There is an ever-greater emphasis on the maintenance of professional standards in communication among medical professionals. Much of the focus to date revolves around discourse between patients and families in the clinical arena and reflects standards developed by accrediting agencies and the government. Little has been written about the communication among professionals occurring in the administrative milieu that is largely unseen by those not engaged in the direct provision of or receipt of medical care. That rumours are a part of the interactive discourse is likely not unfamiliar to most in academia. Their potential for damage to the workplace and individuals is very real and requires recognition and in some situations, corporate action. There are options to reduce the likelihood of these kinds of communications and to manage them actively when they occur. What may result is an environment that leads to greater organisational confidence and individual productivity.

There is likely a certain ebb and flow in casual conversation in most places of work. Academic medical centres are certainly no exception. The vast majority of the material is benign and truly informational, and part of the informal networking that “lubricates” an organisation. On occasion, this discourse can take on a personal nature, particularly if the information is controversial or involves a high profile individual. When this transformation occurs, the information may no longer be benign and its potential to destroy the individual or the organisation may increase.

A PERSONAL EXPERIENCE

One such bit of information came my way recently. I was told that a prominent member of the administration had made the decision to leave our organisation. The information was presented as factual by an authoritative source. In response, I wrote a confidential note of congratulations and expressed both my hope for future success and my sadness at the imminent nature of this individual’s departure. I received a phone call in reply to my missive two days later. I was informed that a decision was yet to be made and that the “facts” at that time were in error. There was an expression of a general sense of anger that the information had been disseminated. Although ultimately this individual did announce their decision to leave, the confidentiality of the search for new employment had clearly been violated at some step along the way.

The note I wrote was intended to be a gesture of kindness and respect. No doubt some readers at this point would accuse me at the least of being naive by writing it all or perhaps of failing to recognise the “value” of this kind of information to offer in trade for other unconfirmed “facts”. My decision was to close the loop as opposed to other possibilities, one of which would have been to enter into the rumour fuelled information stream known as gossip. Fortunately in this situation the information was not of a personally destructive nature, yet when it is, there are real risks for those who are the object of the information, for those who transmit it, and possibly for the organisation as well.

RUMOURS AND ORGANISATIONAL TRUST

My discomfort about this event prompted me to search the literature on the issue of rumours. Practically nothing has been done empirically. That rumour and gossip are long-standing means of communication among humans and are prevalent in healthcare settings in part due to the nature of the organisation comes as no surprise. One author classified rumours into four categories: wish rumours, fear or bogey rumours, wedge-driving or aggressive rumours, and anticipatory rumours. Although rumours can be positive, it often seems that those that have the greatest interest are of a more potentially disruptive nature. Rumours of this nature have the potential to destabilise an organisation and often facilitate the channelling of energies towards self-preservation and away from central operations.

The degree and extent to which organisational trust exists is an underlying dynamic upon which the environment for destructive rumours can be made less conducive. Galford and Drapeau suggest in an article in the Harvard Business Review that three kinds of organisational trust exist: strategic trust—the trust employees have in the people running the show to make the right strategic decisions; personal trust—the trust that employees have in their own managers; and organisational trust—the trust that people have in the organisation itself. They further say that, “If people trust each other and their leaders, they’ll be able to work through disagreements. They’ll take smarter risks, they’ll work harder, stay with the company longer, contribute better ideas and dig deeper than anyone has a right to ask.” There is some evidence that within organisations where trust has been nurtured there will be fewer rumours, more resilience, and quicker recovery time when rumours and miscommunications are discovered.

A key to dealing with potentially destructive rumours may rest with like attempts at their early verification in an effort to determine their accuracy and to provide feedback. This facilitative effect could be enhanced by the creation and maintenance of institutional vehicles for the timely transmission of pertinent information that is reliable and current thereby rapidly shortening the half-life of inaccurate or potentially toxic news. In most cases, a person of authority who provides facts can stop or at least slow down the rate of spread of rumours.

The organisation and structure of academic medical centres is complex and as a consequence may not completely mirror the corporate environment inhibiting somewhat the ability to reproduce this effect. Yet it may be reasonable to assume that the propensity to disseminate unverified information is linked to the quality of the relationships that exist among groups of highly talented and capable individuals. Efforts that strengthen those relationships may act to
stabilise the workplace and create an atmosphere that both fosters healthier communication and preserves confidences.

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REFERENCES