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RISK MANAGEMENT PERSPECTIVES
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Workplace Bullying

How It Affects Patient Safety and Liability Risk Exposure

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RISK MANAGEMENT PERSPECTIVES

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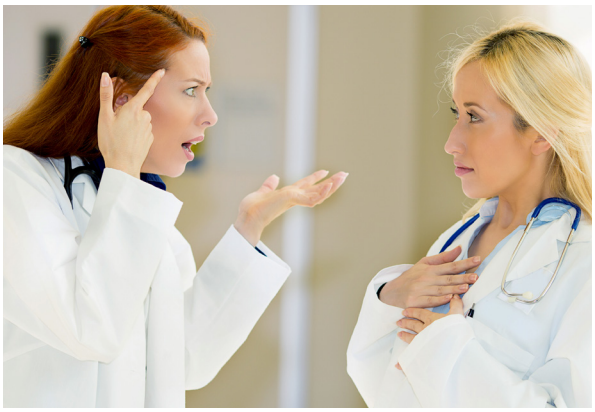
Workplace Bullying

How It Effects Patient Safety and Liability Risk Exposure

INTRODUCTION



Studies suggest that individuals who work in healthcare experience one of the highest levels of bullying in the American workforce.[1] Bullying can range from outrageous, aggressive behavior to subtle patterns of disrespect that might be so common they seem normal.[2,3] The vast majority of individuals on the healthcare team treat others respectfully most of the time; however, some do not.[2] Any member of the healthcare team can be a perpetrator or victim. Bullying transcends age, gender, and experience level.[4] It occurs among professions and within professions. In terms of interprofessional healthcare teams, workplace bullying is most prevalent among nurses and physicians, but the most frequent bullying of nurses is by other nurses.[5] The hierarchical nature of healthcare can contribute to individuals at the top of a hierarchy treating those on a lower level with disrespect.[6] However, bullying also occurs from the bottom up, and laterally.[5]

Bullying can range from outrageous, aggressive behavior to subtle patterns of disrespect that might be so common they seem normal.

Bullying can decrease patient safety and increase liability. Other studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.[7,8,9,10] More generally, bullying affects the victim's ability to think clearly.[2] The stress, anger and frustration resulting from even mild incivility can interfere with working memory, which, in turn, adversely affects cognitive functions necessary for medical decision-making and procedural performance. Bullying undermines coordination, collaboration, teamwork, and communication, which are also essential to delivering safe patient care.[2,11,12,13] For example, when a victim avoids the bully, it can undermine the efficacy of teamwork, collaboration, and coordination. A recent study found that surgeons who were the subject of coworker reports of unprofessional conduct were more likely to experience a surgical or medical complication.[5] Additionally, bullying can take a substantial toll on victims, causing debilitating anxiety and panic attacks, clinical depression, and post-traumatic stress.[1]

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Bullying not only can increase patient injuries (which increase the chance of being sued), but it can complicate the defense of a malpractice claim. When a plaintiff files a lawsuit, he or she generally names everyone on the patient's healthcare team as defendants. Consequently, while the bullies, victims and witnesses find themselves with the common goal of defeating the patient's negligence allegations, victims and bullies tend to blame each other for the patient's injury. This kind of "finger-pointing" diminishes the probability of a defense verdict and increases potential plaintiff's verdict and settlement values.

Individual, organizational, and systemic factors can contribute to bullying. Therefore, preventing and responding to bullying should take place at all levels.[14] This article provides strategies for preventing and responding to bullying using case studies based on closed claims.

DEFINITIONS

Workplace Bullying describes various actions and is known by different labels, for example, horizontal hostility, relational aggression, lateral violence, mobbing, and incivility. It is categorized under disruptive behavior and workplace violence in literature and guidelines. According to the American Medical Association (AMA), bullying is a "repeated, emotionally, or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target. Individual, organizational, and health system factors may contribute to the overall workplace climate or culture that allows unprofessional behavior, such as bullying, to persist."[i] The American Nurses Association (ANA) defines nurse bullying as "repeated, unwanted harmful actions intended to humiliate, offend and cause distress in the recipient."[ii] Any type of bullying can increase patient safety risks, but the strategies for remedying the various types of bullying can differ.[iii] Bullying is used in the most general sense throughout this article, as opinions differ about what constitutes bullying.

Disruptive Behavior — Patient safety literature often refers to overt bullying behavior as "disruptive behavior," although The Joint Commission now uses the phrase "behaviors that undermine a culture of safety."[iv] Having repeated angry outbursts; making threats; pushing; throwing or breaking objects; using profane, insulting, or abusive language; and making demeaning comments are some of the hallmarks of disruptive behavior.[iii]

Workplace Violence — The Joint Commission defines workplace violence as: "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."[v] The Joint Commission New and Revised Workplace Violence Prevention Requirements[vi] for hospitals have been released and will be effective on January 1, 2022.

ADDITIONAL RESOURCE

Joint Commission. Workplace Violence Prevention Compendium of Resources to Support Joint Commission Accredited Hospitals in Implementation of New and Revised Standards[vii]

A compendium of resources that may be used to meet the requirements of the new and revised workplace violence prevention requirements effective January 1, 2022

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Disruptive Behavior Bullying

Yelling and throwing things is perhaps the most obvious and well-documented form of bullying in the healthcare environment. In the following case, the physician leadership and administrators knew the surgeon's bullying behavior was threatening patient safety. However, terminating the surgeon's privileges was a complicated and lengthy process because the hospital did not have effective bullying policies and procedures in place.

CASE ONE

Allegation: The surgeon's bullying created a patient safety risk.

Over a 10-year period, staff, physicians, and patients submitted formal and informal complaints about a surgeon's behavior to various individuals, committees, and administrators. The surgeon was known for making demeaning and threatening comments, grabbing and pushing staff, and throwing things. Physicians and staff reported they feared for their safety when they were around this surgeon. In addition to the emotional toll the surgeon's behavior took on his coworkers, it interfered with hospital operations; for example, his outbursts caused multiple surgical delays. In response to these complaints, the chief of staff, physician advisors, and the nursing director regularly counseled the surgeon. They suggested anger management courses, psychological counseling, and communication workshops. Although the surgeon admitted he had anger management problems, he believed that his record of satisfactory outcomes excused his "minor" behavioral issues.

DISCUSSION

Members of the healthcare team who bully do so in different ways for different reasons. Studies suggest that surgeons are more likely than other physicians to be reported for "disruptive behavior." Verbal outbursts and throwing or hitting objects are common disruptive behaviors.[15,16] These studies do not imply that all surgeons are bullies. In fact, numerous other studies show that all specialties of physicians, staff, and administrators engage in bullying. The studies, however, highlight the complexity of managing bullying behavior, the necessity of understanding the various catalysts of bullying among the different categories of healthcare workers, and the goal of designing anti-bullying programs that have the greatest chance of success.

Although the surgeon admitted he had anger management problems, he believed that his record of satisfactory outcomes excused his "minor" behavioral issues.

It is easy to imagine how the surgeon's behavior could have triggered a patient injury. In a malpractice case, the surgeon's behavior would most likely have come up in discovery. And in that imagined case, evidence of his behavior would reflect poorly on him in front of a jury and would complicate his defense, even if the evidence suggested his treatment was not negligent.

Subtle Bullying

The American Society for Healthcare Risk Management (ASHRM) defines insidious intimidation as a "subset of disruptive behavior that is often not recognized and/or addressed."[17] Because insidious intimidation is often concealed and subtle, it can be challenging to eradicate it. Insidious intimidation includes complaining without justification; using condescending language; rejecting helpful suggestions without consideration; making belittling gestures; having rigid, inflexible responses to requests for assistance; exhibiting patronizing or disrespectful behavior; and displaying unnecessary sarcasm or cynicism.[17] Similarly, a "passive-aggressive bully" uses passive resistance in response to demands for adequate performance.[2] Passive-aggressive behavior among healthcare team members is similar, and may include deliberately ignoring a coworker, intentionally miscommunicating information, failing to respond to requests for consultation, and becoming impatient with questions or education.[18]

In the following case, bullying was not part of the plaintiff's case. The manner in which bullying contributed to the adverse outcome became apparent through the nurse's deposition testimony and the nurse's and physician's employment records. Consider the ways in which administrator inaction could have contributed to the patient injury in the following case.

CASE TWO

Allegation: The family practice physician (FP) failed to act on an elevated PSA test result, which caused a four-year delay in the treatment of the patient's cancer.

The patient presented to a small family practice group for an annual physical. The FP ordered a PSA test and encouraged the patient to make a follow-up appointment to discuss his lab results. He had the test but didn't make a follow-up appointment. One week later, the FP's nurse filed an abnormal PSA test result in the patient's record, not realizing it had not been reviewed by the FP. Four years passed before the patient's next physical. He was diagnosed with prostate cancer. The patient and his wife sued the FP and her group, claiming the four-year delay in treatment reduced the patient's chance of survival.

DISCUSSION

Bullying makes it difficult for victims to concentrate on their jobs.[2] When the FP ordered the PSA test, she and the nurse were avoiding each other. The FP had requested a different nurse be assigned to her because she felt the nurse was loud, inefficient, inappropriately social, disruptive, and never available when she needed her. For her part, the nurse had requested a transfer to another physician because she felt the FP was bullying her. The nurse documented the following examples of the FP's bullying behavior:

- When patients had been waiting for a long time, the FP often blamed her, in a joking manner, in front of patients.
- When the FP misplaced files at her home or in her office, she blamed the nurse.
- The nurse was required to accomplish impossible tasks, then reprimanded for failure; for example, the FP demanded all appointments be scheduled for exactly 15 minutes, regardless of their level of complexity, then blamed her when the scheduling strategy failed. The FP also tasked the nurse with excessive amounts of paperwork and then berated her for spending too much time on it.
- When the nurse provided input on any of the FP's patient care or office management strategies, the FP told her that the job of a nurse was to follow a doctor's orders, not question them.

The effects of bullying are magnified when other team members witness the behavior but, fearing retribution, are afraid to challenge it and defend the victim. Bullying and hopelessness about stopping it creates a culture in which poor clinical outcomes are more likely to occur.[11] Although other staff, clinicians and the administration had witnessed the bullying, no one challenged the FP. The office administrator and the practice partners could never agree on a way to address the FP's behavioral problems; therefore, they did nothing.

The defense of this case was complicated by the willingness of the nurse, other staff and the administrators to testify against the FP, which supported the plaintiff's allegation that the FP's disorganized practice style resulted in the mishandling of the PSA test results. Experts believed treatment of the patient's prostate cancer at an earlier point would have increased his chance of survival.

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Bullying (Incivility) from Both Directions

Physician-nurse incivility is well documented in medical journals and the popular media. It is also apparent in many closed claims. In the following case, the nurses and physicians seemed more focused on antagonizing each other than they were on safely delivering the patient's baby.

CASE THREE

Allegation: Physician-nurse conflict prolonged labor, which resulted in the infant's brain injuries.

At the beginning of a labor and delivery (L&D) nurse's shift, a high-risk prima gravida patient was admitted because her membranes spontaneously ruptured at home. She was at full term, but not in active labor. The patient's obstetrician (OB) ordered oxytocin. The L&D nurse believed the patient needed a C-section, not augmentation; therefore, she delayed starting the oxytocin and did not increase it as ordered. Her plan was to get the OB into the hospital to examine the patient, so that she would realize herself that the patient needed a C-section. Throughout the nurse's shift, she called the OB, who continued to refuse to come in until the patient was in active labor. After the patient developed a fever, and the OB still refused to come in, the nurse instituted the chain of command all the way up to the chief of OB surgery. At each level she was told to follow the OB's orders. At the end of the nurse's shift, the OB examined the patient and found the fetal heart rate patterns reassuring and the fever appropriately addressed by the antibiotics she ordered. The OB reprimanded the nurse in front of the family for not having the oxytocin at the level she ordered and blamed her for the lack of progress. The OB then left to see other patients, and the nurse went off shift. Within the next hour, the patient was complaining of chest pain and shortness of breath. The next L&D nurse on duty called the OB stating she was concerned with the well-being of the mother and fetus. Shortly thereafter, the OB delivered a blue, hypotonic infant via C-section. Cord blood gases indicated the infant was severely acidotic. He survived, but with significant brain injuries.

The OB, in defense of her failure to present to the hospital when requested, cited her unusually high volume of cases with no back-up. (Bullying in the healthcare environment can often be correlated with overwork.)

The child's parents filed a malpractice lawsuit against the OB, nurses, and hospital, alleging the delay in performing the C-section caused the infant's brain injuries. The OB's privileges were also suspended because the medical executive committee (MEC) determined the OB's failure to respond to nurse requests to examine patients was causing patient injuries.

DISCUSSION

The standoff between the nurses and the OB became a contest of wills in which the well-being of the patient was overlooked. The litigation and the investigation associated with the removal of the OB's privileges revealed an underlying environment of incivility and disrespect.

The OB, in defense of her failure to present to the hospital when requested, cited her unusually high volume of cases with no back-up. (Bullying in the healthcare environment can often be correlated with overwork.[19]) Although the OB should have treated the L&D nurse more respectfully, the administration had created an environment that was more likely to trigger incivility. The OB did not receive the sort of support that might have led her to employ positive and productive coping strategies rather than resort to bullying.

Hospital administration also failed to provide the nursing staff with the support they needed to safely manage patients. Administration was well aware of the conflict between the defendant OB and L&D nursing staff. Labor and delivery nurses had lodged multiple complaints, and there were multiple adverse events involving patient outcomes associated with the OB's failure to respond appropriately to nurses' concerns about patient well-being. However, there were no policies and procedures in place that addressed bullying behavior, and the chain of command protocols were not effective. With no administrative support, the nurses had resorted to bullying behavior of their own.

Bullying not only contributed to the patient's injuries in this case, it complicated the defense of malpractice allegations against the defendants. Each of the defendants blamed the other for the infant's injuries. The unsupportive work environment had fostered antagonistic feelings between the L&D nurses and the OB. They were extremely critical of each other during depositions and were expected to testify against each other if the matter went to trial. This benefitted the plaintiffs and had little effect on the attribution of liability among the defendants. As it did in this case, finger-pointing in malpractice cases generally increases settlement and verdict amounts, makes dismissal of parties more complicated, and prolongs litigation.

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The experts who reviewed this case could not support the care and treatment of the patient. They believed the OB should have delivered the infant by C-section hours earlier because of the developing infection and lack of progress. They faulted the hospital for an ineffective chain of command. Experts did not believe the nurse's failure to increase the oxytocin was below the standard of care. Unfortunately for the nurse, the OB had said so many unflattering things about her that the plaintiffs' attorney was unwilling to dismiss her from the case.

The Problem with Defensive Documentation

In Case Three, the OB's documentation in the discharge summary blamed the L&D nurses for the infant's injuries. Defensive documentation is a common finding in medical records that become evidence in malpractice claims. Although blaming someone else in the record may be satisfying, it tends to backfire. During litigation, discovery of disparaging or defensive remarks draws attention to the person who wrote the note. A plaintiff's attorney will most likely want to know what prompted the documentation, which usually results in the writer being named as a defendant in the lawsuit. Defensive documentation also reflects poorly on the writer in front of a jury, as it can be presented as a sign of the writer's insecurities about the care and his or her willingness to throw coworkers under the bus.[20]

If the urge to blame someone else in the medical record arises following an adverse event, pause and assess whether it is a good time for you to enter information in the medical record. Following adverse events, the people involved tend to feel stressed and defensive, which gets in the way of objective documentation. Documentation following an adverse event should include the known facts associated with how the event happened and the care given in response – not subjective comments, speculation, or blame.

ADDITIONAL RESOURCE

NORCAL Group. Responding to Unanticipated Outcomes: First Conversations[21]
Strategies for navigating conversations with patients and families following an unanticipated outcome

Refusing to Examine Patients

One of the most pervasive forms of physician bullying is refusing to be available for a consultation or to examine a patient when summoned.[22] The patient safety implications for this type of behavior are obvious. Numerous closed claims involve physicians who ignore pages, reprimand the person requesting aid, and/or delay evaluations. In the great majority of these cases, the person requesting the consultation was a subordinate (nurse, resident, junior physician). Demeaning, obstructive, and humiliating treatment of subordinates is more common than violent behavior;[2] for example, the surgeon behavior described in Case One. The following two case studies exemplify the variety of ways that this particular form of bullying can contribute to patient injury.

In the following case, the on-call neurologist believed a curt refusal was an appropriate way to teach a young internist the proper protocol for requesting consultations.

CASE FOUR

Allegation: The delay caused by the on-call neurologist's failure to come to the hospital to diagnose the patient's spinal cord impingement resulted in the patient's paraplegia.

On a Monday at 2:00 p.m., a morbidly obese patient with a history of lumbar spine injury arrived at the emergency department (ED) reporting a two-day history of progressive back pain, sciatica, and pain and numbness in both legs. She was admitted, and an MRI was ordered STAT at an outside radiology clinic that could accommodate her size. Due to a series of miscommunications, the MRI was scheduled for Wednesday afternoon. An internist, who was in her first year of practice, visited the patient at 1:00 p.m. on Tuesday. By this point, the patient had lost control of her bowel and bladder function. The internist realized the MRI had not been completed as planned. She called the on-call neurologist and started to explain her reason for breaking usual protocols and calling him: She believed the patient would suffer additional, potentially permanent neurological injuries if they waited until the next day for the MRI results. Before she could finish describing the circumstances, the neurologist cut her off and told her to call back when the MRI results were available for him to review. Staff nearby noted that the exchange with the neurologist had left the internist in tears. She documented that neurology would follow up once the MRI results were received and left the hospital at the end of her shift. Another series of communication failures delayed surgery until the third day of the patient's hospitalization. The patient suffered permanent paraplegia and sued everyone on her healthcare team.

Before she could finish describing the circumstances, the neurologist cut her off and told her to call back when the MRI results were available for him to review. Staff nearby noted that the exchange with the neurologist had left the internist in tears.

DISCUSSION

The neurologist was the target physician-defendant in this lawsuit. When describing the exchange with the internist, he explained that he was teaching her a valuable lesson about how the on-call system worked at the hospital. In retrospect, he realized he should have been more helpful. Experts believed he should have gone to the hospital to examine the patient.

Summoning a Physician

In the closed claims involving treatment delays caused by a physician's refusal to respond to a request to examine the patient, the physicians often cited quality of life and/or workload management for their failure to respond to requests for examination or consultation. Although work/life stress is not an excuse for bullying, using good communication strategies can reduce workplace pressure. Consider the following risk management strategies:[viii,viv]

- **Summoned physician:** Self-correct when you feel over-reluctance or resistance during contact with a nurse or clinician requesting your assistance.
  - If you are summoned inappropriately, use the opportunity as a teaching moment.
- **Nurses and requesting physicians:** Be prepared for resistance.
  - Be assertive if an attending physician responds to a critical message in an unexpected manner (e.g., the physician indicates he or she is not immediately coming to the hospital following the report of an emergent condition), clarify the critical message and restate what you need using communication techniques such as the 2-Challenge Rule, CUS, and/or 4-Step Assertive Tool. Ask the physician if he or she would like any more information than that which has already been provided.
  - If a summoned physician refuses to comply with a request to come to the hospital after you have clearly stated the reasons for the request, state that you are not satisfied with the response and that you will speak with the person responsible for activating the chain of command. Another option is to insist that the physician speak directly with the person who will activate the chain of command to provide a second opinion about the necessity of examining the patient.
- **All:** To accomplish requests and communication in the most succinct and effective manner possible, consider utilizing standardized communication techniques, such as SBAR.
  - SBAR (Situation, Background, Assessment, Recommendation) also has extended versions: I-SBAR, I-SBARQ, and I-SBAR-R. "I" stands for Introduction (or patient Identifiers), "Q" for Questions, and "R" for Read-back.
    - Situation: Tell what is happening with the patient.
    - Background: Give the clinical or contextual background.
    - Assessment: Relay the problem.
    - Recommendations: State your recommendation(s) to correct the problem and what you need from the summoned physician.

ADDITIONAL RESOURCE

Agency for Healthcare Research and Quality (AHRQ). Team STEPPS®

Teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare professionals

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Refusal to examine patients is not limited to on-call specialists. The surgeon in the following case failed to respond to the nurse's concern that a surgery center patient was showing signs of post-surgical internal bleeding.

CASE FIVE

Allegation: The physician's delay in transferring the patient from the surgery center to the hospital resulted in the patient's death.

The patient underwent surgery at a surgery center, which offered an overnight stay option. Although the patient appeared to be recovering normally overnight, by 7:00 a.m. she was hypotensive and tachycardic. An excessive amount of drainage was coming from the surgical drain and the patient seemed at times to have trouble focusing on what the nurses were asking her. At 9:00 a.m., blood was discovered soaked into the bed linens underneath her, but the nurses could not find the source. The nurse asked the surgeon to examine the patient, but he refused. By 10:00 a.m., the nurses were convinced the patient was bleeding internally and needed to be taken back to surgery; however, when one nurse questioned the surgeon about whether to prepare the patient for surgery, the surgeon told the nurse to obtain a blood count before doing anything. By the time the blood count was received, the surgeon realized the patient's condition was critical and transferred her to the hospital, where she later died from uncontrolled internal bleeding. The patient's husband filed a malpractice lawsuit against the entire healthcare team.

The reluctance of the nurses, combined with the uncooperativeness of the surgeon, resulted in the delay in transferring the patient to the hospital, where she might have survived with timely, life-saving treatment.

DISCUSSION

Research indicates nurses are reluctant to call physicians, even as a patient deteriorates, for reasons including intimidation, fear of confrontation, and concerns about retaliation.[7] When communication on the healthcare team is limited to that which is absolutely necessary, the risk of adverse events increases.[2] During interviews with the defendants in this case, it became clear that the nursing staff, in general, avoided asking the surgeon for assistance or input unless they felt it was absolutely necessary. The reluctance of the nurses, combined with the uncooperativeness of the surgeon, resulted in the delay in transferring the patient to the hospital, where she might have survived with timely, life-saving treatment.

The nurses who were present in the surgery center while the incident was unfolding expressed frustration and anger with the surgeon for not addressing the patient's condition. Experts who reviewed the case also believed the surgeon should have appreciated the patient's condition sooner, ordered blood tests sooner, and transferred her to the hospital sooner. However, the nursing expert who reviewed the case believed the nurses had a duty to advocate for the patient much more strongly than they had. Lesson learned: Being bullied does not release a nurse from his or her duty of care toward a patient.

RISK MANAGEMENT STRATEGIES

Minimizing Workplace Bullying

Managing bullying requires a multi-modal approach. Although holding bullies appropriately accountable for their behavior is paramount to the success of an anti-bullying policy, many more processes must be in place to create an environment in which bullying is less likely to occur and, when it does occur, is remedied prior to causing patient injury.

Operations

Medical practice administrators have a vital role in managing bullying. Bullying must be identified and acknowledged, and anti-bullying policies and procedures must be fairly enforced. Effective anti-bullying policies and procedures send a message to the workforce that the administration and leadership are serious about affecting a culture change. Consider the following recommendations: [11,14,19,23]

- **Establish anti-bullying policies and procedures that include:**
  - A definition of bullying behavior that provides enough clarity for individuals to know what behavior is prohibited or reportable, and includes examples of bullying behavior.
    - Include examples of expected behavior.
  - Specification of the policy's application (It should apply to everyone on site).
  - Administrator, clinician, and staff roles and responsibilities.
  - Strategies for responding to bullying.
  - Clear and confidential grievance, investigation, and disciplinary procedures.
  - Requirements for documenting the process.
  - Protections for individuals who report bullying or cooperate in investigatory processes (i.e., non-retaliation clauses).
  - Training requirements.
- **Enforce a "zero tolerance" bullying policy, without exemptions for well-connected or powerful members of the workforce.**
- **Focus on bullying prevention and a culture change instead of relying on reactionary processes.**
  - Assess the prevalence of bullying with confidential/anonymous surveys (e.g., AHRQ's Medical Office Survey on Patient Safety Culture).
  - Ensure physicians and staff understand what constitutes reasonable and competent interpersonal behavior.
    - Evaluate competence.
    - Reward proficiency.
  - Implement a team training program to improve teamwork and team communication, such as AHRQ's TeamSTEPPS® and/or NORCAL Group's Strategies for Optimizing Healthcare Teamwork (available to insureds through MyAccount).
  - Work on team building.
    - Obtain leadership buy-in and commitment.
    - Identify physician leadership champions.
    - Encourage and support a team mentality.
  - Clearly delineate culture change goals.
  - Ensure physicians and staff understand ways in which their contribution helps achieve the culture change goals.
  - Give continuous feedback.
- **Have a plan for managing bullies. For example, in some cases mentoring and coaching might be appropriate; however, probation and termination may be necessary in other cases.**
  - Consider referring the bully to the Employee Assistance Program (EAP).
  - Document counseling, coaching, mentoring and other management of individuals who have been reported for bullying, including recommendations or requirements for behavior change.
- **Provide alternative coping strategies to bullying triggers.**
- **Provide training for physicians and staff in recognizing bullying and complying with the bullying policy.**
- **Stress the risks of bullying and the specific detrimental effects bullying has on victims, bystanders, and patients.**

CONTINUED ON PAGE 14

RISK MANAGEMENT STRATEGIES (CONTINUED)

- **Establish a confidential bullying reporting system.**
  - Encourage patients to report bullying among members of the healthcare team, which can serve as an additional source of quality improvement information.
  - Provide different ways individuals can report bullying. For example, do not require victims and witnesses to only report bullying through their supervisors.
- **Become aware of subtle forms of bullying (e.g., passive aggressiveness and insidious intimidation) in day-to-day social interaction among members of the healthcare team.**
- **When bullying is observed or reported, intervene promptly.**
- **Appropriately investigate every report of bullying.**
- **Perform root cause analyses to uncover systemic problems.**
  - Review bullying incidents and determine whether overwork, stress, lack of control or input, or other work processes may be contributing to bullying; and make changes based on investigation findings.
- **Ensure victims of bullying are adequately supported.**
  - Facilitate the establishment of a support network for clinicians and staff.

Clinicians and Staff

Harshness does not create clinical competence, public shaming does not enforce a higher standard of care, and brutality is not an effective teaching device.[9] Administrators, physician leaders and managers can and should put policies and processes in place to create a healthcare environment in which bullying does not thrive; however, the onus is really on the bully to stop behaving poorly.[24] Consider the following recommendations:

- **Honestly assess your own behavior. If you are bullying someone, stop doing it, or ask for help to stop.**
- **Promote and exemplify respectful behavior.**
  - When under stress, do not let your emotions escalate the situation.
- **Reject and report bullying.**
- **Stand up for people who are being bullied.**
- **Encourage an environment in which anyone who needs help can ask for it, as well as ask questions about patient care.**
  - Do not penalize someone for asking questions or requesting help.
  - Look for opportunities for improvement that can be used as teaching moments.

ADDITIONAL RESOURCES

AMA. Bullying in the health care workplace: A guide to prevention & mitigation[14]
Management strategies and key steps that organizations can use to address bullying in the workplace

ANA. Incivility, Bullying, and Workplace Violence[25]
Position statement articulating the ANA position with regard to individual and shared roles and responsibilities of registered nurses and employers to create and sustain a culture of respect, which is free of incivility, bullying, and workplace violence

The Joint Commission. Sentinel Event Alert. Behaviors that undermine a culture of safety[10]
Suggested operational actions to reduce behaviors that undermine a culture of safety

Workplace Bullying
How It Effects Patient Safety and Liability Risk Exposure

CONCLUSION

As many of these cases show, a practice can be aware of bullying, but not do anything about it. However, when a lawsuit is filed, people are willing to testify about it. Even though it can be daunting to take action in the present, it is better than avoiding the situation until a patient has been harmed, in which case, you may be compelled to report the bullying in a setting where people will be judging your credibility — a courtroom in front of a jury during a malpractice trial.

Bullying is a serious problem. Not only does it affect the mental health and well-being of victims and bystanders, but it also creates a culture of disrespect in which patient injury is more likely.[2] Ridding medical practice of bullying will require a coordinated effort on various fronts. Bullies must stop their harmful behavior. Physician leadership must promote and exemplify respectful behavior. Victims and witnesses must report bullying. Administrators must establish and enforce anti-bullying policies and procedures to create an environment in which bullying is less likely to occur, where the response to bullying is swift and effective, and where the workforce has the resilience to withstand the damaging effects of bullying before patients suffer harm.[24]

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ENDNOTES

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855.882.3412.

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