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Experiences of Patient Incivility: A Qualitative Study

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Abstract

Background: Incivility is one of the most prevalent forms of interpersonal mistreatment. Although studies have examined the full range of experiences of incivility against nurses and other hospital personnel, very few studies examined the forms of incivility that patients face in a hospital. **Objective:** To empirically investigate the range of uncivil experiences targeted against patients. Our study furthers our understanding of the phenomenology of incivility from the patients' perspective. **Method:** We used interpretative phenomenological analysis to analyze participant's (n = 173) experiences of incivility in a hospital. **Results:** We identified 6 major themes of incivility, namely Insensitivity, Identity Stigma, Gaslighting, Infantilization, Poor Communication, and Ignored. **Conclusion:** The findings highlight that instances of incivility are present in almost all aspects of the patient experience and take on unique forms, given the patient's role in the hospital. Implications for health consequences are discussed.

Keywords

incivility, doctor–patient interaction, stigma, well-being

Research has identified incivility as one of the most prevalent forms of interpersonal mistreatment in organizations worldwide, and review research has suggested it is on the rise (1,2). Incivility is low-intensity deviant behavior, in which its intent to harm is "ambiguous"(3). Incivility includes a range of problematic behaviors that violate norms of respect, including being talked down, addressed unprofessionally, and ignored (4). Antecedents of incivility include individual-level perpetrator factors and workplace context; targets face psychological, work, and health-related consequences (5–7).

Given its ubiquity, studies have examined the full-range uncivil experiences in hospitals. Majority of this literature focuses on incivility targeted against hospital employees (8–11), especially nurses (12–15). However, experiences of incivility targeted against patients are rarely examined in research. Research on patient mistreatment often examines the prevalence of high-intensity deviant behaviors such as abuse (16,17). Studies have also focused on interpersonal problems within patient–physician communication (18). While these studies are valuable, not all interpersonal communication problems can be classified as incivility because not all behaviors are rooted in disrespect (19). Further, incivility is conceptualized as a multibehavioral construct that can be perpetrated from various sources. Thus, incivility can occur from individuals other than physicians, and many uncivil behaviors fall outside the communication process. Consequently, the full range of uncivil experiences that patients may face in hospitals are not sufficiently explored.

In this study, we investigated the comprehensive range of uncivil experiences that patients may face in a hospital. Research that has identified the forms of incivility targeted against nurses may not capture the lived experiences of patients. Some forms of incivility nurses face may not map on to the experiences of patients, given their role, and relying on nurses' experiences to understand the breadth and depth of patient experiences provides an incomplete understanding of patient mistreatment.

Methods

The data are part of a larger qualitative study on patient experiences, and the study was determined exempt by the University of Michigan IRB (HUM00141390). Participants

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Table 1. Demographic Information.

Demographics	n (%)	M (SD)
Gender		
Female	107 (61.8%)	–
Male	66 (39%)	–
Age		
Mean age, years	–	36.53 (10.61)
Race/ethnicity		
African American/black	12 (6.9%)	–
Asian/Asian American/Pacific Islander	8 (4.6%)	–
White	132 (76.3%)	–
Latino/Hispanic	12 (6.9%)	–
Middle Eastern	1 (0.6%)	–
Native American	3 (1.7%)	–
Biracial/mixed race	5 (2.9%)	–
Socioeconomic status		
Poor	11 (6.4%)	–
Working class	60 (34.7%)	–
Middle class	87 (50.3%)	–
Upper middle class	12 (6.9%)	–
Upper class	3 (1.7%)	–
Political affiliation		
Very liberal	26 (15%)	–
Liberal	43 (24.9%)	–
Slightly liberal	23 (13.3%)	–
Middle of the road	37 (21.4%)	–
Slightly conservative	16 (9.2%)	–
Conservative	18 (10.4%)	–
Very conservative	8 (4.6%)	–
Other	2 (1.2%)	–
Education		
No formal education	0	–
Elementary school	0	–
Some high school	0	–
Completed high school	12 (6.9%)	–
Some college	68 (39.3%)	–
BA/BS degree	62 (35.8%)	–
Some graduate/professional school	13 (7.5%)	–
Hold graduate/professional degree	18 (10.4%)	–

Abbreviations: M, mean; SD, standard deviation.

(N = 293) were recruited on Amazon TurkPrime from across the United States, and informed consent was obtained from all the participants.(note 1)

Participants included a text response to the question, "Have you ever experienced incivility in a hospital setting (ie, being talked down)? If you have please describe the event here.(note 2)" Majority (59%) indicated experiencing at least 1 instance of incivility in a hospital, and 41% indicated they never experienced incivility. We focus on the sample that experienced incivility (N = 173). See Table 1 for demographics.

We used interpretative phenomenological analysis (IPA)—an inductive methodology used to interpret and identify patterns in the lived experiences of participants—to analyze the data (20,21). We engaged in a close reading and annotation of one participant's experience of incivility, developed preliminary themes, and then sequentially integrated additional participants' experiences (22).(note 3) We constantly reevaluated our interpretation of participant's experiences and revisited the definition of incivility.(note 4) Ultimately, we condensed the preliminary themes into 6 superordinate themes; many responses overlapped with multiple themes.(note 5) In the results, we describe each theme and include quotes to demonstrate the meaning of the superordinate theme.

Results

Insensitivity

Participants most frequently reported experiencing insensitivity (38%) or *affectively negative interactions*. A majority explicitly used the word "rude" to describe their interaction.

> [The] receptionist was rude and did not seem to care when I was going through anxiety [Participant 117, 26 years old, Asian/Asian American/Pacific Islander, Woman].

Some participants even described how the interaction felt rude.

> When the Doctor was a smart mouth and came in and said "congratulations you have a period" it ended up being a very serious infection. [Participant 290, 27 years old, Biracial, Woman].

Participant 290's experience demonstrates some of the potential consequences of rudeness. In this case, the doctor was not only insensitive but gave an incorrect diagnosis. In addition, participants frequently indicated how insensitivity was also communicated through a "rough" touch when the doctor was examining them. The consensus was that insensitivity—verbal and physical forms—only made the participants feel worse when they are already in the hospital not feeling well.

Identity Stigma

Participants (15%) indicated *experiencing rudeness because of their identities*. Many individuals explained how their socioeconomic status (SES)—specifically lack of health insurance—was a significant factor in shaping the treatment they received:

> I had a first time grand mal seizure and wrecked my vehicle. I do not have insurance, so the hospital I was taken to was so rude. I was brought in by an ambulance, they wouldn't give me anything for the severe headache from the wreck and also from the seizure. They wouldn't give me anything to keep me from throwing up. The only thing they did was give me an IV of Keppra to stop the seizures. After finding out I didn't have insurance, they discharged me within 10 minutes. They took me to the bathroom to change clothes, they met me at the bathroom door, handed me my papers and pointed me to the door. I

didn't even get wheeled out after having a seizure and a wreck . . . [Participant 272: 28 years old, White, Woman].

Participant 272 attributes the rapid release from the hospital, absence of a wheelchair, and additional medication with the disclosure of her insurance status. Many participants echoed the same concern of poor medical care and interpersonal treatment because of their SES. One participant's experience highlighted an explanation of why lower SES patients received worse treatment:

. . . [I] was told in plain terms that those who don't pay for their [insurance] have no right to complain about not receiving the best treatment
[Participant 47: 34 years old, Latina/Hispanic, Woman].

This perception suggests that individuals from lower SES do *not deserve* the same quality treatment as individuals from higher SES backgrounds and shouldn't act to rectify inequality in treatment. Overall, these participant's experiences reinforce the research on class-based inequalities in health care, whereby lower SES is associated with higher mortality and morbidity (26).

In addition to SES, participants mentioned they experienced comparable rudeness because of their stigmatized health conditions or appearances. This was common for those with mental health conditions and addictions:

. . . The doctor hated the way I look because I am a tattoo artist and have a lot of tattoos, I broke my foot and the doctor thought I was just there for the pills
[Participant 45: 30 years old, White, Man].

Participants often highlighted how the use of stereotypes associated with their conditions impacted the doctor's perceptions and course of action. Despite participants seeking care or pursuing the recommended course of action, they faced backlash. These experiences demonstrate how identity stigma can exacerbate health inequity.

Gaslighting

Participants (26%) indicated what we categorized as containing elements similar to "gaslighting" or mistreatment in which participants' experiences were *minimized, doubted, questioned, second guessed, or denied* by health-care professionals.

Yes, I was giving birth and was supposed to have a C-section. I got my epidural but I told the doctor that it's not working, they didn't believe me so when they started cutting I started screaming because the epidural was not working.
[Participant 292: 30 years old, White Woman]

. . . I was told I was lying about being sick. I was told that I had lost 45 pounds in 2 months because of a mild cold, and that I was wasting their time. They tried to make me feel like I was a burden, and I was taking away from other patients who they implied were sick. Turns out I was sick, and I needed surgery. Going to a hospital out of town, they diagnosed my problem within 1 visit.
[Participant 275: 34 years old, White Man]

Research has found that gaslighting is used by an individual as a method of gaining or maintaining power over another (27). Patients' power is lost when they are no longer perceived as the expert of their bodily experiences. These participants demonstrate how when their experiences were denied, their own sense reality was called into question—which is a critical feature of gaslighting. The literature suggests that the perpetrator of gaslighting is intentional. Although we do not have data on the intent of the perpetrators, this form is labeled as "gaslighting" because it still contains most of the elements.

Infantilization

A substantial percentage of participants (35%) experienced infantilization, in which participants were *talked down to, addressed in a patronizing way, or treated as a child*:

I am nearly always talked down to and dismissed by doctors. I rarely go to the doctor and put off legitimate illnesses and pains . . . so when I do go, it is serious and want to be taken serious. [Participant 237; 34 years old, White, Woman]

Participants frequently mentioned that doctors challenged their competency by treating them as "stupid" or suggesting that they didn't understand specific details. Some participants describe how they engaged with the medical system differently as a result of facing infantilization. For instance, participant 237 restricts how often she goes to the doctor to avoid facing mistreatment. If individuals pursue medical care only when they believe it is "serious," they may be omitting critical preventive behaviors such as cancer screenings which could have deleterious downstream consequences (28). A few women noted how their experiences of infantilization operated as benevolent sexism. Benevolent sexism is seemingly positive but reinforces a stereotype that women are largely incompetent and dependent, suggesting others are more knowledgeable of their own well-being (29). For instance:

Because my spouse was with me, the doctor talked to him and ignored me. Next, he asked my spouse about the options for my recovery as part of a decision-making process. Finally, the doctor turned to me, jiggled my hand, smiled and said 'we're taking care of you'. [Participant 265: 63 years old, White, Woman]

In this example, the doctor's paternalistic language of "we're taking care of you" and body language communicated he was excluding her from making her own health decisions, which undermines her autonomy.

Interestingly, several participants described facing infantilization when they were in the hospital, but not necessarily a patient.

> When my dad was in the hospital, there were quite a few instances of our family being talked down to. They would also get very defensive when we would point out something that didn't seem right ... [Participant 167: 32 years old White, Woman].

This point ties to the larger problem of incivility in hospitals, regardless of one's role. The data suggest that anyone who is present in a context where incivility occurs—including visiting family—is subject to experiencing infantilization.

Poor Communication

Another theme was poor communication (7%) in which participants believed the *health-care professionals were not effectively communicating with them.*

> Yes, when my wife was admitted into emergency, we didn't really know what was going on with her. A doctor, we had never met, walked in after some tests and told her she had a tumor and walked out. No explanation or compassion [Participant 136: 43 years old, White, Man].

One form of poor communication included health-care professionals not providing enough *information* to patients and families about specific conditions. Participants mentioned that they were trying to make informed decisions but were unable. Participants perceived lack of quality information as a source of disrespect. Additionally, there were instances of poor communication in which participants did *not receive verbal warning* before their bodies were touched.

> ... The most uncivil was the surgeon, with no warning, plunging scissors from a bedside stand into my abdomen and cutting open my healed wound to drain a large abdominal abscess which flowed out all over me and my bed. After cooking this infection for over a week, spiking/breaking fevers, losing 25 lbs, a nurse came into my room and started scolding me for not having been up walking. No one had mentioned this to me nor had ever helped me try to walk. I told her I would walk if I was supposed to ... [Participant 116; 66 years old, White, Woman].

She reflects on how her traumatic experience was worsened by multiple, chronic forms of poor communication. Despite wanting to follow medical advice, she couldn't because she was not given complete information—reinforcing the body of literature linking communication and medical adherence (30). Uniquely, she later goes on to describe how she decided to become a nurse *because of* these instances of incivility to help change the interpersonal communication problems.

Ignored

Participants (10%) also indicated being ignored by health-care professionals. Some individuals describe *how their voices, contributions, or concerns were ignored*:

> I've had my complaints flat out ignored and I had to return at a later date because of it. The doctor acted too busy to deal with me for more than five minutes [Participant 250: 22 years old, African American/Black, Woman].

In addition to their voices being ignored, many individuals commented on how they felt their sense of humanness was ignored and they felt reduced to being an animal or an object.

> Yes, the receptionist acted like I was just a number and if I asked a question, she acted like I was just trying to cause her problems and had no right to ask questions [Participant 99; 39 years old, White, Woman].

Participants believed they were not perceived holistically, and their humanity disregarded. These instances of feeling ignored are consistent with dehumanization—denied elements of being a human being (31). Research has demonstrated that within the medical context, dehumanization is likely to occur between individuals with large power gaps (ie, patient and doctor). Importantly, participant 99 demonstrates that dehumanization can occur from anyone in the hospital context, including the receptionist.

Discussion

Our study uniquely captured the phenomenology of incivility from the patients' perspective. By conceptualizing participants as the expert of their life experiences, we identified 6 superordinate incivility themes. We found that these general themes reflect incivility being present in almost every aspect of the patient experience and perpetrated from a variety of sources. For example, upon entering a hospital, one may face identity-based mistreatment from the receptionist because of their SES, or when talking with a doctor in the emergency department, the reality of one's experiences of suffering may be doubted. Together, these themes capture the dynamic interpersonal aspects of the patient experience, which differ from the experiences of hospital employees who are studied often. Our findings underscore the importance of focusing exclusively on a patient sample.

We found multiple forms of incivility reinforced power structures. Identity stigma, gaslighting, and infantilization contained noteworthy instances of participants losing power and control. Research has found that a reduced sense of control is associated with negative health consequences; thus, it is possible that incivility undermines individual control, which in turn undermines health (32). Because incivility is ubiquitous, it is imperative for researchers to consider incivility on a large scale and investigate how its prevalence

impacts health trends. For instance, does incivility experienced in health-care settings impact identity-based health inequalities such as the race divide in the morbidity and mortality of conditions such as cardiovascular disease and cancer? Future research should investigate the cumulative effects of incivility on health outcomes.

We unexpectedly found that participants mentioned the consequences of experiencing incivility. While incivility is classified as a "minor" form of mistreatment, our finding suggest that the consequences are not necessarily minor. One notable example was the consequences of gaslighting, which included not receiving an accurate or timely diagnosis. It is possible that if their conditions were diagnosed immediately, more invasive and costly forms of treatments down the line—like emergency surgery—could be avoided. Many also articulated experiences of trauma and indicators of posttraumatic stress even years after the experience. Therefore, this study points to the need to further investigate the full range of health consequences.

It is necessary to ground these consequences within larger context of the economic costs of health care. Everyday instances of incivility against patients may result in ineffective decision-making processes and inaccurate diagnoses—all contributing to rising health-care costs. We recommend health-care administrators establish norms of interpersonal respect across all departments.

Among participants with the shared experience of facing incivility, the current study captured a broad band of the experiences and highlighted the contextual complexities and nuances of patient-targeted incivility. Our online sample permitted us to gain a wider constitution of the patient experience (24). It is necessary for researchers to follow-up on subsamples of participants to gain even deeper understanding. For instance, researchers could interview a subset of individuals without health insurance to further our understanding of identity stigma incivility. Future research should also consider how specific contextual factors (eg, presence of social support) and patients' medical histories (eg, acute vs chronic conditions) inform the instances and impact of incivility.

Conclusions

Incivility experienced by patients at hospitals differ from experiences of nurses, take on unique forms, are perpetrated from multiple individuals, and suggest critical consequences. Future research must continue to capture the phenomenology of patient incivility, since it is an essential component of improving patient well-being.

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Notes

1. Four hundred participants were initially recruited, and 107 were excluded because they had never been to any hospital before, did not answer the primary question for the current study, or included a nonsensical answer.
2. Participants were recruited from across the United States. The data in the current study reflect an aggregate of incivility experiences from many hospitals and not those of a single hospital. Participants were also instructed to exclude the names of specific people or specific hospital names.
3. The current study responds to the larger call in the literature regarding the push toward novel implementation of IPA (23). Following Mahalingam and Rabelo (22), we used text responses to a single question as our source of data. This permitted a more diverse sample (along demographics and location) to promote the integration of multiple perspectives in IPA (24).
4. The definition of incivility guided our coding and our final set of themes. The incivility literature makes critical distinction between incivility and other negative interpersonal behaviors, and we only considered experiences that mapped onto incivility.
5. Saturation was evident after no additional data emerged, and there was clear informational redundancy (25).

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