

Nursing Practice

Discussion

Conflict resolution

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While staff may have to deal with patients who are unhappy or frustrated with the service or care they receive, some simple strategies can help define conflict

The right to be rude: managing of conflict

In this article...

- › Differentiating between inappropriate and abusive behaviour
- › Causes and consequences of rudeness
- › Strategies staff can implement to resolve conflicts

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NHS staff are expected to behave respectfully and courteously to patients, but the same standards of behaviour do not apply to patients. While abusive behaviour is unacceptable from patients, what may be perceived as “rudeness” is often a result of emotions or other factors that may not be obvious. If healthcare staff see such patients as rude, it may negatively affect the care they give. This article discusses what may lie behind “rude” behaviour and presents a model that staff can use to reframe their perceptions of and responses to it to ensure a positive outcome.

NHS staff are under increasing scrutiny with regard to the care and compassion they display towards patients. Since April 2015, the Friends and Family Test has been implemented across the NHS in England; this assesses patients’ experiences by asking if they would recommend the service they have used to friends and relatives.

As stipulated in the nursing code of conduct (Nursing and Midwifery Council, 2015), nurses and midwives are required to “treat people with kindness, respect and compassion”. Furthermore, NHS staff are expected to uphold their specific employer’s code of conduct, which governs standards of behaviour in their organisation.

Complaints

The NHS has been criticised in the media in recent years for poor care (Campbell, 2015), and many patient complaints are received. In 2013/14 an average of over 3,300 patient complaints per week were received, equating to 479.1 per day; 57% of complaints received relate to “all aspects of clinical care” and “staff attitude”, with nurses, midwives and health visitors being the second-highest staff group about whom complaints were received (Health and Social Care Information Centre, 2014).

Managing these complaints has significant cost implications for the NHS, but patient dissatisfaction also has the potential to increase risks to staff safety. For example, over 15,000 assaults on staff were reported in 2013/14 where there were no medical factors at play – that is, the assailants were in control of their actions (NHS Protect, 2014); this represented a 15% increase on the previous year (NHS Protect, 2013). Assuming patient dissatisfaction was a causative factor in many of these assaults, it becomes apparent why effectively managing unhappy service users at the earliest opportunity will benefit staff.

This article discusses patient behaviour that staff may perceive to be rude, and suggests a model that can be used to enable staff to reframe their perceptions of this behaviour, and improve their abilities to cope with it and defuse the situation. The model can be used with patients and service users in all settings, and also with patients’ relatives and others who behave in an apparently rude manner.

Appropriate behaviour

With so much emphasis placed on the standards of staff behaviour, it is

5 key points

- 1** Research indicates that many complaints made in the NHS relate to staff attitude
- 2** A patient’s frustration may come across as rudeness
- 3** Healthcare staff should try not to take complaints personally
- 4** Taking inappropriate behaviour personally can result in the situation escalating, rather than being resolved
- 5** Not all inappropriate behaviour is abusive

BOX 1. ABUSIVE BEHAVIOUR

The following components indicate that behaviour is abusive:

- The behaviour is physically threatening. Would a reasonable person be fearful if they were exposed to it?
- The behaviour is causing, or likely to cause, harm or damage to people or property
- The behaviour is verbally abusive – for example, racist, sexist, homophobic, involves name-calling etc

BOX 2. THE DELUDE COPING MODEL

- D** - Don't take it personally
- E** - Engage with the patient
- L** - Listen to the patient
- U** - Understand the problem and solution
- D** - Deal with it
- E** - Escalate the concern

sometimes forgotten that patients are also obliged to behave in an appropriate manner. However, the behaviour staff are entitled to expect from patients is different to the behaviour they are expected to show patients. If staff want to improve their practice and care, it is vital to understand that patients have the right to be rude.

At first glance this seems to be a controversial statement. In my role as an NHS conflict practitioner, I often encounter nurses who reject it out of hand before exploring it. However, the consequences of failing to fully understand this notion, in addition to complaints and increased risks for staff, can include:

- » Poor practice;
- » Stress;
- » The risk of misconduct allegations.

A sound starting point in grasping the patient's right to be rude is to understand what constitutes "rudeness".

What is rudeness?

Rudeness can generally be defined as a lack of manners or discourteous behaviour. Initially, it may be tempting to argue that patients should always use manners and be courteous when dealing with NHS staff; however, on closer inspection, most health professionals already reject this notion.

In British culture, for example, the words "please" and "thank you" are generally held to be courteous. However, if an older patient fell and cried out for help, or an acutely sick patient mumbled about needing a drink, would any staff member make the patients say "please" before offering support? Both patients are in urgent need of care and dependent on staff for this – surely no health worker would withhold that care because they had not demonstrated good manners.

However, what if we change the scenario? A recent patient complaint I came across involved a staff nurse greeting outpatient attending an appointment with a smile and warm words of welcome. The patient's response was to use an exasperated tone of voice and point out that she would rather not be anywhere near the

NHS as they "killed her mother 10 years ago". The nurse indignantly advised the patient she had not been involved in her mother's care and that her rude behaviour was unacceptable; the patient was warned if she continued to behave in this manner she would be refused treatment.

In this complaint, the patient was also in need of care and dependent on the NHS for it – however, her behaviour seems less acceptable than that of the patients in the two previous scenarios. It could be argued that the difference in this scenario is that, unlike the first two, the patient had more choice. The first two patients were clearly in need of immediate assistance, whereas the "rude" lady had no such excuse for her behaviour; she simply chose to be rude.

If staff feel patients are choosing to demonstrate a lack of manners, as opposed to such behaviour being a consequence of an obviously traumatic situation, the relationship between staff and patient is far more likely to become uncooperative. This idea has been explored by social psychologist Morton Deutsch (2014), who talks about the importance of reciprocation in social relationships:

"[In a social situation] each party is required to treat the other with the fairness that they would normatively expect if in the other's position. It assumes reciprocity from the other – fairness to and from the other. The fairness in behaviour, process and outcomes expected is normative. As defined by one's culture, it is how the conflicting parties should or should not behave towards one another if they are, at a minimum, to avoid a destructive conflict... the norms against violence, disrespect, deceit... are widespread standards for avoiding destructive conflict."

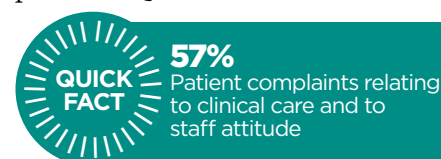
In summary, Deutsch is stating that in social situations, where one person is courteous and the other is not, an uncooperative and competitive relationship is more likely to form. The nurse's behaviour in the complaint above fits exactly with this theory: she was courteous to the patient, the patient did not reciprocate and the nurse's response was to "compete" by pointing out that she was not involved in the care the patient's mother received.

Causes and consequences of "rude" behaviour

If nurses operate with the underlying expectation that in an NHS environment they are entitled to be "respected" in the same way that they show "respect" to others, they will be prone to consistently perceiving behaviour as "rude" and subsequently classifying it as unacceptable.

"Rude" behaviour is often a symptom of situations that are common across health-care settings.

Patients may be experiencing fear, frustration, pain, mental illness, infection, hypoglycaemia, head trauma, dementia, learning disability, abuse, bereavement, hypoxia, hearing impairment or any number of complex social, physical or mental issues. How can staff know within 10 seconds of meeting a patient whether he or she is experiencing one of these? The short answer is, they cannot. How long might it take to learn about a patient's underlying social, physical or mental problems? Quite some time.



If nurses decide a patient is rude and get sucked in to an uncooperative relationship with that patient they:

- » Fail to listen;
- » Fail to care;
- » Fail to ask the right questions;
- » Fail to empathise.

However, if staff accept that patients have the right to be rude, a limit must be imposed. Some forms of behaviour are unacceptable from patients; these are called abusive behaviours. Box 1 outlines the key components of abusive behaviour, which is fundamentally different to rudeness. Abusive behaviour should always result in positive action being taken in accordance with local guidelines and policies. However, unless patients' (or relatives') actions meet one of the three criteria in Box 1, they are not behaving inappropriately.

If staff fail to appreciate a patient's right to be rude there is a risk that they might take offence and decide to informally "punish" the patient for this behaviour in some way. One example of this could be deliberately, albeit subtly, making "rude" patients wait slightly longer for non-urgent care to "teach them a lesson". It is reasonable to assume that staff who allow themselves to take offence and behave like this are less likely to provide good care and more likely to attract complaints.

Coping strategies

The DELUDE model (Box 2) can be used by both students and staff to improve their coping strategies. The model is easy to remember and, when properly embedded into practice, can help improve their understanding and skills in coping with

Nursing Practice Discussion

BOX 3. UNCOOPERATIVE WORKING

A staff nurse refuses to get a wheelchair for an older patient because the patient's daughter said, "Get my mother a wheelchair now, we are sick of waiting around for one," which the nurse considers to be "rude".

The nurse is quite capable of getting the chair and, by not doing so, is delaying a discharge. In doing this the nurse is engaging in a win-lose mode of behaviour with the intention of showing the "rude" daughter who is in charge.

If the nurse depersonalises the situation and considers the iceberg, there is no need to worry about how the patient's daughter asked for the chair. She was not abusive and the way she expressed herself was a symptom of her stress and worry about her mother's condition. Viewed in this way, no offence is taken, the situation does not escalate, and discharge is not delayed.

BOX 4. SAYING NO

Brenda Murray, aged 75, has a degenerative eye condition that will almost certainly result in her becoming registered blind. In her desperation not to lose her eyesight and her independence, Ms Murray purchases an "alternative remedy" online that requires administering by intravenous injection. She first asks her GP, then the practice nurse, to administer the injection for her. However, neither is legally allowed to do so, and are forced to say no. Both explain the situation to Ms Murray clearly and with compassion. She is understandably upset and emotional, but no direct solution or compromise is possible in this situation.

"rude" – or as they should be called, "frustrated" – individuals. The first step of the model – don't take it personally – is by far the most important.

Don't take it personally

The first skill is to reframe the idea of rudeness to see something else instead. To do this it is helpful to think about two simple concepts:

- » The iceberg effect;
- » Depersonalisation.

Syed (2010), a sports psychologist, argues that when people see an elite level of skill or athletic ability they are tempted to judge the performer as "naturally gifted", thereby accounting for their ability. In reality, no world-class athlete gets to the pinnacle of their field without years of hard work and purposeful practice. Syed uses the example of an iceberg to explain this: 90% of an iceberg is submerged in water and therefore hidden from view. It is easy to look at the tip of the iceberg and assume it is the whole story when, in fact, most of it cannot be seen – in this case, years of dedication and painstaking practice to get to the top.

In the same way, when health professionals interact with the patients in their care they only see the tip of the iceberg. For example, when patients are perceived to be rude they may actually be in pain but ashamed to admit it, or frightened because of a bad previous healthcare experience. There are countless possible experiences in the hidden part of the iceberg that account for non-reciprocal behaviour on the surface.

Although it is not possible to see beneath the tip of the iceberg, staff can bear in mind that rude behaviour may be a by-product of something else; "rudeness" can, therefore, be reframed as behaviour that cannot yet be explained. Once this step is taken, it is possible to recognise that the unexplained (rude) behaviour is not aimed at individual staff on a personal level.

The patient would have had the same underlying problem and presented with the same behaviour (initially at least), regardless of which staff member they met.

Depersonalisation, meanwhile, can reduce a nurse's desire to defend or justify themselves on a personal level to "rude" patients because the nurse understands they are not being attacked. When a nurse recognises these patients are upset about their situation, and not with them personally, it is much easier to focus on finding out more and trying to understand what is beneath the surface of their "iceberg".

Engage with the patient

Engaging with patients makes it possible to show interest in their concerns and that you care about them. This can be communicated by a mixture of tone of voice and body language, and helps reassure the frustrated party that you want to help. Often a simple phrase such as, "I am really sorry you aren't happy" or "I am sorry we haven't met your expectations" – neither of which are admissions of fault – will help soothe the patient and demonstrate that you want to find a way forward. The process of engaging is powerful but is only possible if you have not already taken offence, which is why depersonalisation is such an important first step.

Listen to the patient

This overlaps to some extent with the engaging process. In simple terms, allow patients who are frustrated to express their perceptions and problems without interrupting, seeking to justify particular actions or correcting them. It is therapeutic for patients in busy healthcare settings to find a staff member who genuinely appears to want to listen and hear their concerns. Allowing patients to offload concerns can help reduce their frustration.

Understand the problem and solution

During the initial listening process, do not

put pressure on yourself to instantly understand frustrated patients' concerns. After giving them opportunity to express their unhappiness, it is useful to clarify:

- » What their concerns are;
- » What they would like to happen to put things right.

Attempting to put things right is crucial. In some cases this is straightforward but in others it can be more complex. In all cases, however, it is worth asking questions to check you have understood the problem. It can be useful to repeat back to patients what they have said and want next, to ensure you are clear about how to proceed.

Deal with it

There are three ways to fix frustrated patients' concerns and improve their perceptions of the service they receive:

- » Find a direct solution;
- » Find a compromise;
- » Say no.

Finding a direct solution

Direct solutions can give frustrated patients what they want, when they want it. This sounds simple, but staff who have taken offence at patients' behaviour do not want to work cooperatively with them; an example of this is outlined in Box 3.

Finding a compromise

This involves explaining – with compassion and empathy – why a direct solution cannot be offered and working with the frustrated patient to find alternative solutions. The alternatives may not make the patient happy but will hopefully provide some degree of satisfaction.

The most commonly used compromise is time – when patients' needs or wishes

can be met, but not in the timescale they would like. It is important to remember that reaching a compromise requires a cooperative mode of behaviour; this is why engaging is so important – if there is no rapport the frustrated patient is unlikely to agree to a compromise.

Saying no

Saying no is an essential part of assertive behaviour, but how it is done can mean the difference between a cooperative relationship and a competitive one. If you are unable to comply with a patient's wishes it is important to:

- » Explain with care that you cannot do what they want;
- » Give the reasons why;
- » Search for a compromise.

Sometimes there may not be a compromise available and the situation must be left in the hands of the patient. The scenario in Box 4 gives an example of this, and the professionals have to say no to the patient.

If the patient remains unhappy, the last option is to escalate the concern or get the patient to find another solution.

Escalate the concern

In situations such as that described in Box 4, the only remaining option is to escalate the concern to someone more senior to explain the situation again. The information given by the more senior staff member is the same as previously explained, but the patient may be more likely to accept it as true coming from a more senior source. If this is unsuccessful, a further senior tier of staff may be able to engage with the patient and have the explanation accepted; if not, as a final recourse, the patient has the right to make an official complaint.

Conclusion

The six principles of the DELUDE model are straightforward, but are all based on the concept of depersonalisation being properly understood. On the back of my work identification badge and on a poster in the staff room for my department I have the letters INP written in block capitals – they remind me: “it’s not personal”. Once you accept this idea, the “rude” patients disappear and, instead, it is possible to see frustrated people who need help.

Healthcare staff should accept that their patients may have mental, physical or social factors present that reduce the odds of them interacting in the pleasant, friendly way that might be expected in other aspects of life. Staff should also remember that, as long as patients are not abusive, they are not breaking any rules.

Professional carers need to accept that “rude” behaviours are not absolute; they are subjective judgements we make as individuals. When tempted to make such judgements, it is vital to remember that, whether it is visible or not, there is always an iceberg. In addition, no one has the right to insist that their own personal version of politeness is universally practised by others. If staff can get this right, patients are more likely to receive high-quality care, healthcare services are more likely to be recommended to friends and families, and compassion and empathy will be at the forefront of everything health professionals do. **NT**

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