerland, 5 Department of Visceral Surgery, Lausanne University Hospital CHUV, Lausanne, Switzerland

- Evaluation of situational triggers for tense communication in the OR and assessment of the impact of tense communication on collaboration quality w/in the surgical team.
- Goal to assess tense communication episodes in the OR, with a focus on triggers and to distinguish between personal and situational influences on the occurrence of tense communication in the OR
- Unique approach in that most studies focus on surgeon personality or hierarchy in the OR
  - ***Fundamental Attribution Error-*** denotes the general tendency to attribute the actions of others to stable characteristics of the person while underestimating situational influences
- Focus on personal predispositions are likely to underestimate contextual factors that trigger tense episodes.

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- Trained observers assessed communication in 137 elective abdominal operations led by 30 different surgeons at 2 University hospitals in Europe
  - Expressed tension- communication emitted in a negative affective tone (includes expression of dissatisfaction, incivilities, overt aggression, condescending language); behavior is not always intending to harm

- 340 tense communication episodes (2.48 tensions per surgery; 0.57 per hour),
- Individual surgeons accounted for 24% of the tension while situational aspects accounted for 76% of tension
- 12 surgeons had no tense communication; 72 operations had no tense communications
- Most tensions initiated by surgeons (97.4%, and main targets were other surgeons and scrub techs)
- 72% of tensions triggered by coordination problems; 21% by task-related problem; 9% by other issues
- More tension related to lower perceived teamwork quality for all team members except the primary surgeon
- Coordination-triggered tensions significantly lowered teamwork quality for assisting surgeons, scrub tech, and circulators
- Conclusion- situational aspects have more influences on occurrence of tension than does individual surgeon and most tensions are triggered by coordination problems.

Systemic Impacts

- Review of why acute healthcare staff behave unprofessionally toward each other and how such behavior can be reduced.
- Workplace disempowerment and organizational barriers (uncertainty, confusion, stress, lack of resources, lack of social cohesion, harmful cultures) are primary contributors to unprofessional behavior.
- Interventions predominantly focus on individual education or training without addressing systemic, organizational issues.

Aunger JA, Abrams R, Westbrook JI, Wright JM, Pearson M, Jones A, et al. Why do acute healthcare staff behave unprofessionally towards each other and how can these behaviours be reduced? A realist review. Health Soc Care Deliv Res 2024;12(25).

Systemic Impacts- effectiveness of interventions

- *4 broad ideas:*
  1. Interventions should focus on systemic issues → likely to be more effective than addressing problematic individuals
  2. Seek ways to build trust with management/senior staff
  3. Focus on identified target audience and insure inclusivity and fairness
  4. Consider trade-offs in intervention (ex interventions that encourage bystanders to intervene may lead to moral injury if individuals do not feel capable of intervening)

- *15 implementation principles:*

  Covering a broad section of the organization, co-creation with staff, dedicated staff to lead the work, skilled facilitation, multiple strategies, ongoing evaluation, early intervention, maximizing existing opportunities (ie onboarding process) to establish social norms, cultivating perceptions of justice, etc..

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Where's the ethics?

- I argue:
  - Team members have an ethical obligation to limit disruptive behavior
  - Institutions have an ethical obligation to ensure a workplace that minimizes systemic and organizational triggers of disruptive behavior.
- Application of an ethics lens may promote a more nuanced discussion of how to improve workplace culture

Ethical analysis of workplace behavior

- The Ethical Framework that one engages may identify what motivates certain behaviors in the workplace.

  → Reflection may yield insight into workplace conflict and novel paths toward resolution.

- Deontology
- Virtue ethics
- Utilitarian/Consequentialist

Ethical analysis of workplace behavior: Deontology

- Ethical theory in which the morality of an action is based on whether the action itself is right or wrong under a series of rules and principles rather than based on the consequences
  - Workers are ends, not just means. They have inherent dignity requiring respect
  - Workers have certain rights based on the way work and jobs are designed, and employers have certain obligations
  - For example, employers are ethically obligated to promote safe work environments for workers in dangerous or hazardous settings (physical and psychologically safe environments)
- Is it too lofty of a goal to expect organizations/institutions to do what's "right" simply because it's the "right" thing to do?

Ethical Challenges in Workplace Bullying and Harassment: Creating Ethical Awareness and Sensitivity

Helen LaVan and W. M. Martin

Ethical analysis of workplace behavior:
Virtue Ethics

- Focus lies on the character of the individual. Individual traits are the basis of ethical decisions/actions.
- A good person will be a good employee (compassionate, trustworthy, honest); By having virtues, one will make the right choice when faced with ethical dilemmas
- Professional civility framework- problematic behaviors compromise productivity and employee wellbeing; the value of work as an end in itself
- May minimize the impact of the system- even a “good” person may struggle to be civil when under-resourced, stressed, etc.

Ethical Challenges in Workplace Bullying and Harassment: Creating Ethical Awareness and Sensitivity

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Ethical analysis of workplace behavior: Utilitarian/Consequentialist

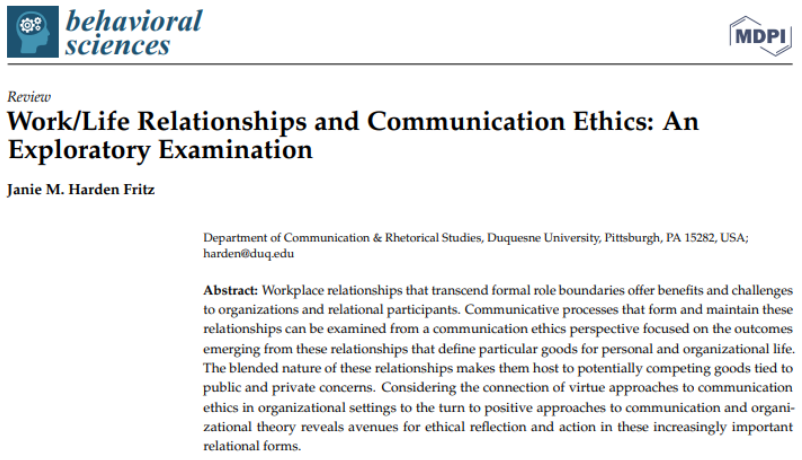
- Ethical theory in which actions are measured by the extent to which a decision secures the greatest good for the greatest number of people
  - What "good" are we measuring?
    Productivity, revenue, patient satisfaction, OR efficiency, employee well-being?
  - Greatest good for whom?
    Workers? Leaders? Hospital? Patients?
  - Cost benefit analysis of given actions
- May be the best way to ensure organizations prioritize?

Ethical Challenges in Workplace Bullying and Harassment: Creating Ethical Awareness and Sensitivity

Helen LaVan and W. M. Martin

Ethical analysis of workplace behavior

- Communication ethics may guide how we interact with colleagues to gain internal (self-worth, friendship, etc) and external (assistance with tasks, information, opportunities) life goods.
- Communication between and among employees is vital to the success of organizations
- Organizations may want to study relationship constitution and ongoing relationship development
- Intersection of organizational ethics, organizational communication ethics, and interpersonal communication ethics



behavioral sciences

MDPI

Review

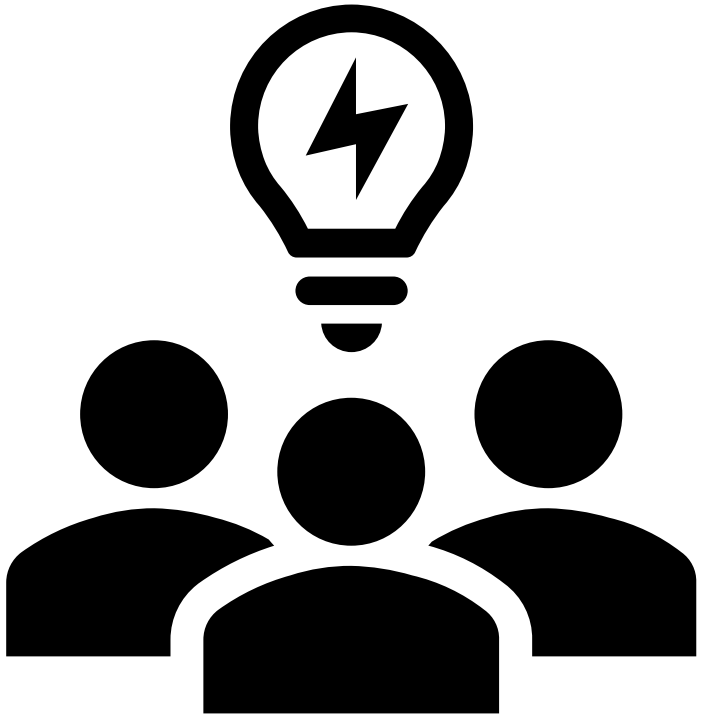
Work/Life Relationships and Communication Ethics: An Exploratory Examination

Janie M. Harden Fritz

Department of Communication & Rhetorical Studies, Duquesne University, Pittsburgh, PA 15282, USA; harden@duq.edu

Abstract: Workplace relationships that transcend formal role boundaries offer benefits and challenges to organizations and relational participants. Communicative processes that form and maintain these relationships can be examined from a communication ethics perspective focused on the outcomes emerging from these relationships that define particular goods for personal and organizational life. The blended nature of these relationships makes them host to potentially competing goods tied to public and private concerns. Considering the connection of virtue approaches to communication ethics in organizational settings to the turn to positive approaches to communication and organizational theory reveals avenues for ethical reflection and action in these increasingly important relational forms.

Which Ethical Framework do you think is most appropriate to guide this discussion?



However, you frame it…

- “To the extent that structural and cultural factors in the workplace environment foster [disruptive] behavior, and to the extent that organizational leaders fail to take action against it, the organization itself could become hostile to the persons who work there. The result is an uncivil culture marked by fear. In this case, the organization could be understood as treating people as a means to an end.”

- “If perpetration of such behavior is unethical, then it rests with leaders in various environments where the behavior takes place (ie workplace, OR…) to identify both macro and micro level practices in order to avoid the problem.”

(Frits Communication ethics and bullying.)

The Institute of Medicine agrees…

- Not because such behavior is “unethical” but because it is “unsafe”
- Institute of Medicine Culture of Safety: “the beliefs, values, and behavioral norms shared between individuals in a team that combine to create a commitment to safety.”
- Disruptive behavior (implicit biases, microaggressions, disrespectful tone, and ineffective communication between members) can lead to increased complication rates in surgical patients.
- Power differentials, perception of the surgeon as the captain of the ship, etc may make it difficult for open, effective communication and maintenance of a culture of safety in the OR
- Clear and accessible reporting system for safety concern must exist to foster a culture of safety

Disruptive behavior is under reported

- Survey of 23 perioperative organizations in 7 countries (anesthesiologists, nurses, surgeons, OR technicians)
- Measured exposure to 5 forms of disruptive behavior:
  - Directed toward respondent
  - Directed toward colleagues w/in respondents' profession
  - Directed toward others in the OR
  - Directed toward patients
  - Directed toward no one in particular
- 97% of respondents under-reported disruptive behavior
- Clinicians report less than 1/5 of the disruptive behavior they are exposed to
- 21% of clinician expressed some degree of satisfaction with management’s response to their reports

Disruptive behavior in the operating room is under-reported: an international survey Fast I et al. 2020 J Can Anesth 67: 177-185

Reporting systems…

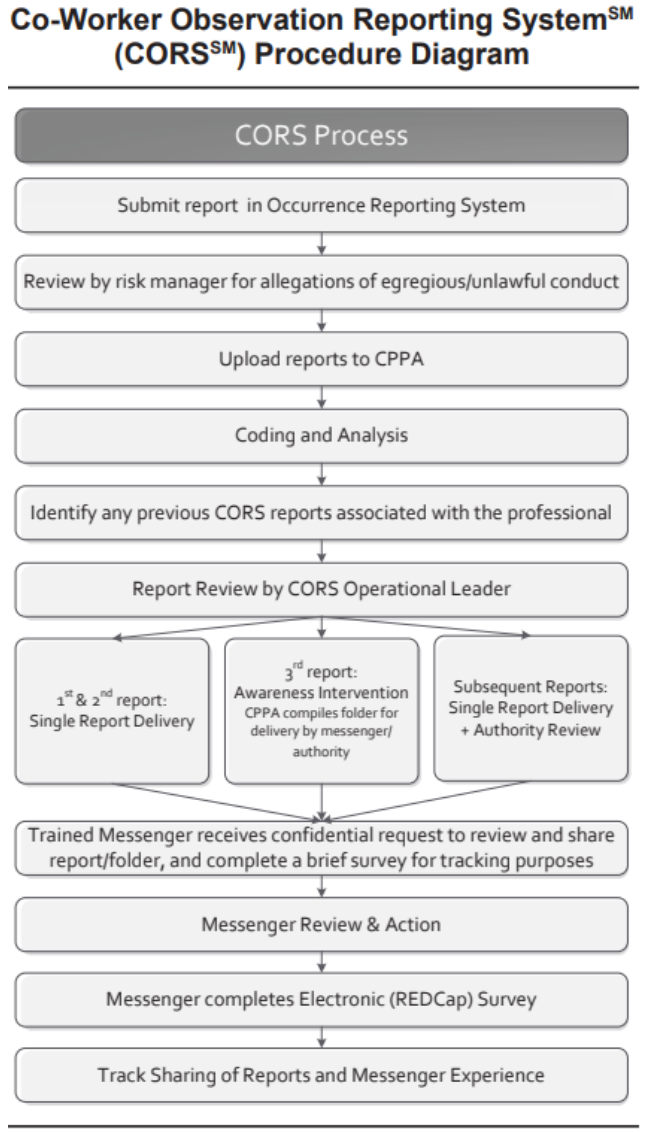
- In some healthcare organizations, the safety reporting system is used to report communication/behavioral issues with co-workers
- Weaponizes the safety reporting system
- Development of behavior reporting systems that differ from safety reporting systems

Co-Worker Reporting Tools

- Vanderbilt Center for Patient and Professional Advocacy
- Peer Advocate Program

Vanderbilt Center for Patient and Professional Advocacy: Co-Worker Observation Reporting System

- Started 2013, now supports >100,000 healthcare workers
- Mission Statement: "To make medicine kinder, safer and more reliable through preeminent programs in education, research and service, fostering professional accountability and risk prevention.
- Anonymous report made through online reporting system
  all reports uploaded to system for coding, analysis, escalation as appropriate
- Peer-messenger engages in a 1-sided, "cup of coffee" conversation with an identified team member, encourages self reflection
- Leaders committed to sharing all reports to align employees with organizational core values
- The 1-sided conversation may lead to imbalanced- accountability



Eckhouse et al. 2025. Early experience of the peer advocate program. JACS. 240(2): 148-157.

Peer Advocate Program

Washington University School of Medicine, Barnes Jewish Hospital, St. Louis Children's Hospital

Attempt to transition behavior reporting away from safety reporting

Goal: “effectively managing communication and behavioral disconnects that allows for restorative conservation and communication” “de-weaponize the system”

Role of a Peer Advocate

- Maintains confidentiality of the initiating team members able
- Immediate resolution, mediation or escalation as appropriate

Eckhouse et al. 2025. Early experience of the peer advocate program. JACS. 240(2): 148-157.

Peer Advocate Program

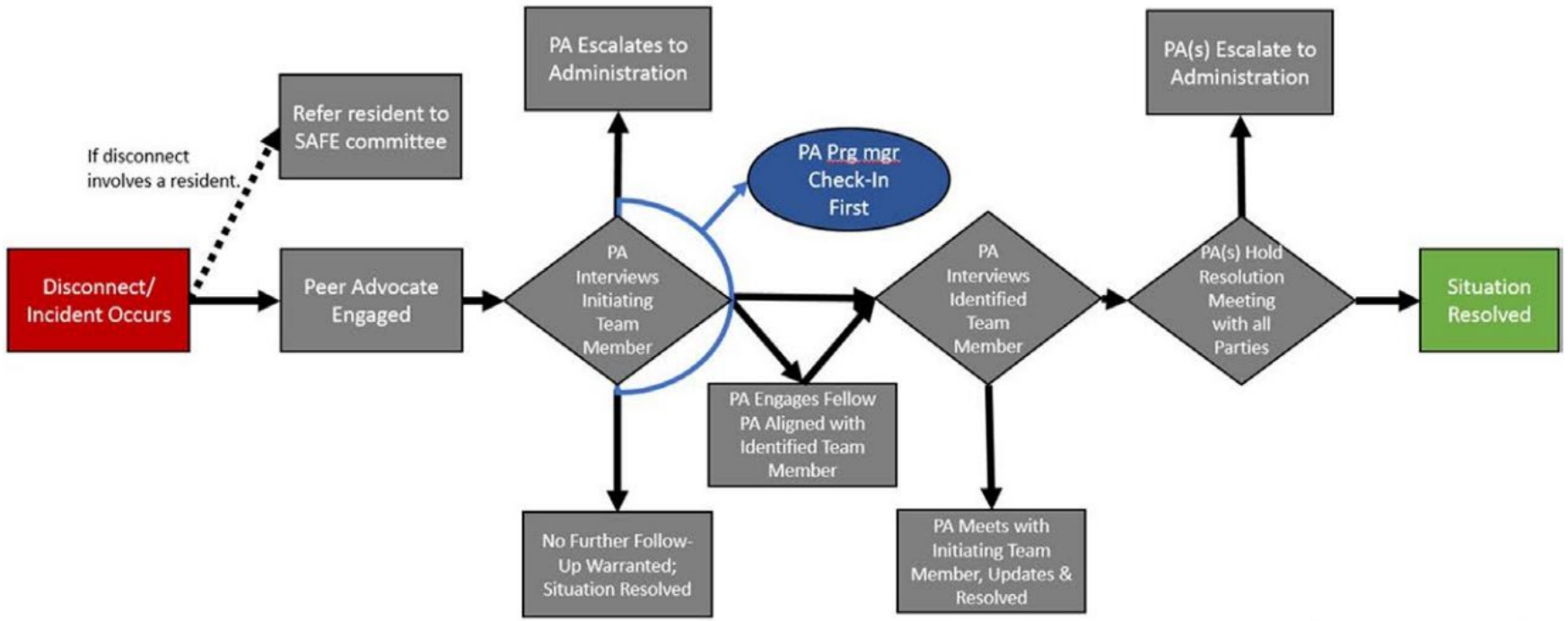


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Table 2. Details of the Events that Used the Peer Advocate Program

Event details	Total, n (%)
Total events through PA program	39 (100)
Initiating team member	
Nurse	32 (82.1)
Surgeon	3 (7.7)
Anesthesiologist	2 (5.1)
Trainee	2 (5.1)
Identified team member	
Nurse	10 (25.6)
Surgeon	21 (53.8)
Anesthesiologist	3 (7.7)
Trainee	5 (12.8)
Type of event	
Disrespectful behavior	34 (87.2)
Aggression	1 (2.6)
Tone of voice	1 (2.6)
Dismissive behavior	1 (2.6)
Racial bias	1 (2.6)
Gender bias	1 (2.6)
Action	
PA program conversation	10 (25.6)
Mediation through PA program	11 (28.2)
Escalation	7 (17.9)
Safety event reporting system	1 (2.6)
Other	10 (25.6)
Conclusion	
Resolution	21 (53.8)
Escalation to leadership	7 (17.9)
Escalation to human resources	1 (2.6)
Other	10 (25.6)

PA, peer advocate.

Published descriptions of reports

Cool code
"A [report] was filed following my successful resuscitation of a patient after cardiopulmonary arrest. I was accused of being 'too calm' [and] my 'demeanor did not express the urgency of the situation.'"

Pumping room
"While my baby was breastfeeding, I asked a [OR staff member] whether it was possible to find a quiet room where I could pump between cases. I had heard that there was a small, vacant room next to the room where the cardiac bypass equipment is stored. The [team member] filed a [report] about my asking for a quiet room for breast pumping, claiming I posed an infection risk."

Euthanasia
"After extensive discussions with the family, my ICU team decided to withdraw support for a terminal patient. One of the [team members] involved disagreed on our method of withdrawing support. Rather than discussing [the] concerns with the team, [the team member] wrote a [report] accusing me of 'euthanizing' the patient. In our state, euthanasia is considered murder. Because of the [report], my institution was obliged to report this to the state. I was investigated for murder. The investigation determined that my team and I acted properly in withdrawing support. The documentation fully supported every decision we made (thank God!). I still have PTSD from having been accused of murder, prompting an investigation. Supposedly that which doesn't kill you makes you stronger. Not this time. It left me deeply wounded."

Dress code
"A baby in the neonatal ICU was accidentally extubated. The NICU team was unable to reintubate the infant, so a stat call went out for anesthesia assistance. I showed up and successfully intubated the baby. After checking placement of the endotracheal tube and making sure it was secured into place, I documented the procedure and left. I was written up by a [team member] for wearing an OR jacket over my scrubs. Evidently that violates the NICU dress code."

Bad shot
"During a code, I hastily prepped the arm for an a-line with chloroprep and tossed the prep stick into the trash can. After the code I discovered that a [team member] had filed a [report] because I missed the trash can and hit the back wall."

Shafer SL. Asamonitor.

Published descriptions of reports

"A resident then recounted her recent experience. The transplant surgeons evaluated one of her hospitalized liver transplant patients and informed the patient that antirejection medications were indicated. Subsequently, the patient had questions that [another team member] could not answer. The [team member] sent a text message to the intern to speak to the patient at the bedside. The intern, still rounding, did not know the answer to the question so texted back, "I don't know." The patient became frustrated about the lack of response, so [the team member] sent several more text messages to the intern for a different response. Meanwhile, unbeknown to the [team member], the intern was simultaneously trying to contact the surgeons to obtain information, but the team was in the operating room and did not answer. By midafternoon the [team member], increasingly frustrated, phoned the intern and harshly stated, "You really need to figure this out *now*!" The intern, upset, asked [the] senior resident what to do. The senior resident stated that this [team member's] behavior was unprofessional and filed a safety event report about them. The [team member] also filed a safety event report about the intern's lack of responsiveness to a patient's needs. As the resident finishes her account, other residents are nodding their heads and many hands are raised wanting to share similar experiences."

Meyers JS et al. Gotcha! Using patient safety event reports to report people rather than probes. J Grad Med Educ 2020; 12525-528.

Do the reporting systems themselves create distress for workers and negatively impact culture?