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## **Workplace Bullying: Hazard for Healthcare Professionals**

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Liz, a 2 year veteran perioperative nurse supervisor throws up every Sunday evening. She dreads the tension at work. It starts the moment she parks her car in the lot, robs her of relief during breaks, and lasts until she is safe behind the wheel again. The misery is a certainty. Unpredictable is what novel, arbitrary demand her surgeons will invent each shift. And there is the nurse manager and her cronies who resent Liz's attempts to introduce anything new. They've done things their way for years and undermine her every step. She posts the vacation schedule in ink. They still mark the days they want off in pencil without even a day's notice. The vice president tells her to "work it out between yourselves" whenever she implores him to intercede. Human resources maintains that woman-on-woman harassment is not illegal. It doesn't violate any policies either. Liz's psychiatrist prescribes anti-depressants and meds for hypertension but he really wants her to quit for her health's sake. And her kids and husband grew tired of hearing about her dilemma months ago. There is no foreseeable solution.

### **The Phenomenon**

For many healthcare workers like Liz each day is a living hell characterized by an unremitting exposure to outrageous mistreatment at the hands of a tyrannical bully and accomplices. It's a non-physical type of violence that is rarely discussed. It's harassment but not recognized as such because there is no discernible discrimination. When the harasser and targeted person are both members of protected status groups, women in Liz's case, there is no prohibition, no protection. The offensive, intimidating, threatening work environment is certainly hostile, just not illegally hostile.

The best name for this different kind of harassment based on simple interpersonal cruelty is Workplace Bullying. Andrea Adams coined the phrase in the mid-1990's in Britain. It is also known as psychological harassment (from Quebec provincial law), psychological violence (NIOSH has begun to classify bullying as a category of workplace violence), or mobbing (from Sweden as named by Heinz Leymann, the founder of the international movement).

Workplace Bullying is repeated, health-impairing mistreatment driven by a perpetrator's need to control targeted individuals. Bullies also undermine legitimate business interests in the process. They keep work from getting done. It is estimated that about one in six U.S. workers is bullied.

Bullying is typically some combination of verbal abuse, demeaning hostile conduct or the interference with productivity, either by deliberate acts of sabotage or acts of omission.

Women and men are bullies. Women comprise 58% of the perpetrator pool according to our research at the Workplace Bullying Institute (WBI). Half of all bullying is woman-on-woman.

Overall, women comprise the majority of bullied people (80%). Without laws, and none exist in the U.S., employers are reluctant to recognize, let alone correct or prevent destructive behavior, preferring to dismiss bullying as "personality clashes."

In 71% of the cases, the bully outranks the target. Peer bullying is 17%. Bullying is not traditional conflict. Instead, it is unilateral aggression triggered by one person's exercise or abuse of power at the expense of the target.

### **Healthcare is a Bullying-Prone Environment**

*Targets are prosocial, a common trait among healthcare workers.*

It used to be that financial certainty attracted healthcare professionals. But now, one is more likely to want to "help" others and hope that remuneration will follow. Prosocial people, the opposite of anti-social types, are likely to trust others until exploited, to try to cooperate when team assignments are given, and to show empathy and concern for others. They are ripe for abuse when a scheming machiavellian intimidator occupies their workplace, either as boss or co-worker. "Hi Machs," as they are called, use others to accomplish their personal goals. To them, others are mere pawns valued only for utility to the user.

We should always avoid the fallacy of blaming victims. However, healthcare workers who accept the myth that disrespectful mistreatment is an unavoidable, justifiable routine have taken the first step toward targethood. To bullyproof yourself, you have to believe you deserve personal dignity and that no one has the right to steal yours away.

*Interdependent tasks are easily sabotaged.*

Many healthcare procedures are complex and sequential in nature. Multiple sub-processes, completed nearly error-free by several different people, lead to positive outcomes. Saboteurs find it easy to confound the success of people they target. Of course, the cleverest ones don't fail in their role; they rarely are found out. They manage to cause someone else in the chain to fail. Consider a mean-spirited preceptor in the surgical suite. Her role is to tutor newbies. But when a case starts to bleed uncontrollably and the surgeon is screaming at the novice to stop it, the preceptor can let the new nurse take all the blame by sitting idly by and doing nothing. In this way, the axiom "nurses eat their young" is perpetuated.

*Bullies are promoted and rewarded.*

According to a 2004 survey of physicians by the American College of Physician Executives, over half reported that behavioral codes designed to curb abusive or disruptive physicians (present in about 75% of the workplaces surveyed) are inconsistently enforced. We all know them, the troublemakers, "rainmakers." They bring in lots of revenue because of their specialties (usually cardio). Often bullies are key financial stakeholder in several interlocking enterprises -- group practices, labs, clinics, surgery centers. Their host-partner hospitals feature them in TV commercials and on billboards. One golden "billboard boy" was on trial for traumatizing his chief perfusionist in a verbal scuffle when the chief dared to defend his staff who had been

berated by the superstar bully. Despite numerous lawsuits and settlements, he is the featured doc in the hospital's new multi-million dollar heart center.

They disrupt and torment staff who endure their boorish irresponsible conduct on a daily basis. Worse yet, they toxify the workplace that patients rely upon for healing. Institutional administrators are too timid to confront them. And, in many cases, witnessing partners who do have leverage to compel them to stop, give them a pass. Rationalizations include "he's a jerk but a great conversationalist," or "well you just have to learn to anticipate his moods." Where is it written that fellow professionals sign on to be co-dependents as if the healthcare work environment is a family with chemical dependency issues?

*Hyperaggressive professionals are excused.*

The fact is that in America, aggression at work is valued more than interpersonal skills. Hospital, clinic and lab administrators rarely confront the destructive narcissists. Regretably witnessing partners who do have leverage to compel them to stop, give a pass. Apologists say "he's a jerk but a great conversationalist," or "well you (targets) just have to learn to anticipate his moods." Colleagues shouldn't have to be co-dependents. Your work environment is not a family with chemical dependency issues (this is separate from the serious matter of a genuinely impaired professional). The socialization of technically skilled, but morally-challenged, superstars must have skipped lessons in humility, empathy and cooperation. Their impulsivity belies their intelligence. They never acquired *emotional* intelligence. It is unlikely that middle-aged bullies, men or women, who attributes their success to the intimidation and humiliation of others for a lifetime will change now.

*The value of "making the numbers" dominates.*

Despite the lofty rhetoric of mission, vision and values statements (always beautifully printed and framed), especially in church-related organizations, hospital workplace cultures are notoriously at variance with "respect and dignity for all individuals." Quotas are uncritically adopted. What matters most are cases, getting through as many as possible in the shortest time. In fact, triage-diagnostic procedures for veteran professionals are akin to the game of Name That Tune. The need to be fast fosters a competition to see who can finish first based on the *least* amount of information. Errors can result for two principal reasons. First, the quick-draw, prideful diagnostician is prone to stereotypical judgments, a phenomenon called illusory correlation. Just hearing one symptom leads to a certain conclusion. However, because of her or his zeal, less obvious indicators can be ignored. Second, nurses and technicians, and of course patients, are reluctant to challenge the physician or PA. Bottom-up error correction is rare because the lower-status professional finds it nearly impossible to cross the power gradient. Rank has to be ignored to stop the procedure or the surgical case. Fear of retaliation and traditional hierarchical compliance prove insurmountable to all but the most fiercely independent and courageous among us.

## **Impact on Individuals**

Workplace Bullying is as much a social movement as it is a workplace improvement initiative because of the health consequences suffered by targeted individuals. A host of stress-related complications, as you clinicians well understand. Cardiovascular, gastrointestinal, immunological problem onset can be triggered by the bully's systematic deconstruction of the target's worklife. Over three-quarters of targets endure debilitating anxiety, 39% are diagnosed with clinical depression, and 30% of women suffer post-traumatic stress (PTSD). Imagine a war wound *caused by work*. It is unconscionable.

### **Why Employer\$ \$hould Care**

Here are several reasons for employers to address workplace bullying:

- It is 3 times more prevalent than sexual harassment. Employers know the response protocol for illegal harassment. They should extend the protections with a specific anti-bullying and refine the enforcement process.
- It is costly: Bullied targets, often the most talented employees, are driven from the workplace. Turnover is expensive. Generations of great nurses have been driven from hospitals because of classic bullying environments.
- Witnesses are affected. One UK study reported observers' vicarious trauma. Bullying workplaces instill fear, which in turn, jeopardizes quality patient care.
- Employee recruitment and retention are made more difficult when the employer's reputation suffers from the antics of one or more petty tyrants.
- Traumatized employees deserve compassion. Mental health professionals are summoned after recognizable forms of trauma (e.g., post-homicide). Know that humans require relief from oppression especially when exposure time is long (targets stay in harm's way a mean 22 months).

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About the author

Dr. Gary Namie is a social psychologist and former organizational development director for two healthcare hospital systems and former professor of management. The Work Doctor® (workdoctor.com) is the only U.S. consulting firm to comprehensively address workplace bullying. He is also co-founder of The Workplace Bullying Institute, an education and research organization and co-author of *The Bully At Work* (Sourcebooks, 2003, 2009).