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SURVEY ON PERCEPTIONS OF THE CUP OF COFFEE INTERVENTION

by

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SURVEY ON THE PERCEPTIONS OF THE CUP OF COFFEE INTERVENTION

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Dedication

I dedicate this project to my family. My grandparents, James and Ellen Brannon, Effie Albert, George Washington and Mary Angelique, "Old Mama" instilled in me the importance of education because of the options it provided. They reminded me frequently that what I learned, I also learned for them. My parents, George P. and Gloria Washington, provide unwavering support for me, always encouraging me to set high goals and achieve them, even if the path would take me back to school in midlife! My brother and sister-in-law, Gordon and Taunya Washington, modeled faith, determination and perseverance despite great challenge over the past two years. My husband, Mc Arthur Readoux II, came into my life right after I'd decided to return to school so he's been with me on this entire journey. Without his support, encouragement, love and willingness to drive me back and forth to Clear Lake this journey would not have been as interesting, achievable or as sweet. Thank you babe, this one is for you!

I also dedicate this project to the little girl I once was. She hated doing hard things and would frustrate easily but she had big dreams and a huge faith in God. Thanks for the inspiration Sis'. I can't wait to see what we do next.

Acknowledgements

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ABSTRACT

SURVEY ON PERCEPTIONS OF THE CUP OF COFFEE INTERVENTION

Gia Washington Readoux
University of Houston-Clear Lake, 2018

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The purpose of this project is to investigate the perceptions of the Cup of Coffee Conversation (COC) by Dr. Gerald Hickson. The Cup of Coffee Conversation is a specific intervention for medical staff with lapses in professionalism or uncivil behavior in the medical workplace. This project focused on survey development; a survey was developed to investigate the perceptions and responses of the medical staff participants to this specific intervention. It is expected that survey findings will reveal positive endorsement of the COC by medical staff respondents. All information gathered by this survey, whether positive or negative, will be considered in the organizational development a dedicated department for professionalism within a nationally accredited medical school.

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CHAPTER I

INTRODUCTION

The purpose of this project is to investigate the perceptions of the Cup of Coffee Conversation (COC) by Dr. Gerald Hickson. The Cup of Coffee Conversation is a specific intervention for medical staff with lapses in professionalism or uncivil behavior in the medical workplace. This project focused on survey development; a survey was developed to investigate the perceptions and responses of the medical staff participants to this specific intervention. The staff are all employees at a nationally accredited medical school. This study was supported by a dedicated department whose focus is to decrease incivility within the medical school.

In this intervention, the identified staff member is invited to a peer-to-peer conversation about a specific incident reported. I developed a survey that inquires about the respondent's response to the intervention and perception of its value.

Lapses in professionalism may range in significance of counterproductive work behavior such as harassment, verbal or physical aggression, or incivility, such as intimidation, rude or demeaning behavior. These lapses impact various workplace environments, including medical education environments. Organizational leaders should have comprehensive approaches for educating, evaluating and identifying lapses in professionalism that are established and maintained through intervention and remediation (Nance et al., 2009). Several top tier academic institutions have programs focused on professionalism: Mayo Clinic Program in Professionalism, University of Penn Health System, Brigham and Women's Hospital and Mount Sinai's Code of Professionalism (Shapiro, et al., 2014). These programs may receive institutional, departmental grant and philanthropic support. Protecting the workers of the medical environment through an

emphasis on professionalism and reduced incivility should be a goal of medical organizations leaders.

How do lapses in professionalism begin? In what environments are they permitted to thrive and what are the risks if this occurs? A review of literature on job attitudes, counterproductive work behavior and incivility will be discussed below.

Job Attitudes

The study of job attitudes provides a context for further understanding incivility in the workplace and counterproductive work behavior. It is difficult to determine if job attitudes are the antecedent for uncivil work behavior or if uncivil work behavior precipitates job attitudes, but research indicates a definite connection between job attitudes and incivility within organizational climate and culture (Alexander-Snow, 2004; Ambrose, Huston, & Norman, 2005; Salin, 2003). Incivility in the workplace was found to have a definite impact on workers productivity, attitude and health as determined by Bartlett, Bartlett and Reio (2008). Azizan and Razlina (2015) found a negative relationship between workplace incivility and job attitude, whereas if job attitudes were positive, incivility was found to decrease. Sliter, Sliter and Jex (2012) asserted that there is a relationship between behavior and job attitude in which one's behavior determined the job attitudes conveyed.

Findings revealed that only 30% of workers were engaged, involved in or committed to their workplace. Seventy percent of American workers reported disengagement, and 18% of those individuals reported being actively disengaged at work. Actively disengaged employees possess negative attitudes about work, low job satisfaction, low motivation toward job related tasks and are likely working against organizational goals (Sorenson & Garman, 2013).

Judge and Kammeyer-Mueller (2012) assert that work engagement reflects how an employee directs his or her energy in the workplace. It would follow, therefore, that the active disengagement of employees contributes to work environments with low energy, low commitment to organizational goals and a culture devoid of positive interactions, a likely breeding ground for incivility and unprofessional behavior (Bartlett et al., 2008). Active disengagement can have detrimental effects on work groups by changing others' behaviors and attitudes which could result in a broader negative impact on the organization as a whole (Gallup, 2013; Sorenson & Garman, 2013). Attitudes in general are defined by Eagly and Chaiken (1993) as, "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (p. 1). According to Judge and Kammeyer-Mueller (2012), "Job attitudes are evaluations of one's job that express one's feelings toward, beliefs about and attachment to one's job" (p. 343). Moreover, job attitudes are thought to be predictive of behavior in the workplace (Judge & Kammeyer, 2012; Olson & Zanna, 1993). Negative job attitudes can initiate negative work behavior that includes counter productivity and incivility, contributing to a poor organizational climate and lack of commitment among employees.

Organizational commitment is considered a global job attitude, as it reflects an employee's bond with his or her organization; representing the degree to which an employee is attached to the organization, internalizes the overall goals, mission and values of the organization and makes behavioral choices to support it (Judge & Kammeyer, 2012; Solinger et al., 2008). Employees with high organizational commitment are found to exhibit affective commitment, a concept predictive of job performance (Dunham et al., 1994; Judge & Kammeyer). Individuals with low organizational commitment would not identify with their respective employers, and would act, likely with volition and perhaps without, in ways directly oppositional to the

goals and values identified by the organization. An organization with high commitment to customer service, promoting a pleasant and friendly atmosphere and positive interactions among staff would likely not have frequent rude and demeaning behavior, short and curt responses or negative interactions among its staff (Sorenson & Garman, 2013). An organization with actively disengaged employees with poor job attitudes and a lack of commitment to the organization would likely be indicative of an environment rife with problematic organizational culture and climate; one that is permissive of counterproductive work behavior and incivility.

Counterproductive Work Behavior

Incidents of unprofessional behavior as studied in this project fall within categorization of counterproductive work behavior (CWB). Counterproductive work behavior is defined as "volitional acts that harm or are intended to harm organizations or individuals in organizations" (Jex & Brett, 2014, p.151). This behavior runs in opposition to an organization's goals and can be considered as low or high intensity and vary in frequency. For example, high intensity, low frequency CWB may be as sexual harassment or physical violence. Low intensity, high occuring CWB are behavioral incidents exhibited by employees such as being late or absent from work or exhibiting rude, uncivil or unprofessional behavior to others.

High Intensity Yet Infrequent CWB: Physical Aggression and Sexual Harassment

Physical violence and sexual harassment in the workplace are two forms of infrequent, yet highly intense counterproductive work behavior. Both physical violence and sexual harassment have been highlighted when profiled in mainstream news and because of this attention it may appear to be more frequently occuring than it actually is. The high intensity of these types of acts within the workplace creates concern and panic among those who witness and are targets of this CWB.

Physical aggression or violence in the workplace is infrequent compared to other CWBs, but it is notable that violence and other injuries by persons became the second-most common fatal event in 2016 (BLS, 2017). Workplace violence is described as physical acts of aggression that occur in an organizational setting (Jex & Britt, 2014). Physical aggression may be influenced by environmental characteristics, such as monotonous work in a highly structured environment like a factory. Individual characteristics may influence the act of physical aggression in the workplace. Typical perpetrators of workplace violence are male, have a past history of violence, substance usage, lack of conscientiousness, low agreeableness and low emotional stability (Jex & Britt, 2014). Physical aggression may also present in high pressure environments like hospital emergency centers where stakes are high for physician accuracy in life or death situations. Research in environmental safety concerns found psychiatrists and emergency center physicians to be at highest risk of aggression and violence (AMA, 1995; Morrison, 1998). If the work environment is perceived to be one high in provocation, where employees perceive that their needs are overlooked or feel they are treated unfairly, the potential for violence in the workplace increases.

Sexual harassment has been a frequently discussed topic within popular culture recently. Highlighted by the #MeToo and #TimesUp movements that often center on sexual harassment of women in the entertainment industry, the concept of sexual harassment has recently been on the minds of many Americans. Sexual harassment is defined as verbal or physical contact implying submission, unwelcome sexual advances and requests for sexual favors in the context of an individual's employment (Equal Opportunity Commission, 1980; Jex & Britt, 2014).

Sexual harassment is prevalent, as both historical and current reports indicate. Women are more likely to be victims than men, and the victims of sexual harassment are

also more likely to be in subordinate roles with high visibility in relation to the perpetuator, such as a trainee or medical staff person in a medical environment (Nance et al., 2009). Notably, sexual harassment and general incivility in the work environment were found to be present in problematic workplace culture (Lim & Cortina, 2005).

Low Intensity Yet Frequent CWB: Absenteeism and Incivility

Absenteeism is the attempt of an employee to withdraw from work by being late, take extended breaks, or leave early at the end of the day or taking days off without justifiable reason (Jex & Britt, 2014). In the medical setting, employee absences have a significant impact on patient experiences and the work environment of all staff. Consequences of frequent absences or late arrivals by medical staff result in difficulty maintaining shift coverage and/or excessive work, unbalanced teams and lack of adequate supervision of trainees. Additionally, frequent absences can greatly affect patient connection, patient satisfaction and overall patient ratings in the medical environment and related health care organization (Nance et al., 2009).

Andersson and Pearson (1999) define workplace incivility as "low intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (p. 457). According to Treen (2017), incivility encompasses a wide range of behaviors including, but not limited overt behavior such as: dismissive body language, talking over others, making jokes at someone's expense, being rude to customers or suppliers and using rough language or criticism. More subtle forms of incivility present as: passive-aggressive comments, being routinely late for meetings, gossiping, carrying on a private conversation or texting during a meeting, withholding information, or excluding people. Other authors have asserted that hostility, sarcasm, condescension, ignoring and making demanding remarks are also acts of incivility.

Incivility is frequently occurring but low intensity and the intentionality is more difficult to discern. These negative behaviors may be initiated by supervisors, coworkers and customers.

Andersson and Pearson (1999) assert that incivility occurs more as a process rather than specific events; as it reflects workplace norms and permitted behaviors. It would follow then that if an employee works among negative, rude or sarcastic individuals, he or she will likely act similarly as uncivil behavior is in the atmosphere of the of the work setting. This behavior modeling is promoted by social learning theory (Bandura & Walters, 1963; Jex & Britt, 2014). Therefore, it is understood that incivility incites reciprocity and negative overcompensation from those that it targets and witnesses. According to Treen (2017) "incivility breeds incivility" and it must have a permissive workplace culture to flourish.

The Costs and Consequences of Workplace Incivility

Workplace civility "makes a difference", according to Porath (2017). Reports of uncivil behavior among employees and between supervisors and employees have been found to increase in frequency and severity over the past 15-20 years (Schilpzand et al., 2016). Speculation as to the causes of the increased reports of incivility are linked to changes in work habits; for instance, it could be due to the increase of more employees with the option to work from home, inadvertently resulting in less well-developed work relationships, and individuals who feel less connected the organization and less respected. Additionally, differences in communication style, reliance on social media, email and instant messaging allows for the expectation and high demands of working outside of traditional work hours places pressure on employees and creates gaps in understanding and communication. Notably, researchers indicate that the culture of courteous and polite

behavior has declined substantially in the broader dominate culture, and this may in turn reflect the observed increase in workplace incivility (Jex & Brett, 2014).

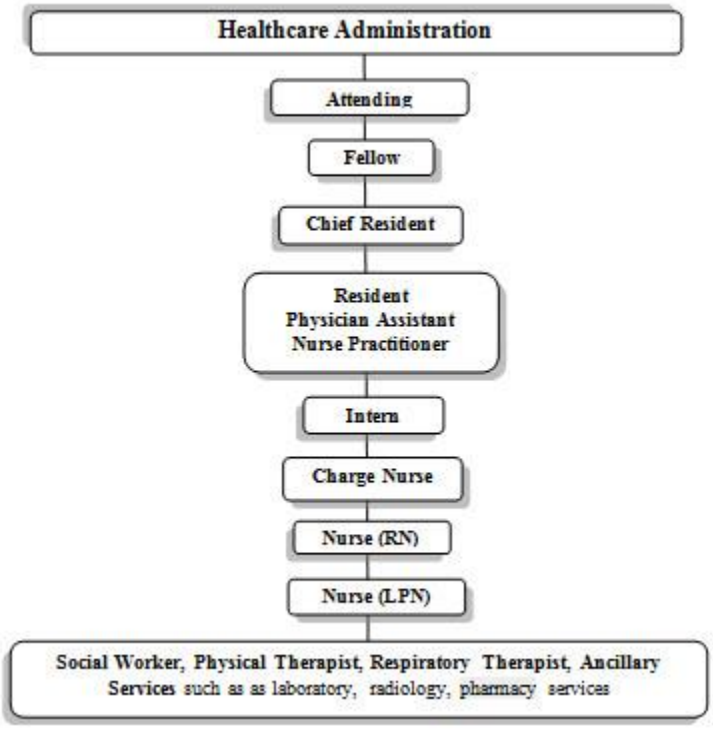
It is estimated that 98% of workers experience incivility, and about half report such conduct at least weekly (Porath & Pearson, 2013). Workplace performance is directly affected by incivility (Treen, 2017). Incivility affects employee turnover when employees resign from jobs due to the hostile environment and do not inform their employers the reason for leaving (Lim & Cortina, 2005). Those who feel disrespected at work are more likely to lower their job performance as a consequence, whether unconsciously or deliberately (Schilpzand et al., 2016). Expenses related to incivility in the work environment are generally deemed to be $14,000 per employee annually, due to project delays and cognitive distraction from work (Pearson & Porath, 2009). Incivility is also linked to active disengagement among employees. Findings by Gallup determine that the United States suffers a $450 billion to $550 billion loss in productivity per year due to active disengagement by employees (Sorenson & Garman, 2013).

Great and far reaching are the effects of incivility as it also takes a toll on customer experiences and perceptions of the organization. According to Porath and Pearson (2013), a customer who witnesses one brief negative interaction can lead to attributions about employees, the organization and the brand. When employees suffer from an uncivil workplace they are less likely to engage in teamwork, share ideas and knowledge, be innovative, and contribute to others. In essence, incivility kills collaboration, teamwork, and weakens the learning atmosphere, essential components in a medical environment (Edmondson & Lei, 2014; Porath, 2017). The harmful effects of incivility extend beyond the targeted victim to those who observe it. The effects of workplace incivility is held responsible by the organizational leaders who are silent about it which is why reporting systems like the one investigated in this project are imperative.

Incivility in the Medical Environment

Why might this type of commitment to decreasing incivility be important in the medical education setting? Drawing from social learning theory, it is possible that incivility occurs in medical education due to the specific cultural values and practices present in medical education. Here, the culture of medical education is defined by high power distance, as asserted by Hofstede and Bond (1984). High power distance between medical faculty and trainees (descending order of rank: attending; fellow; resident, program year 2 or 3; intern, program year 1; and medical student) is embedded in the culture of medical education. The occurrence of medical and clinical errors have devastating and life altering effects, the culture is rife with high demands with low ambiguity and communication errors can occur due to the fast paced nature of the environment. Medical training is structured on the relationships established within hierarchical teams comprised of medical professors with "Attendings" (instructional supervisors) at the top and fellows, residents, interns and ancillary staff in the lower hierarchy (refer to Figure 1). Teaching occurs "downward" through the hierarchy, and those students lower in status are in a prime position to be treated uncivilly if the minds and manners of the superiors are not guarded. In this way, medical trainees could be similar to employees working in countries with a cultural high level of power distance, as they are less likely to consider being ignored or yelled by their supervisors to be an act of uncivil conduct, as this is often expected in such high stakes environments (Hofstede & Bond, 1984). While trainees or other medical staff who rank below Attending Physicians may accept the occurrence of incivility they are likely no less affected by it. As noted above, experiencing incivility could have high negative outcomes for medical trainees who may have lower affect, negative moods and lower confidence when they are operating in an environment that requires a high level of functioning.

Figure 1.
The professional chain of command, an unofficial chart. (Christensen, 2010)



Experienced and witnessed incivility may also be outcomes of the impact of social learning and the cultural hierarchy in the medical environment. Experienced incivility focuses on the feelings, thoughts, and behaviors of employees who are the targets of the incivility workplace behavior. Studies have found that characteristics of targets of workplace incivility fall in particular categories (Cortina et al., 2013; Lim & Lee, 2011; Sliter et al., 2012). These include: ethnic/racial backgrounds, (i.e., being a racial minority in the workplace); age and generation, where the target is often younger in age, or from a younger generation than the perpetuator; the target has physical characteristics (i.e., the target is overweight), and difficult interpersonal or personality characteristics such as being disagreeable and/or overly anxious (Cortina et al, 2013; Lim & Lee, 2011; Sliter et al, 2012). The research results on the occurrence of gender

differences are inconclusive with some studies finding females are more often the target of incivility while other studies have found that men may more often the target (Schilpzand et al., 2016).

Studies on what employees experience after being the target of incivility reveal largely negative outcomes. Findings reveal targets suffer from emotionality or self consciousness (Bunk & Magley, 2013), emotional exhaustion (Kern & Gandey, 2009; Sliter et al., 2010), depression (Lim & Lee, 2011), negative affect, lower positive affect (Giumetti et al., 2013) and low affective trust in others (Cameron & Webster, 2011). Lower levels of energy and high levels of stress were also reported among targets (Sliter et al., 2010). Moreover, less commitment to the organization, less motivation, and lower job satisfaction and in life in general were reported more often by targets of incivility compared to those who do not experience incivility (Schilpzand et al., 2016).

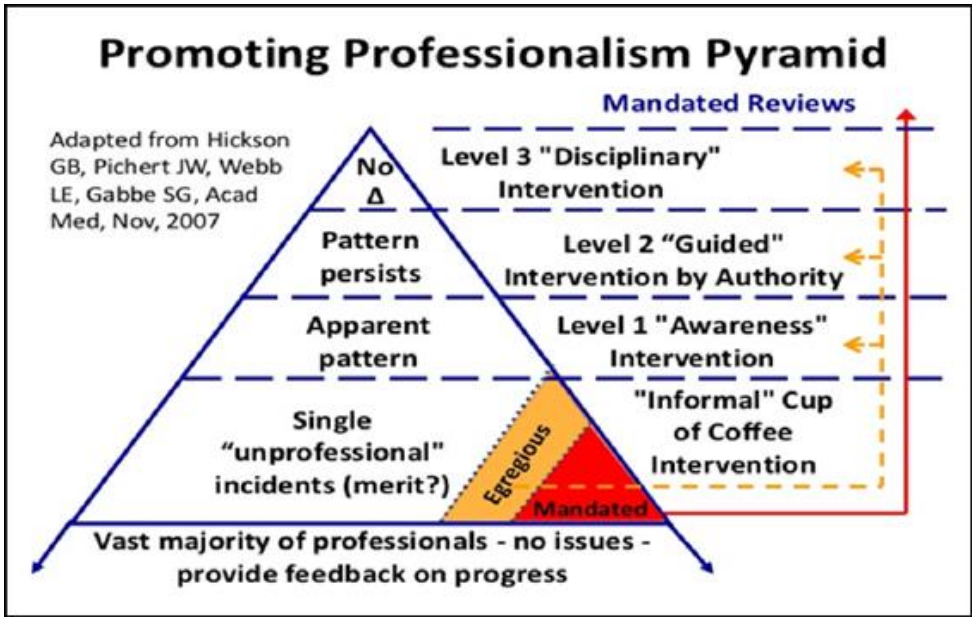
Witnessed incivility relates to those who are third party observers or witnesses of workplace incivility. Gender differences in witnessed incivility reveal female witnesses of uncivil behavior are more negatively affected by it and view it as more inappropriate than males (Montgomery et al., 2004). Witnesses report the negative outcomes to be higher levels of negative affect, a reduction in task performance, creative performance and helpfulness toward others. Participants who witnessed either one of their peers or an authority figure behaving in an uncivil manner had lower performance on routine and creative tasks, engaged less in citizenship behaviors and had high dysfunctional ideation in a study by Porath and Ezra (2009). Witnessing incivility predicts emotional exhaustion, especially when the witness takes the target's perspective and when the incivility is witnessed first had rather than informed of the incivility by someone else (Totterdell et al., 2012).

While most healthcare providers present themselves as professional, lapses in professional behavior do occur in medical settings and should be addressed in a timely manner (Hickson, et al., 2007). Research indicates that patient reports of dissatisfaction related to a healthcare providers' behavior rages between 20%-25% (Hickson et al., 2002; Hickson et al., 2007). The allegations of poor or improper behavior by physicians may range in severity from minor incidents such as misperceptions or misunderstandings to moderately severe yet isolated events to significant patterns of negative behavior. First offenses could therefore be thought of as anomalies and warrant an informal intervention, such as the Cup of Coffee Conversation (COC).

Cup of Coffee Conversation: An Informal Intervention

Professors at Vanderbilt University Medical Center (VUMC) developed a process to identify, measure and address incivility and unprofessional behaviors entitled the Patient Advocacy Reporting System (PARS; Hickson, et al., 2007; figure below). As noted in the figure, the PARS system reflects four levels of intervention. These are: 1) informal conversations for single incidents 2) non-punitive awareness interventions with a pattern of unprofessional behavior is established, 3) leader-development action plans if patterns persist, and 4) imposition of disciplinary processes if plans fail. The Cup of Coffee Conversation (COC) is the first level of the PARS and the focus of this project.

Figure 2.
PARS Pyramid



The COC occurs in a private setting where the lapse in professionalism is reviewed between the medical staff member observed to demonstrate unprofessional behavior and a medical colleague. The medical colleague conducting the COC calls upon their formal training and principles of sharing bad news (Pichert et al., 2007; Suchman et al., 1997), and the medical professional is allowed an opportunity to respond. The individual who exhibited the lapse in professionalism is invited to offer his or her perspective on the issue in question and to discuss why this incident may have occurred. The medical colleague is asked to stress the appreciation of the contributions made by the medical professional and discuss both professional and unprofessional ways of responding. The COC provides an initial step in accountability for the medical professional in question and an opportunity for the medical staff conducting the COC to appropriately address incivility within the medical environment. The authors assert the

every physician needs skill for conducting informal interventions with peers, and they can obtain this training through the COC, making it valuable to both the professional with the lapse in professionalism and the colleague who discusses it with them. According to Hickson et al. (2007), most COCs do not need to be documented because feedback about the incident has already likely occurred, as initiated from the staff member's supervisor due to the reporting requirements related to the event. The COC is employed as a mechanism for reflection and learning between medical colleagues.

Cup of Coffee Intervention in the Affiliated Medical Education Institution

A nationally accredited medical school in the Southern region of the United States is the affiliated institution for this project. Within this institution, a dedicated department whose focus is to promote professional behavior among faculty and staff provides the context for this project.

The dedicated department was created in 2014 to promote professionalism and to address lapses in professionalism within the medical school. The department was charged with developing a predictable, transparent, and fair approach to identify and manage professionalism lapses. A foundational step in this process was to educate the community about professionalism, its importance and how to recognize both positive and negative behavior in the workplace. With a more cohesive definition of appropriate behavior, the department sought to increase awareness of how to report a professionalism concern. A 24-hour hotline answered by a human operator was established for reporting a concern, allowing the option for concerns to be submitted anonymously, confidentially, or as an identified reporter. Beyond establishing a user friendly method to report concerns, the department developed a system to address the concerns that were reported. This system includes an initial informal intervention known as a "Cup of Coffee" intervention (Hickson et al., 2007). This intervention occurs in a informal conversation, informing the

individual that a professionalism concern has been reported and aims to facilitate reflection on the behavior that has been viewed as unprofessional. If subsequent issues arise, there is an identified process of escalation, which includes sequentially: discussion with the individual's Chair of the Department, suggested remedial interventions, mandatory remedial interventions, disciplinary actions and finally potential for termination if a pattern of unacceptable behavior persists. During the time period of 2014-2018, there have been 221 registered professionalism concerns in the affiliated institution (Friedman, et al., 2018). Current records reflect some descriptive information about those with reported professionalism concerns, including demographics, department, academic degree, and professional rank. As of March 2018, the department asserts that 93% of individuals who received a Cup of Coffee intervention during the 2014-2018 time period did not receive any additional reported concerns (Friedman, et al., 2018).

CHAPTER II

METHODS

The Survey Development

Surveys are used as important tools for organizational development and change (Falletta & Combs, 2001). When used properly in organizations, employee surveys can yield valuable information essential to the future success of the organization. When surveys are used in organizational development, they often reflect an action research orientation and aim for strategic action planning and large-scale change (Falletta & Combs, 2001). The present survey was developed as an initial step toward action research and for strategic planning for the department dedicated to professionalism among medical staff.

Action research is a systematic process of collecting data based on a specific goal or organizational problem (Falletta & Combs, 2001; French & Bell, 1995). Surveys are instruments for action planning and change. Important issues for organizations to address, idea generation, solutions to concerns and determining the best approach for intervention and implementation can be investigated with proper survey development. The survey developed to investigate the participant's perceptions of the COC was developed with these endeavors in mind. Findings generated by this survey will be used to further develop the dedicated department and influence organizational behavior in addressing lapses in professionalism.

This survey was developed over a series of meetings with a core group of four faculty members who share affiliation with the department dedicated to promotion of professionalism. The meetings took place over the Fall and Spring semesters of the 2016-2017 academic year.

Initially the item development for the survey focused on the abilities and behavior of the medical colleague in their effort to conduct the intervention and encourage reflection and learning in the professional with the lapse in professionalism. The survey development then evolved to reflect interest in investigating the subjective effect of the COC on the medical professional. Later drafts of the survey revealed developers' interests in the attitude toward the COC and subjective feelings of the employee subject to the COC intervention. As noted, the authors of the COC assert that repeated COC intervention is unnecessary and further, documentation unnecessary as well (Hickson et al., 2007). As it stands, there is no current literature that indicates the outcomes of the COC or the participant's experiences other than the author's' assertion. This project aims to be the first step in investigating the participants' perceptions of the COC.

Several drafts of the survey items were developed resulting in a narrowed list of 20 questions. The time points of one month and six months were chosen as specified points to assess the impact of the COC intervention on the participants over time. The survey was designed to be applicable at the specified time points and allow for further reflection and feedback for the COC.

Survey Items

Survey items focus on the participant's subjective feelings about being identified for and participating in the COC. The items ask for his or her perception of the utility of the intervention, the impact it had on his or her professional development and identity and future behavior. Moreover, the survey investigates the participant's perception of justice regarding his or her involvement in the COC. Additional items reflecting interactional, procedural and distributive justice were added to assess the participant's perception of fairness.

Interactional Justice

Interactional justice was defined by Bies and Moag (1986) to be the interpersonal treatment people receive as procedures are conducted. Colquitt asserted interactional justice occurs when those in power and decision making control convey dignity, respect and sensitivity while thoroughly explaining the rationale for decisions made. Items reflecting interactional justice were included to investigate how dignity, respect and sensitivity were conveyed to medical professionals participating in the COC. Having to participate in the COC due to a lapse in professionalism may be difficult for some medical professionals and it was important that the survey investigated their interpersonal experience during the intervention.

Distributive Justice

Distributive justice relates to social allocation of goods and fairness in outcomes (Cohen-Charash & Spector, 2001). In the case of this survey development, an item was included that investigated the participant's perception of equity in the COC process. This item in particular questioned the participant's perception of equity recognition of their efforts at work. We were concerned that the COC participant may feel that their involvement the intervention would negate or diminish the effort they put into their job as a medical staff employee. We desired to ensure that a survey item reflected implicit norms for equality in this type of procedure (Colquitt, 2001).

Procedural Justice

Colquitt (2001) defines procedural justice as a focus on the processes that lead to decision outcomes. Procedural justice relies upon voice during a decision-making process to fair process criteria. Harrison (2003) found that the ability to give voice to grievances had a particularly cathartic effect on disputant emotions (the "voice" component of procedural justice).

Shapiro and Kirkman (2001) were the first to publish on the concept of anticipatory injustice and argued that workplace members, especially as organizations struggle to adapt to change, anticipate that organizational injustices are likely to occur within everyday work processes. They further argue that employees will anticipate interactional, procedural, and distributive injustices and this will lead to counterproductive and self-defeating behavior on the part of organizational members.

Thibaut and Walker (1975) highlighted two essential criteria for procedural justice. First, procedural justice must include process control which is the individual's ability to state views and arguments during a procedure. Decision control is the second criteria; this reflects the individual's ability to influence the actual outcome itself. Lind and Tyler (1988) assert that procedural justice reflects that people are valued by those in authority over them, and in their collective organization. When applying this to a work setting, employers who promote opportunities for procedural justice create environments where employees know that their opinions have value.

Specific items reflecting procedural justice, distributive justice, and interactional justice were included in the final version of the COC survey. These items are based upon those developed by Colquitt (2001), Thibaut and Walker (1975), Leventhal (1980) and Bies and Moag (1986).

Procedural Justice

- I was able to express my views and feelings during the Cup of Coffee intervention. (Colquitt, 2001; Thibaut & Walker, 1975)
- The Cup of Coffee Intervention was free of bias. (Colquitt, 2001; Leventhal, 1980)

Distributive Justice

- The Cup of Coffee Intervention reflected the effort I put into my work. (Colquitt, 2001; Leventhal, 1976)

Interactional Justice

- During the Cup of Coffee Intervention, I was treated in a polite manner. (Bies & Moag, 1986, Colquitt, 2001)
- During the Cup of Coffee Intervention, I was treated with dignity. (Bies & Moag, 1986; Colquitt, 2001)
- During the Cup of Coffee Intervention, I was treated with respect. (Bies & Moag, 1986; Colquitt, 2001)
- During the Cup of Coffee Intervention, the medical colleague refrained from improper remarks or comments. (Bies & Moag, 1986; Colquitt, 2001)

Qualtrics

Qualtrics is an online diagnostic assessment and employee experience tool used by major corporations to assess engagement, trends, talent and culture within organizations. Qualtrics is recommended for use in this study as the online tool for participants to complete the survey at the one month and six-month time points. Qualtrics was chosen as the recommended methodology tool to ensure confidential reporting and ease of access to the participants at the identified time points. While Qualtrics is not in current use by the medical institution affiliated with this project, it is recommended the dedicated department be the first within the institution to use this online tool. The developers of the Qualtrics system assert that the system measures employee experiences across the lifecycle has been demonstrated to assist Human Resources departments in making decisions (Giona & Haggard, 2017).

Cup of Coffee Intervention Road Map

1) A participant (medical education employee) is notified of his or her expected participation in Cup of Coffee (COC) intervention. This statement is included in the email or phone invitation, *"We are examining the Cup of Coffee intervention and would like your feedback once the process is complete. You will receive instructions on how to provide feedback at the conclusion of your meeting*". The participant's responses will be entered into Qualtrics, the online survey tool that will assign a code number. The participant's identifying information and code number will be kept in a confidential password protected file. One administrative assistant will have access to the password protected file.

2) A trained medical colleague conducts the COC intervention. At conclusion,the participant is informed: *"Your feedback on this program is valued. You will receive an email with information on how to provide anonymous feedback on this process. Data analysis will be handled by an affiliate to the Center for Professionalism and summarized for themes with other participants' responses."*

3) As the participant leaves the private area, following his or her Cup of Coffee intervention, the Administrative Staff states*, "An email with a link to survey on this process will be sent to you in a few weeks. You will be asked to set up a password so that you may also provide feedback again in a few months".*

4) A few days before the participant's one-month anniversary, an email is sent with a link to the survey and instructions for password log on.

5) A few days before the participant's 6 month anniversary, an email is sent with a link to the survey and instructions for log on.

Proposed Analysis

The analysis for the survey results will be both qualitative and quantitative to describe and summarize the data gathered. A statistician who works with the dedicated department will lead the statistical analysis of the data gathered by this survey.

It is anticipated that results will reveal the COC had a positive impact on most participants. It is expected survey responses will reveal that the COC intervention is conducted justly and without bias. I expect survey respondents to favorably endorse having an opportunity to reflect upon the incident of the identified lapse in professionalism. In the case that the survey reveals respondents unfavorably endorsed the COC, the information will be considered valuable and contributory. I anticipate unfavorable responses will be examined closely and used to influence decisions that will change aspects of the dedicated department and its use of the COC.

CHAPTER III

DISCUSSION

As the culture of healthcare changes, many providers complain of being over-monitored, paid minimal wages, overworked and improperly compensated. Reports of burnout among healthcare providers has increased significantly within the past 10 years, due largely to increases in technology, research and general advances in medicine (Gundersen, 2001). Frustration and burnout among medical staff members provides a prime environment for incivility to flourish. As noted in the introduction section, workplace incivility has far reaching impacts (Cortina et al., 2001). Whether the impact of the incivility is the target, the perpetrator or the witness, the effect on the attitudes, productivity, work climate and organizational goals can be significant.

The survey developed for the current project has significance and makes an impact on the organizational development of the affiliated medical school. Leadership of the medical school identified a need to address the incivility and unprofessional behavior of the medical staff within its ranks several years prior to the development of this project. It is possible that the uncivil and unprofessional behavior observed relates to burnout among the staff, the influence of the dominant culture's decrease in polite behavior over time or incivility related to negative job attitudes. Whatever the antecedent, behavioral problems among staff members directed at subordinates and to patients was recognized and the need for intervention was identified, so much so that a dedicated department was established for that endeavor. Thus far, the dedicated department has done its job providing education to the general body of the medical institution about professional behavior and managing burnout, job related stress and the impact of negative attitudes on poor behavior within the medical institution. This survey aims to assist the dedicated department in its goal of addressing the needs within the medical school. The survey

provides an opportunity for the selected intervention to be evaluated from the perspective of the medical professional subject to the intervention.

The main objective of the dedicated department supporting this project is to provide education and reflection regarding professional behavior among the staff of the institution. The director of the dedicated department selected the COC of the Patient Advocacy Reporting System (PAR; Hickson et al., 2007) to address these concerns within the affiliated institution. The PARS system and similar systems are already in use by other top tier medical colleges as ways to address and intervene upon unprofessional behavior among medical staff (Shapiro et al., 2014).

The survey developed for this project contributes to the mission of the dedicated department and the broader mission and goals of the medical school by providing an opportunity for learning and feedback that could initiate change in the organization's strategy. The findings of this survey will be interpreted by the dedicated department and presented to the medical institution leadership in an effort to determine if the COC intervention is impactful and whether or not the COC intervention should continue in use at the affiliated medical institution. This survey reflects organizational justice and provides an opportunity for the identified medical professional to have a voice, providing feedback about their experience with the COC. The comments and themes voiced by the survey respondents will be used to determine the suitability of continued use of the COC intervention within the affiliated medical institution and provide feedback to the developers of the PARS system on its utility among the identified staff within the affiliated institution.

In developing this survey, I was driven by the potential emotional reaction of the identified medical professional. When identified for having a lapse in professionalism and scheduled for the COC, would the medical professional feel threatened, concerned or

angry? Would they feel they were targeted unjustly and perhaps perceive provocation toward them? Employees may engage in counterproductive work behavior as reaction to being treated unjustly by the organization as a whole or by individuals within the organization (Jex & Britt, 2014). Research has shown that several forms of CWB are related to the perception of unjust treatment or provocation (Cortina et al., 2001; Schilpzand et al., 2016). It is possible that an individual identified for a lapse in professionalism would feel they were unjustly identified by the medical institution, perceive provocation and think that the reporting person is out to punish them or make them look bad at work. A highly trained medical profession may feel they are immune to feedback or that their identified lapse in professionalism was justified. Furthermore, if that were the case, could they then begin to exhibit even more counterproductive work behavior and professionalism? The items selected for this survey would provide an opportunity for these particular individuals to voice their concerns and state clearly their opinion on this intervention. Ideally, I desired to know whether this intervention was helpful to them or not. I hoped this survey would provide an avenue to vent any frustration associated with this intervention and lessen the likelihood that they demonstrate frustration through any other form of CWB.

The study of incivility and projects like the current one have relevance and significance in organizational development, particularly in the realm of medical care. Spartlen (1994) found workplace mistreatment in a health care setting to be directly related to interpersonal violence. If workplace incivility and unprofessional behavior is not identified and addressed it contributes to an environment that permits an increase in incivility and the potential for greater emotional and physical risks to employees. It has been suggested that, in the workplace, violence is rarely a spontaneous act but more often the culmination of escalating patterns of negative interaction between individuals (Baron

& Neuman, 1996; Kinney, 1995). Thus, workplace incivility could then be the forerunner to high intensity, aggressive acts such as physical violence the workplace. This is noteworthy, as the harm could easily escalate beyond the employee. In the medical environment, this risk for potential physical harm could also apply to trainees, patients and their families, resulting in an even higher impact, one that includes significant litigation issues for the medical organization. The primary benefit of this survey is that a relatively well-established method of intervention for lapses in professionalism was examined among medical staff participants from a major medical institution. The findings of this survey provide valuable information for the strategic planning of the dedicated department and the institutional leadership. This project could be applied to the use of the COC intervention or other interventions like it in various work environments.

Future Directions

As of completion of this writing, the affiliated institution has not disseminated the survey described in this project. The dedicated department that conducts the COCs within the affiliated institution has started informing participants that a survey seeking opinions of the COC intervention will be forthcoming. A barrier to having this survey instituted as a current practice is due in part to the slow pace of organizational change regarding implementation of a new policy and/or procedure of which this survey is a part. Implementation of this survey must obtain approval of many of the organizational leaders before it can be disseminated to participants. Once the organizational leadership approves this survey for use, it will hopefully be distributed to the next medical staff member to receive the COC.

I anticipate that the findings of the survey will reveal that the COC is a useful intervention. The developers of the COC and broader PARS state that this intervention has been received favorably and is impactful. The authors' primary support for this

statement is that repeated COC interventions or escalation within the PARS for the same individuals is usually not necessary (Hickson et al., 2007). I expect respondents to rate the COC intervention highly and describe it as a valued opportunity to reflect upon their lapse in professionalism with the support of a colleague in a non-punitive manner. Given that the COC is conducted by a physician colleague and not a supervisor or member of hospital administration, I expect that most COC participants will report they felt respected, listened to and supported during the COC intervention. I also believe most COC participants will be invested in procedural justice and opt to complete the survey in order to have his or her voice heard regarding the intervention.

This survey would likely be beneficial in various organizations. As this survey investigates a participant's perspective on an intervention focused on a specific lapse in professionalism in a medical setting, other medical environments with similar systems for identifying and addressing lapses in professionalism may benefit. Important characteristics of other organizations that would use this survey would be those that regularly solicit the opinions of employees and those that frequently use surveys to gather data that affect change in organizational practices. I believe this survey will have a high response rate because medical staff in the affiliated institution are asked to share opinions on policies and procedures quite frequently and subsequently, recommended changes are instituted. Therefore, this survey this not out of normal practice for individuals in the affiliated institution, even if the respondents have been identified because of an isolated event of unprofessional behavior. This type of survey may be more difficult to use in organizational settings were the work atmosphere is hostile and employees are led to believe that they do not have a voice in the work environment. Fortunately for the respondents at the affiliated institution, this is not the case.

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APPENDIX A

COC INTERVENTION SURVEY

Our institution is committed to helping our community become as collegial and professional as possible. You recently participated in a Cup of Coffee intervention (COC) about professionalism concerns. We would appreciate your anonymous feedback about the experience. The following brief survey is intended to help us improve the process. We hope that you will participate and share your thoughts with us.

Reason for Cup of Coffee Intervention

Drop down menu used; participant will check:

- Anger toward others
- Rude behavior toward others
- Condescending comments made to staff
- Condescending comments made to patients
- Physical aggression
- Yelling at staff or patients
- Harassment behavior towards others

1) The Cup of Coffee intervention has impacted by behavior at work in a positive way.

Strongly Agree Agree Disagree Strongly Disagree

Specific changes I made were:

Drop down menu used; participant will check:

- To monitor my voice and lower my tone with others
- To be patient with others
- To demonstrate active listening to others
- To demonstrate respect toward others
- To not make assumptions that others are wrong and I am right

2) Did you find the Cup of Coffee intervention to be useful? How?

3) I was able to express my views and feelings during the Cup of Coffee intervention.

Strongly Agree Agree Disagree Strongly Disagree

4) The Cup of Coffee Intervention was free of bias.

Strongly Agree Agree Disagree Strongly Disagree

5) The Cup of Coffee Intervention reflected the effort I put into my work.

Strongly Agree Agree Disagree Strongly Disagree

6) I became aware of the impact of my behaviors, gestures, etc. on others after the Cup of Coffee intervention.

Strongly Agree Agree Disagree Strongly Disagree

7) How did you feel following the Cup of Coffee intervention?

8) I changed my behavior after the Cup of Coffee intervention.

Strongly Agree Agree Disagree Strongly Disagree

9) The Cup of Coffee intervention increased my effort toward behavior change at work.

Strongly Agree Agree Disagree Strongly Disagree

10) I am committed to behavioral change after participating in the Cup of Coffee intervention.

Strongly Agree Agree Disagree Strongly Disagree

11) The Cup of Coffee Intervention

a. Helped me reflect on my behavior

Strongly Agree Agree Disagree Strongly Disagree

c. Improved my communication with others

Strongly Agree Agree Disagree Strongly Disagree

12) After the COC experience:

a. I became more self-aware.

Strongly Agree Agree Disagree Strongly Disagree

b. I became more self-conscious or concerned about my work performance.

Strongly Agree Agree Disagree Strongly Disagree

13) Were there any insights that you gained from the COC experience? What were they?

14) Did the Cup of Coffee intervention motivate you to seek other interventions (such as anger management therapy, executive coaching, etc.?)

15) Were you aware of the concerns discussed in the COC conversation before that session? *Or* How aware were you of your behavior before the Cup of Coffee intervention?

Items 16-19 refer to the medical colleague who conducted the Cup of Coffee Intervention.

16) During the Cup of Coffee Intervention, I was treated in a polite manner.

Strongly Agree Agree Disagree Strongly Disagree

17) During the Cup of Coffee Intervention, I was treated with dignity.

Strongly Agree Agree Disagree Strongly Disagree

18) During the Cup of Coffee Intervention, I was treated with respect.

Strongly Agree Agree Disagree Strongly Disagree

19) During the Cup of Coffee Intervention, the medical colleague refrained from improper remarks or comments.

Strongly Agree Agree Disagree Strongly Disagree

20) How would you rate your Cup of Coffee intervention? (1= least helpful, 5= neutral, 10= most helpful)

1…….2…….3…….4…….5…….6…….7…….8…….9…….10