Why do acute healthcare staff behave unprofessionally towards each other and how can these behaviours be reduced? A realist review

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Published August 2024
DOI: 10.3310/PAMV3758

Scientific summary

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Health and Social Care Delivery Research 2024; Vol. 12: No. 25
DOI: 10.3310/PAMV3758

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Background

Unprofessional behaviour (UB) in healthcare systems can have significant negative impact on staff well-being, patient safety and organisational costs. UB encompasses a range of behaviours – such as incivility, microaggressions, harassment and bullying – that remain prevalent in healthcare systems around the world. In 2022, Workforce Race Equality Standard data indicated that the percentage of staff experiencing UB from colleagues in the National Health Service (NHS) was 22.5% for white respondents and 27.6% for ethnic minority respondents.

Unprofessional behaviour can impact negatively on the psychological well-being of both targets and witnesses. This may result in higher rates of staff sick leave and turnover. Conservative estimates suggest that damages from bullying alone cost the NHS approximately £2.28 billion per annum. The negative impacts of UB also extend to patient safety, which can be compromised if staff members who are victims of UB are unable to speak up – leading to medical errors and poor patient outcomes. Managing, mitigating and preventing UB can assist in addressing the increasing workforce crisis in health care and declining rates of patient satisfaction, as well as improve patient outcomes.

Extant literature has focused predominantly on bullying. Literature exploring the implementation and effectiveness of interventions designed to reduce UB is often underpinned by the belief that the more people know about UB – including how to recognise and challenge it – the more likely it is to be reduced. However, this is very challenging to do and places the responsibility on individuals. Interventions to reduce UB in health care may need to be tailored to specific contexts and may need to go beyond increasing awareness and assertiveness to address deeper systemic issues.

This is a complex, widespread and urgent issue that is heavily reliant on context and has negative impact on staff well-being, patient safety and organisational costs. A realist review methodology may be an ideal method for examining the interacting components of UB between staff in acute healthcare settings.

Objectives

This review aimed to:

- Conceptualise and refine terminology, by mapping behaviours defined as unprofessional to understand differences and similarities between terms referring to UB (e.g. incivility, bullying, microaggressions) and how these terms are used by different professional groups in acute healthcare settings.
- Develop and refine context, mechanism and outcome configurations (CMOCs), to understand the causes and contexts of UB, the mechanisms that trigger different behaviours, and the outcomes on staff, patients and the wider system of health care.
- Identify strategies designed to mitigate, manage and prevent UB and explore how, why and in what circumstances these work and whom they benefit.
- Produce recommendations and comprehensive resources that support the tailoring, UB and their impacts.

Methods

Realist reviews seek to understand why an intervention may work in one context but not another. This involves building an understanding of how various contextual factors affect the activation of mechanisms (i.e. changes in participant reasoning) to produce various outcomes. Often these relationships are not well articulated in the literature, so realist research draws on retroductive reasoning to unpack this information, drawing on 'hunches' as well as inductive and deductive reasoning to ask, 'why do things appear as they do?'. The aim of this is to build CMOCs that underpin programme theories and to build an understanding of how contributors drive UB and how different strategies may be used in different contexts to address UB.

Realist reviews also enable grey literature to be drawn upon. Our review had six main stages:

1. Formulating initial programme theories drawing on informal literature searches of NHS England, The King's Fund, British Medical Association, Health and Care Professions Council and NHS Employers websites, as well as literature already known to the study team and in the study protocol. This comprised 38 studies after screening for relevancy and rigour.
2. Performing systematic and purposive searches for peer-reviewed literature on EMBASE, Cumulative Index to Nursing and Allied Health Literature and MEDLINE databases as well as grey literature on Health Management Information Consortium, National Institute for Health and Care Excellence Evidence Search, Patient Safety Network, Google and Google Scholar databases, and NHS Employers and NHS Health Education England websites. Searches were conducted in November 2021, then expanded to include United States of America (USA) literature in August 2022 and updated in December 2022.
3. Selecting appropriate documents while considering rigour and relevance. The above searches identified 5967 total titles and abstracts across all databases after deduplication. We applied strict conceptual-richness criteria to include the most relevant and useful literature. Searching and screening in November 2022 resulted in 64 included sources. Additional searching in August 2022 resulted in the addition of 36 sources; the December 2022 search added a further 10 sources. This meant that 110 sources were used for theory refinement (step 2 onwards) while 38 were used in step 1 for initial theory generation, with 148 sources included in total.
4. Extracting data using NVivo 12 software (QSR International, Warrington, UK) using a mix of inductive and deductive code creation. Key excerpts were also extracted separately into a Word document so that patterns across literature could be collated and investigated. Characteristics of included sources were extracted into an Excel spreadsheet.
5. Synthesising data with the aid of the data categorised within NVivo, where data were coded according to UB definitions, contributors, interventions, and strategies. This enabled us to compare and contrast, reconcile, adjudicate and consolidate different sources of evidence to build an understanding of which contexts affect how interventions work, and why and how various UB contributors may work.
6. Refining and testing initial programme theories against additional identified literature. At this stage, CMOCs and programme theories were either confirmed, refuted or added to our step 2 analysis.

Stakeholder feedback was also incorporated at five points in the project through the following process: (1) record theory presentation to stakeholders for refinement, (2) record suggested alterations, (3) perform purposive searching to sense-check non-aligned suggestions, (4) discuss discrepancies within the team to determine consensus and action taken and (5) represent changes made to stakeholders/group for further sense-checking.

Results

Terminology

We explored the use of UB-related terminology in the literature and found that forms of UB can be placed on a spectrum according to how specific they were, whether they were visible to the organisation or their targets, and whether they required a hierarchical structure to occur. We also found that there is little agreement within the literature about how to define dimensions of UB. This may cause confusion and make it challenging to synthesise the literature on this topic. In practice, the lack of a shared definition or understanding of UB could lead to difficulties in understanding its prevalence, reduce the likelihood of individuals reporting UB and hinder the effectiveness of interventions to address UB.

Contributors to unprofessional behaviour

We explored how UBs are developed and experienced by staff in acute healthcare settings. We were able to create a comprehensive programme theory that categorised contributors into four aspects:

- Workplace disempowerment: factors such as hierarchy can lead to people becoming an easier target for instigators, foster a sense of unfairness and cause a reduction in psychological safety, which can all facilitate propagation of UB.
- Organisational uncertainty, confusion and stress: factors such as organisational change or a lack of resources contribute to increased instances and experiences of UB. When staff are more likely to experience a lack of control in their day-to-day work, this can exacerbate pre-existing stress, create challenges in building relationships and worsen UB.
- Social cohesion: a lack of social cohesion among colleagues – including reduced ability to communicate effectively (e.g. due to stress and pressure as outlined above) – can lead to the undermining of social relationships between staff that would otherwise enable a greater ability to cope with and collectively address UB.
- Enablement of harmful cultures that tolerate UB: leadership and organisational culture can enable, model or tacitly permit UB. This can create an environment in which UB becomes part of an organisation's fabric and the social norm.

Our programme theory depicts how these contributors interact and, in so doing, identifies the many overlapping mechanisms across each area and type of UB.

Outcomes of unprofessional behaviour on staff, patients and organisations

- Our review identified that UB is experienced more frequently by people from a minoritised background. More broadly, we also highlighted impacts on staff psychological well-being as a result of UB. Intra-professional forms of UB were found to be more harmful to well-being than interprofessional UB, perhaps due to the differing strengths of social ties within and between groups. We identified that the economic impact of UB to organisations is significant.
- We were able to create a programme theory regarding how the presence of UB can impact staff and thereby patient safety through various mechanisms, such as inability to communicate and loss of learning.

Interventions and strategies to reduce or mitigate unprofessional behaviour

- We identified 42 interventions that sought to reduce UB between acute healthcare staff. The majority were developed and implemented in the USA (n = 30), with none reported from the United Kingdom (UK). The interventions included single-session or multiple-session designs, combined with other actions such as codes of conduct, professional accountability and reporting interventions and structured culture-change interventions. However, most interventions did not draw on theoretical frameworks to inform their design, report theoretical underpinnings, provide an understanding

of why and how the intervention is expected to work or report any comprehensive long-term evaluation. Only one intervention targeted UB impacting minoritised groups (racism).
- Of the 29 studies that assessed intervention effectiveness, the majority (*n* = 23) reported positive results – but this depended on the outcome measures these studies chose. Interventions drawing on single-session designs were reported as less effective compared to multiple-session interventions. There was a trend towards more complex interventions reporting greater effectiveness.
- Interventions can have degrees of flexibility, allowing for variation as to which components or strategies participants are exposed to. However, this makes them more resource-intensive to implement and harder to evaluate. We also found (via information from our stakeholder group) that there are interventions taking place in practice that are not adequately reported in the literature, making it difficult to assess their effectiveness. Finally, we did not include interventions to improve civility or professionalism alone, which may also address some contributors to UB.
- The review identified 13 categories of strategies to reduce UB. These strategies included direct or indirect approaches to instigators (such as informal or disciplinary actions), improving awareness and knowledge of UB for all staff, improving teamwork, setting social norms through leadership role-modelling and code of conduct, and reporting and escalation systems. Improving leadership competence and empathy, workplace redesign and changing recruitment and dismissal processes were also identified, as were external pressures on organisations and strategies to aid implementation. Overall, the strategies highlighted the importance of addressing UB from multiple angles and levels (individual, team, organisational and societal), involving all staff and management levels, and creating a culture of respect and accountability.

When do unprofessional behaviour interventions and strategies work?

The study identified 12 key dynamics that can be summarised into four broad categories helping to optimise the effectiveness of interventions aimed at reducing UB in healthcare settings. Firstly, if interventions can focus on systemic issues such as organisational uncertainty, this is likely to be more effective than addressing problematic individuals. Secondly, seeking ways to build trust with management and other senior staff members is crucial. This relies on interventions being seen as authentic and leaders being role models. Thirdly, interventions need to be focused on an identified target audience and ensure they are both inclusive and fair. Lastly, there are trade-offs in intervention design that must be considered – that is, whether to build interventions in a theory-based or practice-first manner or to focus on effectiveness or ability to evaluate. For example, interventions encouraging bystanders to intervene are important for culture change but may lead to moral injury if individuals do not feel capable of intervening.

Findings also emphasised the importance of maintaining a focus on why reducing UB is important (to improve patient safety and staff psychological well-being), encouraging triage of messages in systems that enable anonymous reporting and comprehensive evaluation of interventions to better understand what works, where and why.

We identified a further 15 key implementation principles that may help the effectiveness, sustainability and perception of UB interventions in healthcare organisations. Examples include: covering a broad section of the organisation, co-creation with staff, dedicated staff to lead the work, skilled facilitation, multiple strategies, ongoing evaluation, maximising visibility, assessing the organisational landscape before implementation, early intervention, maximising existing opportunities such as onboarding processes to establish social norms during induction, manager engagement, cultivating perceptions of justice, avoiding mixing of hierarchies in session-based interventions, and avoiding simply moving the target or instigator of UB.

Conclusions

Unprofessional behaviour is a pervasive issue currently poorly addressed by existing interventions. We identified many contributors to UB, most of which relate to worker disempowerment and organisational barriers. However, most existing interventions do not address these systemic, organisational contributors to UB, instead relying on education or training workshops to boost individual knowledge or awareness, identify problematic individuals or improve UB targets' ability to speak up. Such approaches may reduce UB prevalence; however, it is unclear whether this has lasting positive impact or improves staff psychological well-being and patient safety. Future interventions would benefit from being designed and tested in UK settings, drawing on contemporary behavioural science principles to help inform their design, and focusing on systemic issues within organisations. We provide 12 key dynamics and 15 implementation principles to guide organisations.

Study registration

This study was prospectively registered on PROSPERO CRD42021255490. The record is available from: www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021255490.

Funding

This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme (NIHR award ref: NIHR131606) and is published in full in *Health and Social Care Delivery Research*; Vol. 12, No. 25. See the NIHR Funding and Awards website for further award information.

Health and Social Care Delivery Research

ISSN 2755-0079 (Online)

A list of Journals Library editors can be found on the NIHR Journals Library website

Health and Social Care Delivery Research (HSDR) was launched in 2013 and is indexed by Europe PMC, DOAJ, INAHTA, Ulrichsweb™ (ProQuest LLC, Ann Arbor, MI, USA), NCBI Bookshelf, Scopus and MEDLINE.

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: journals.library@nihr.ac.uk

This journal was previously published as *Health Services and Delivery Research* (Volumes 1–9); ISSN 2050-4349 (print), ISSN 2050-4357 (online)

The full HSDR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr.

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This article

The research reported in this issue of the journal was funded by the HSDR programme or one of its preceding programmes as award number NIHR131606. The contractual start date was in October 2021. The draft manuscript began editorial review in April 2023 and was accepted for publication in December 2023. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HSDR editors and production house have tried to ensure the accuracy of the authors' manuscript and would like to thank the reviewers for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this article.

This article presents independent research funded by the National Institute for Health and Care Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the HSDR programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the HSDR programme or the Department of Health and Social Care.

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