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Bullying has no place in health care

Issue:

Civility is a system value that improves safety in health care settings. The link between civility, workplace safety and patient care is not a new concept. The 2004 Institute of Medicine report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," emphasizes the importance of the work environment in which nurses provide care.[1] Workplace incivility that is expressed as bullying behavior is at epidemic levels. A recent Occupational Safety and Health Administration (OSHA) report on workplace violence in health care highlights the magnitude of the problem: while 21 percent of registered nurses and nursing students reported being physically assaulted, **over 50 percent** were verbally abused (a category that included bullying) in a 12-month period. In addition, 12 percent of emergency nurses experienced physical violence, and **59 percent** experienced verbal abuse during a seven-day period.[2]

Workplace bullying (also referred to as lateral or horizontal violence) is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators.[3] Bullying is abusive conduct that takes one or more of the following forms:[3]

- Verbal abuse
- Threatening, intimidating or humiliating behaviors (including nonverbal)
- Work interference – sabotage – which prevents work from getting done[3]

There are five recognized categories of workplace violence:[4]

- Threat to professional status (public humiliation)
- Threat to personal standing (name calling, insults, teasing)
- Isolation (withholding information)
- Overwork (impossible deadlines)
- Destabilization (failing to give credit where credit is due)

In the scientific literature, several types of bullying have been studied: intimidation, harassment, victimization, aggression, emotional abuse, and psychological harassment or mistreatment at workplace, among others.[5]

Bullying does not include illegal harassment and discrimination, and while bullying can create a hostile work environment, it is not the same as the organization allowing an illegal hostile work environment (for example, the employer tolerating inappropriate jokes). Other examples that are not bullying include setting high work standards, having differences of opinion or providing constructive feedback.

The Workplace Bullying Institute estimates that 65.6 million U.S. workers are directly impacted by or have witnessed bullying. A 2014 Workplace Bullying Institute survey found that 69 percent of bullies are men and 57 percent of targets are women, and that women bullies target women in 68 percent of cases. It is more common than sexual harassment, and can be direct physical, verbal or indirect bullying (such as social isolation).[4] Bullying is typically deliberate, causes negative effects on the victim, and is an attempt to control employees. Bullying is behavior that is aggressive, intentional, and frequent. Bullies tend to target employees who have inadequate support or are not able to defend themselves from the aggression. An essential component of bullying is that it is perceived as a hostile act by the target.

Some examples of bullying are a manager who is never pleased with performance, gossiping or spreading rumors, intentionally excluding an employee from team meetings, being told "you are too thin skinned," or being repeatedly called to unplanned meetings with the manager where the employee is denigrated. Factors that contribute to this problem include a culture that allows bullying (normalization of deviance), poor staffing levels,

(Cont.)

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excessive workloads, power imbalances and poor management skills. Specific organizational factors that can lead to workplace bullying are role conflict and ambiguity, work overload, stress, lack of autonomy and a lack of organizational fairness.[6,7]

In the health care setting, 44 percent of nursing staff members have been bullied. Nurses tend to accept nurse-on-nurse bullying as part of the job, particularly the new or novice nurse, thus the coining of the phrase "nurses eat their young."[8] In a study of 284 health care workers, it was found that 38 percent of U.S. health care workers reported psychological harassment.[5]

The most common health care settings where bullying is prevalent are behavioral health units, emergency departments and intensive care units. In long term care settings, bullying occurs more frequently during evenings and night hours. The targets of bullying are employees who are typically under 40 years old; female physicians; and unmarried, female employees with less education and who have children at home.

Impact of workplace bullying

The impact of bullying behaviors on the organization are lower morale, lower productivity and increased absenteeism (due to physical, psychological and emotional harm), followed by rapid and increased turnover, which compromises patient safety. Workplace bullying also leads to lawsuits, compensation for disability, loss of profits, negative impact on organizational reputation, and a corrosion of the patient to health care worker relationship. Employees, patients and families who witness behaviors that are not civil are concerned about how care can be impacted. For example, a nurse who is openly critical of another nurse, or a physician who is openly critical of a nurse.

The impacts on patient and care team safety include under-reporting of safety and quality concerns, and increases in harm, errors, infections and costs. As an example, the estimated cost of replacing a nurse is $27,000 to $103,000.[9] Bullying exacerbates the stress and demands of already stressful and demanding professions. Bullying contributes to burnout and drives talented and caring people out of the health professions. The kinds of improvements needed in patient safety and health care cannot be achieved if talented people are lost.

Battling workplace bullying

Gerry Hickson, MD, and his colleagues at Vanderbilt University Medical Center (VUMC) have recognized that a significant barrier to eliminating bullying is under-reporting of the problem by health care professionals. Dr. Hickson includes a risk event reporting system in the VUMC set of "surveillance tools."[10]

A team led by Dr. Hickson is implementing a Co-Worker Observation Reporting System℠ (CORS℠) at VUMC. The CORS℠ project aims to encourage collegial respect and accountability and to couple safe, contemporaneous reporting with consistent, timely delivery of the captured stories.[11] The indications are that self-reporting of unprofessional and disrespectful behaviors increases self-regulation and civility.

Alan Rosenstein, a physician and leading expert in unprofessional behavior, states that, with respect to eliminating behaviors that undermine a safety culture, "The primary goal should be to improve care relationships by increasing understanding and responsiveness to individual (physician, staff, patient) needs (emotional Intelligence), provide training in diversity, stress, anger, and conflict management, improve communication and collaboration skills, and enhance an organizational culture that respects and supports physicians, staff, and patient-centered care."[12]

A method used to prevent bullying of novice nurses is cognitive rehearsal. In the original 2004 study,[13] 26 newly licensed nurses hired by a large acute care tertiary hospital in Boston, Massachusetts, participated in an exploratory descriptive study. They were taught about lateral violence in nursing practice and the use of cognitive rehearsal techniques as a shield from the negative effects of lateral violence on learning and socialization. Knowledge of lateral violence in nursing appeared to allow newly licensed nurses to depersonalize it, thus allowing them to ask questions and continue to learn. The learned cognitive responses helped them confront the lateral violence offender. Confrontation was described as difficult, but it resulted in the

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resolution of the lateral violence behavior. Overall, the retention rate in this study population was positively affected.[13]

Safety Actions to Consider:

In the 2013 Joint Commission publication, "Improving Patient and Worker Safety," civility is described as a necessary precursor for a safety culture in which care teams and patients must be treated with respect.[14] Civility matters, which means behaviors that undermine a culture of safety are not tolerated. W. Edwards Deming stated that "quality is everyone's responsibility." Leaders especially have a critical role in battling bullying behaviors, including:

- Establishing a safety system and culture that does not tolerate bullying behaviors. Make this a core value of all leaders in the organization.
- Confronting bullies and supporting the targets of bullying.

To correct bullying behaviors that can undermine a safety culture, all health care facilities should consider taking the following specific safety actions, which are highlighted in The Joint Commission's Sentinel Event Alert, Issue 40:[15]

- Educate all team members on appropriate professional behaviors that are consistent with the organization's code of conduct
- Hold all team members accountable for modeling desirable behaviors
- Develop and implement policies and procedures/processes that address:
    - Bullying
    - Reducing fear of retaliation
    - Responding to patients and families who witness bullying
    - Beginning disciplinary actions (how and when)

  In developing these policies and procedures, solicit input from an inter-professional team that includes representation of medical and nursing teams, administrators, and other employees.[15]

Resources:

1. Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Nov. 3, 2003 (accessed May 24, 2016)
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4. Rayner C and Hoel H. A summary review of literature relating to workplace bullying. Journal of Community & Applied Social Psychology, 1997;7:181-191
5. Ariza-Montes A. Workplace bullying among healthcare workers. International Journal of Environmental Research & Public Health, 2013;10:3121-3139
6. Bowling NA and Beehr TA. Workplace harassment from the victim's perspective: A theoretical model and meta-analysis. Journal of Applied Psychology, Sept. 2006;91(5):998-1012
7. Topa G, et al. Acoso laboral: Meta-analisis y modelo intergrador de sus antecedents y consecuencias. Psicotherma, 2007;19:88-94 (English translation available online)
8. Meissner JE. Nursing, Mar. 1996;16(3):51-3
9. Li Y and Jones CB. A literature review of nursing turnover costs. Journal of Nursing Management, 2012;21(3):405-418
10. Hickson GB, et al. From front office to front line. 2nd edition. Oakbrook Terrace, Illinois: Joint Commission Resources, 2012:1-36
11. Hickson GB, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. The Joint Commission Journal of Quality and Patient Safety, 2016;42:149-161

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12. O'Donnell J and Unger L. 'Disruptive' doctors rattle nurses, increase safety risks. USA Today, Sept. 30, 2015 (accessed May 14, 2016)
13. Griffin M. Teaching cognitive rehearsal. Journal of Continuing Education in Nursing, Nov.-Dec. 2004;35(6):257-263.
14. The Joint Commission. Improving patient and worker safety: Opportunities for synergy, collaboration and innovation. Nov. 2012
15. The Joint Commission. Behaviors that undermine a culture of safety. Sentinel Event Alert, July 8, 2008;40
Note: This is not an all-inclusive list.

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