Five fundamentals of civility for physicians: Part 2

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This second of two articles on the fundamentals of civility for physicians focuses on communication, self-care, and responsibility. Adopting these behaviours empowers us to take responsibility for our own well-being which, in turn, enables us to do and be our best under all conditions.

KEY WORDS: civility, communication, self-care, responsibility, professionalism, conduct, respect, burnout, leadership, CanMEDS roles

Incivility in the health care system can have an enormous negative impact and consequences. In contrast, civil behaviour promotes positive social interactions and effective workplace functioning. This second of two articles focuses on the final three fundamentals of civility: effective communication, self-care, and responsibility. An earlier article dealt with respect and self-awareness.1

Communicate effectively

Words are powerful. They can flay like whips. Hastily chosen, they can unnecessarily hurt and discourage. On the other hand, words well chosen, considerate, and timely can lift spirits, motivate, and connect us.

When we communicate with someone, be it in person, online, virtually, or in real time, we must remember that we are interacting with another human being, living, breathing, working, and vulnerable – just like us. At its core, civil communication is courteous and respectful. Sadly, this can be forgotten during the course of medical training, practice, and public discourse.

Everyday communication

Here are some common sense considerations for civil conversation.

• Greet others warmly. Gently push vital preoccupations to the side, just for a moment.
• Be inclusive. When others approach, invite them to join the conversation.
• Thinking the best of others is a decent thing to do. Draw on your respect for them.
• Engage in conversation genuinely when the opportunity arises. The ball has been tossed to you. Turn it over in your hands, feel it for a moment, then toss it back.
• Be curious. What are they thinking? Feeling?
• Maintain your integrity. Share to the extent that you are comfortable without being dishonest or misleading.

Two kinds of silence

Silence can help or hinder civility in communication. Active listening is the first kind of silence. If communication is sending and receiving information, then listening is as important as speaking. Not talking in key situations is the other, unhelpful, form of silence. Communication withheld when it is expected, needed, or would be appreciated is a pernicious choice.

Listening

Imagine a time when you had a good conversation with a colleague or friend: you came away feeling buoyed up, heard. How did you know that?

They didn’t talk that much and they didn’t talk over you, waiting for an opening in your narrative so they could punch through with their own ideas. They faced you with a relaxed posture and didn’t fidget. They smiled occasionally. They set their smart phone aside. Pauses in the conversation were comfortable spaces that invited you to share more detail. When they did speak, it was to ask a question that really confirmed they were trying to understand what you were saying and feeling. They didn’t hurry away.
Plan your listening deliberately: behave as if you are listening and be a cooperative listener. Silence is your tool. Focus on the other person and what they are saying. Self-awareness is key. Listen to your inner voice busily reviewing, comparing, identifying, maybe judging, planning your next words, tempting you to interrupt. Silence it – until the right moment.

Praise
I think that many physicians find it difficult to offer praise. Why compliment someone for simply performing as we expect? The answer is that a well-deserved compliment is a considerate act of support. It is capital deposited into the inter-personal bank of good will. Genuine praise strengthens relationships now, facilitating more difficult conversations later, should they be needed.

Constructive feedback
If it’s a challenge to offer praise, then it’s really tough to provide constructive feedback and guidance. When a colleague is underperforming, struggling, distressed, distressing others, and/or behaving in an unprofessional manner, approaching them as a friend, colleague, or leader is a responsible thing to do. There are many guiding frameworks to consider when giving constructive feedback. Motivational Interviewing (MI) is one of them.

MI offers principles for effective communication with someone who is resistant to, or ambivalent about, change. A motivational conversation is embedded in a collaborative and supportive relationship. The physician leader is a guide who helps to clarify his or her colleague’s goals and explore effective behavioural strategies to move toward achieving them. Unhelpful strategies also need to be identified – often by the colleague on their own. This is known as developing discrepancy: “How’s that working for you?” Learning how to roll with resistance is vital: a bloody-minded response to a bloody-minded stance calcifies obstinacy. Ultimately, an effective motivational approach supports the other’s self-efficacy in finding ways to make necessary change.

Although it is beyond the scope of this article to go into MI strategy in depth (or other effective communication paradigms), here are some tips that help structure difficult conversations:

- Plan and rehearse your conversation ahead of time.
- Choose a place and time that is private and unhurried.
- Use empathy and open reflection on what you are hearing: “I imagine you found yourself in a difficult position…”
- Seek to genuinely understand and support the other person’s goals whenever possible.
- Use open-ended questions without judgement: “tell me more about that…,” “help me understand…”
- Focus on accepted facts and behavioural observations, not the person: “I’d like to discuss an incident that arose in the OR last week…” rather than: “How can you have been so thoughtless…?”
- Monitor your own emotional reactions, biases, and “stories” you are telling yourself about the other person and their circumstances.
- Clarify expectations and preferred outcomes objectively.
- Clarify consequences/contingencies that are relevant to the circumstances.
- Support positive behavioural choices and outcomes.

Watch out for these common conversation stoppers:
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• "You…" (accusatory “finger wagging”)
• "You always…" (exaggerated over-statement)
• "You never…" (exaggerated under-statement)
• "Don’t take this personally, but…” (it is personal)
• "With all due respect…” (it is not respectful)
• "I shouldn’t have to tell you this, but…” (inappropriate assumptions)

Receiving feedback
Just as giving feedback requires skill, so does receiving it with an open mind. Not one of us can judge ourselves perfectly. If it rings true, gracious acceptance is appropriate. If not sure, then perhaps a thoughtful response such as: “You’ve given me something to consider. Thank you for that.” And if you just can’t accept the feedback as valid, then a civil response might be something like: “I appreciate that’s how you see things, but that just doesn’t make sense to me.” Counterattack – adopting an aggressive stance, will quash any hope of useful dialogue, blocking positive outcomes and the promotion of respectful workplace relations.

Communication in the digital age
Electronic communication and social media have changed so much about the way professional communication takes place. Like all innovation, electronic and online communication offer many benefits, but also pitfalls that open the door to new forms of incivility. Whether it’s an entry into an electronic medical record, email, tweet, or blog, there appears to be something about sitting at one’s computer that permits unpleasant messaging of all forms.

Our thinking and communication practices must evolve with the digital revolution to preserve personal and professional integrity and high-quality relationships in the workplace. As the CMA Code of Ethics affirms: “Treat your colleagues with dignity and as persons worthy of respect.” This ought to be the case whether our communications are face to face, in writing, online, in social media, or in any other form of communication in the digital age.

Here are some thoughts about maintaining civility in electronic and online communication:

• Keep professional and personal communications separate.
• Email communication should be brief and respectful. Use face-to-face communication to resolve conflict.
• Consider all comments posted online to be public. Would you say them to or about someone in person, in front of others?
• Be mindful and respectful of local corporate/institutional social media policy when functioning as an advocate within the health care system.
• The necessary role of advocate and the right to free speech do not protect physicians from the consequences of libel and defamation.
• Remember that digital communication never goes away. The uncivil comment you make in a moment of pique often can’t be taken back and the record is permanent!
• It is our ethical obligation not to impugn the reputation of colleagues. Pause for a moment, especially if your emotions are high, before completing any digital entry or pressing “send.” Re-read the message later. Ask yourself: “Is there anything defamatory about this message? How would I feel if this were a message posted by someone else referring to me?”

Take good care of yourself
“If you’re not tough enough to stand it, you should get out.” This is a time-honoured meme of our profession: self-sacrifice, denial of our own basic physiological and emotional needs, is a professional virtue. But one day, taut and “toasted,” this is the doctor who lashes out at a colleague or co-worker in a most uncivil way. Tightly wound, he or she will “shoot the first thing that moves.”

Civility and burnout
When a person has to perform day after day under demanding conditions beyond their personal comfort zone, unable to unburden themselves, there is fatigue, exhaustion, distress, burnout, illness, and, for some, incivility. This is a time when one is most likely to fall back on deeply ingrained modalities of flight or aggression.

Burnout looms as one of the greatest challenges to the medical profession. Nearly half of physicians surveyed report some degree of burnout, no matter what their specialty or where
they are.\textsuperscript{6,7} This is inhumane and unacceptable.

Maslach described the dimensions of burnout as exhaustion (physical and emotional depletion), depersonalization (cynical detachment), and a sense of ineffectiveness.\textsuperscript{8} Major antecedents of burnout include excessive workload, perceived lack of control, insufficient reward, poor professional community support, a sense that fairness is absent, and a mismatch between one’s personal and occupational values and those perceived in the workplace.\textsuperscript{9}

Highly motivated doctors with intense investment in their profession are particularly at risk.\textsuperscript{9} So often have I heard doctors explain their workplace incivility this way: “I do what I do and say what I say only to get the best possible care for my patients.” I believe they are being sincere even as they are unaware of the paradox: treating co-workers badly has negative impacts on patient care. Chronic stress-related irritability, impatience with others, and failing empathy all predispose to workplace conflict and low morale.

### Personal Resilience

Optimizing one’s own health and resilience practices is a choice within our control. Much has been written about the self-care practices that bolster resilience, including my own BASICS series.\textsuperscript{10,11} Resilience can be thought of as the ability of an individual to respond to stress in a healthy, adaptive way, such that personal goals are achieved at minimal psychological and physical cost; resilient individuals not only “bounce back” rapidly after challenges but also grow stronger in the process.\textsuperscript{12}

Self-care is foundational. In an environment that demands peak performance from us every day, attending to basic personal needs provides the vitality necessary to go out into the world and apply our skills in a way that enables a genuine connection to colleagues, co-workers, and patients. Beyond the intuitively obvious benefits of taking care of ourselves, we now know that healthy lifestyle practices for doctors translate into better care for patients.\textsuperscript{13,14} Truly, even for the most dynamic of doctors, paying attention to our own needs makes sense.

### Community

Resilient physicians say that their professional friendships, alliances, and networks keep them healthy.\textsuperscript{11} Doctors come together in many ways that foster genuine mutual support – journal clubs, Balint groups,\textsuperscript{15} Finding Meaning in Medicine groups patterned on the work of Rachel Remen\textsuperscript{16} are but a few examples. With a few simple guidelines, peer support groups are easy to form.\textsuperscript{17}

Any professional grouping of doctors and co-workers, like family health teams, hospital or university departments, can be considered as communities worthy of self-care. In effective workplace communities, practical decisions about work distribution, remuneration, resource sharing, and so on are made in a spirit of fairness, friendship, and mutual support. Conflict, when it inevitably appears, is managed respectfully and effectively. In healthy workplaces, doctors can be genuine with one another and share their experiences as well as their feelings of stress and vulnerability. Compassionate professional communities acknowledge the self-care needs of their members and know how to respond when someone is over-burdened or suffering. These are all matters of compassion and imagination. Physician leaders set the tone.
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The culture of medicine

The health of doctors and, therefore, the health of our profession and the populations we serve are taking shape as a core professional value. This and other aspects of civility are clearly described in the widely used CanMEDS competency framework in the “Professional” section.18

Gone are the days when self-care practices for doctors were considered just a good idea—a luxury for which we had neither time nor sufficient motivation. Organized medicine at every level is weighing in on physician health through policy and program development. Physician health is a political issue.19

Be responsible

Sharone Bar-David describes the broken windows theory: when a neighbourhood broken window is not fixed expeditiously, crime rates will rise. Likewise, when incivility is not addressed promptly, whenever and wherever it arises, it will escalate and spread through a community and culture like a contagious disease. It is our individual and collective responsibility to prevent that.20

Being responsible for ourselves

The way we treat people matters, always and in any situation; for that we are responsible. Extraordinary accomplishment and exemplary behaviour in some circumstances do not permit or forgive belittling, shaming, or any other such treatment of colleagues, co-workers, learners, or patients at other times.

Our primary mission can also obscure personal responsibility. When others on the health care team feel the hurtful impact of a doctor’s incivility, they are unable to work well with that individual. Patient care can be compromised as a result.

Recognizing our internal locus of control, we can take responsibility for our own choices by making civil choices that are the ones most likely to have a positive impact on everything and everyone around us. It is our personal responsibility to understand the five fundamentals of civility and apply them in our daily lives.

Being responsible for others

Even considering a medical tradition of rugged individualism, there are times when we are “our brothers’ keepers.” Sometimes, there are witnesses when a doctor behaves in a manner that is disruptive or hurtful toward others. An observer to an episode of incivility who chooses not to react in any way is a bystander, a part of the problem. Clarkson21 talks about the “bystanding slogans,” thoughts that can block a helpful response. Here are a few of them:

• “It’s none of my business.”
• “Someone else will take care of this.”
• “I don’t want to be hurt myself.”
• “I don’t know what to do.”

The responsible thing to do is to become aware of these and counter them with more rational and helpful thoughts. Here are some suggestions, considering the examples listed above:

• “It is incumbent upon me to help. We are all in this together.”
• “If I don’t say something, it’s likely no one else will and the problem will persist, maybe worsen.”
• “That person might be suffering in some way, and helping them is worth the risk that they might lash out at me.”
• “I’ll get some advice about what to do next.”

Armed with a sense of responsibility, a little courage, good timing, and some practical advice, anyone can approach the individual whose behaviour must be challenged. A simple initial question, “Are you okay?” signals compassion and invites engaging conversation.

Being responsible for workplace culture

Workplace cultures (“the way we do things around here”) vary tremendously: collegial, respectful, fragmented, competitive, supportive, toxic, healthy, and so on. Doctors often work in health care teams even though they may not be directly employed by their hospital or other health care institution. That can set the doctor apart from other co-workers. There are also cultures within cultures, where the social tone can vary widely and civility values seem to be at odds with one another. The same doctor can be rude and intimidating in the operating room yet warm and supportive on the wards.

Leadership is key. All doctors are leaders by virtue of their
professional standing and the patient care dynamic. But it is the special responsibility of our designated physician leaders, be they department heads, chiefs of staff, university chairs, residency program directors, political representatives, or others, to understand their role in shaping and guiding workplace values and cultures.

It is also incumbent on physician leaders to understand the systemic contributors to physician stress and to implement the various organizational strategies that promote physician engagement and reduce burnout.22

**Being responsible for the culture of medicine**
The idea of memes (like genes in a biological sense) as units of transmissible cultural information is intriguing.23 It can be argued that there are a number of medical memes contributing to the “incivility crisis” in the medical profession. Some examples include:

- Superior knowledge and technical excellence permits and forgives rudeness and other forms of incivility.
- The ultimate responsibility for patient outcomes lies solely with the doctor, thereby justifying any form of workplace and/or public behaviour no matter how it might affect others.
- Patients’ well-being comes first (ahead of our own).

These memes inform our attitudes and beliefs. They are modeled for us, overtly or implied, reinforced through training and practice, and passed along to each subsequent generation of doctors. But are they true? Unalterable? Which of our memes ought to be preserved and which ought to be changed or discarded? Our senior colleagues, seasoned by experience, may have a particular wisdom to offer. The newest members of our profession possess modern personal and social values that might improve the humanity of our profession. We ought to listen to them.

**Our professional goal is to heal whenever possible and to comfort, always. We are honoured to work and connect closely with others on this mutual mission.**

In today’s complex professional environments, characterized by
stressful political and economic changes, power imbalances, multiple agendas, technological evolution and revolution, and so much more, civility as a shared responsibility might be the only way through.

**Conclusion**

Civility begins with fundamental courtesy based on respect – for ourselves as well as others. Naturally, if we are to make civil behavioural choices, conscious effort based on self-awareness and effective communication skills is required. Even in the face of conflict and fierce disagreement, civility leaves us, and others, feeling intact and safe. Civility empowers us to take responsibility for our own well-being which, in turn, enables us to do and be our best under all conditions. Individually and collectively, we bear responsibility to inject civility into our professional relationships, communities, and culture, to fix the “broken windows” in the house of medicine.

Our professional goal is to heal whenever possible and to comfort, always. We are honoured to work and connect closely with others on this mutual mission. Civility is the vehicle we need to deliver our skill, knowledge, and compassion to others.

Let’s keep this conversation going.

**References**


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