Healthy Workplace Legislation

Utah 2014

HEALTHY WORKPLACE Bill

workplacebullying.org

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What is Workplace Bullying?

Workplace Bullying is more than incivility, rudeness or misperceptions. It is defined as **Malicious, repeated, health-harming mistreatment:** verbal abuse, threats, humiliation, intimidation, work sabotage or exploitation of a known vulnerability. All of which prevent work from getting done, undercut employer productivity and harm employee health.

Harassment Laws are Insufficient

Current laws are "status based" in that the target of bullying must be a member of a protected status group in order for the harassment to be illegal.

Employers Wait on Laws Before Acting

Though bullying is costly, U.S. employers choose to ignore it until a law compels corrective action.

Here's the Solution: The Anti-Bullying/Anti-Abuse Law for Adults at Work

HEALTHY WORKPLACE Bill

What the HWB Does

For employers

- Precisely defines an "abusive work environment" — creates a high standard for misconduct.
- Requires evidence of health harm.
- Protects conscientious employers from vicarious liability risk if internal correction and prevention procedures are practiced.
- Gives employers a reason to terminate or sanction offenders.

For workers

- Provides an avenue for legal redress for health —harming cruelty at work that does not exist
- Allows bringing suit against the abuser or liable employer (if neglectful)
- Allows for restoration of lost wages and benefits
- Encourages employers to prevent and correct future instances.
- Plugs the gaps in current state and federal civil rights protections.

The HWB Does Not

- Involve state agencies to enforce any provisions of the law
- Punish good, ethical, abuse-intolerant employers
- Supersede workers comp laws or bargaining agreements
- Increase cost of doing business in the state
- Incur costs for adopting states
- Use the term "workplace bullying" - it is abusive conduct

Introduced in 21 states since 2003

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Current discrimination and harassment laws rarely address bullying concerns. Bullying is four times more prevalent than illegal discrimination, but is still legal in the U.S. People deserve protection against arbitrary cruelty that has nothing to do with work.

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Justification of Need for the Healthy Workplace Bill

In the General Workplace:

(1) Workplace bullying, mobbing, and harassment can inflict serious harm upon targeted employees, including feelings of shame and humiliation, severe anxiety, depression, suicidal tendencies, impaired immune systems, hypertension, increased risk of cardiovascular disease, and symptoms consistent with post-traumatic stress disorder.

(2) According to WBI Zogby surveys, between 37 and 59 percent of employees in the general workforce directly experience health-endangering workplace bullying, abuse, and harassment, and this mistreatment is approximately four times more prevalent than illegal forms of harassment and discrimination.

(3) If mistreated employees who have been subjected to abusive treatment at work cannot establish that the behavior was motivated by race, color, sex, sexual orientation, national origin, or age, there are likely no protections by the law against such mistreatment.

(4) Legal protection from abusive work environments should not be limited to behavior grounded in protected class status as that provided for under employment discrimination statutes.

(5) Existing workers' compensation plans and common-law tort actions are inadequate to discourage this behavior or to provide adequate relief to employees who have been harmed by abusive work environments.

(6) Abusive work environments have serious consequences for employers, including reduced employee productivity and morale, higher turnover and absenteeism rates, and increases in medical and workers' compensation claims;

(7) The social and economic well-being of Utah is dependent upon healthy and productive employees.

(8) Abusive workplace environments are costing Utah billions of dollars each year.

In the Medical Workplace:

(9) The safety of the citizens of the State of Utah is dependant upon ethical practices in the medical workplace.

(10) The preservation of ethics in the medical workplace is dependant on an environment which inhibits intimidating and disruptive behaviors.

(11) In a 1992 study of medical records, adverse events occurred in 2.9% of hospitalizations in the State of Utah and 32.6% of these adverse events were due to negligence. More

detailed studies in other regions suggest that the 2.9% of adverse events based on medical records may in actuality be between 8-10%.

(12) In a survey conducted by the Institute for Safe Medical Practices, 49% of all respondents reported that their past experiences with intimidation had altered the way they handle order clarifications or questions about medication orders.

(13) In a Sentinel Event Alert issued by the Joint Commission on the Accreditation of Healthcare Organizations, intimidating and disruptive behaviors foster medical error, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new position in more professional environments. Intimidating and disruptive behaviors are acknowledged to be prevalent. A remarkable 40% of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.

(14) Medical practitioners who do not remain silent are subject to being targeted for devastating health-harming workplace abuse which may cost them their careers, their social support system, their physical and psychological health, and even their lives. Damages permeate through the targets families, the workplace and the greater community.

THE 2013 HEALTHY WORKPLACE BILL

An Act Addressing Workplace Bullying, Mobbing, and Harassment,
Without Regard to Protected Class Status

Authored by:
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Section 1 -- Preamble

(a) Findings

The Legislature finds that:

(1) The social and economic well-being of the State is dependent upon healthy and productive employees;

(2) At least a third of all employees will directly experience health-endangering workplace bullying, abuse, and harassment during their working lives, and this form of mistreatment is approximately four times more prevalent than sexual harassment alone;

(3) Workplace bullying, mobbing, and harassment can inflict serious harm upon targeted employees, including feelings of shame and humiliation, severe anxiety, depression, suicidal tendencies, impaired immune systems, hypertension, increased risk of cardiovascular disease, and symptoms consistent with post-traumatic stress disorder;.

(4) Abusive work environments can have serious consequences for employers, including reduced employee productivity and morale, higher turnover and absenteeism rates, and increases in medical and workers' compensation claims;

(5) If mistreated employees who have been subjected to abusive treatment at work cannot establish that the behavior was motivated by race, color, sex, sexual orientation, national origin, or age, they are unlikely to be protected by the law against such mistreatment;

(6) Legal protection from abusive work environments should not be limited to behavior grounded in protected class status as that provided for under employment discrimination statutes; and,

(7) Existing workers' compensation plans and common-law tort actions are inadequate to discourage this behavior or to provide adequate relief to employees who have been harmed by abusive work environments.

(b) Purpose

It is the purpose of this Chapter:

(1) To provide legal relief for employees who have been harmed, psychologically, physically, or economically, by deliberate exposure to abusive work environments;

(2) To provide legal incentive for employers to prevent and respond to abusive mistreatment of employees at work.

Section 2 -- Definitions

(a) Abusive work environment. An abusive work environment exists when an employer or one or more its employees, acting with intent to cause pain or distress to an employee, subjects that employee to abusive conduct that causes physical harm, psychological harm, or both.

(1) Abusive conduct. Abusive conduct includes acts, omissions, or both, that a reasonable person would find abusive, based on the severity, nature, and frequency of the conduct. Abusive conduct may include, but is not limited to: repeated verbal abuse such as the use of derogatory remarks, insults, and epithets; verbal, non-verbal, or physical conduct of a threatening, intimidating, or humiliating nature; or the sabotage or undermining of an employee's work performance. It shall be considered an aggravating factor that the conduct exploited an employee's known psychological or physical illness or disability. A single act normally will not constitute abusive conduct, but an especially severe and egregious act may meet this standard.

(2) Psychological harm. Psychological harm is the impairment of a person's mental health, as established by competent evidence.

(3) Physical harm. Physical harm is the impairment of a person's physical health or bodily integrity, as established by competent evidence.

(b) Adverse employment action. An adverse employment action includes, but is not limited to, a termination, demotion, unfavorable reassignment, failure to promote, disciplinary action, or reduction in compensation.

(c) Constructive discharge. A constructive discharge shall be considered a termination, and, therefore, an adverse employment action within the meaning of this Chapter. A constructive discharge for purposes of this Chapter exists where: (1) the employee reasonably believed he or she was subjected to an abusive work environment; (2) the employee resigned because of that conduct; and, (3) the employer was aware of the abusive conduct prior to the resignation and failed to stop it.

Section 3 – Unlawful Employment Practices

(a) Abusive Work Environment. It shall be an unlawful employment practice under this Chapter to subject an employee to an abusive work environment as defined by this Chapter.

(b) Retaliation. It shall be an unlawful employment practice under this Chapter to retaliate in any manner against an employee who has opposed any unlawful employment practice under this Chapter, or who has made a charge, testified, assisted, or participated in any manner in an investigation or proceeding under this Chapter, including, but not limited to, internal complaints and proceedings, arbitration and mediation proceedings, and legal actions.

Section 4 – Employer Liability and Defense

(a) An employer shall be vicariously liable for an unlawful employment practice, as defined by this Chapter, committed by its employee.

(b) Where the alleged unlawful employment practice does not include an adverse employment action, it shall be an affirmative defense for an employer only that:

(1) the employer exercised reasonable care to prevent and correct promptly any actionable behavior; and,

(2) the complainant employee unreasonably failed to take advantage of appropriate preventive or corrective opportunities provided by the employer.

Section 5 – Employee Liability and Defense

(a) An employee may be individually liable for an unlawful employment practice as defined by this Chapter.

(b) It shall be an affirmative defense for an employee only that the employee committed an unlawful employment practice as defined in this Chapter at the direction of the employer, under actual or implied threat of an adverse employment action.

Section 6 – Affirmative Defenses

It shall be an affirmative defense that:

(a) The complaint is based on an adverse employment action reasonably made for poor performance, misconduct, or economic necessity; or,

(b) The complaint is based on a reasonable performance evaluation; or,

(c) The complaint is based on an employer's reasonable investigation about potentially illegal or unethical activity.

Section 7 -- Relief

(a) Relief generally. Where a party is liable for an unlawful employment practice under this Chapter, the court may enjoin the defendant from engaging in the unlawful employment practice and may order any other relief that is deemed appropriate, including, but not limited to, reinstatement, removal of the offending party from the complainant's work environment, back pay, front pay, medical expenses, compensation for pain and suffering, compensation for emotional distress, punitive damages, and attorney's fees.

(b) Limitations on employer liability. Where an employer is liable for an unlawful employment practice under this Chapter that did not include an adverse employment action, emotional distress damages and punitive damages may be awarded only when the actionable conduct was extreme and outrageous. This limitation does not apply to individually named employee defendants.

Section 8 -- Procedures

(a) Private right of action. This Chapter shall be enforced solely by a private right of action.

(b) Time limitations. An action under this Chapter must be commenced no later than one year after the last act that constitutes the alleged unlawful employment practice.

Section 9 – Effect on Other Legal Relationships

(a) This Chapter does not supersede rights and obligations provided under collective bargaining laws and regulations.

(b) The remedies provided in this Chapter shall be in addition to any remedies provided under any other law, and nothing in this Chapter shall relieve any person from any liability, duty, penalty or punishment provided by any other law, except that if an employee receives workers' compensation for medical costs for the same injury or illness pursuant to both this Chapter and the workers' compensation law, or compensation under both this Chapter and that law in cash payments for the same period of time not working as a result of the compensable injury or illness or the unlawful employment practice, the payments of workers' compensation shall be reimbursed from compensation paid under this Chapter.

This version dated: August 31, 2012

Workplace Bullying
Introduction to the 'Silent Epidemic'

Gary Namie, PhD and Ruth Namie, PhD

Founders of the Workplace Bullying Institute and
Workplace Bullying Institute - Legislative Campaign
Bellingham, Washington
Authors of *The Bully At Work*

Proposed legislation:
The Healthy Workplace Bill

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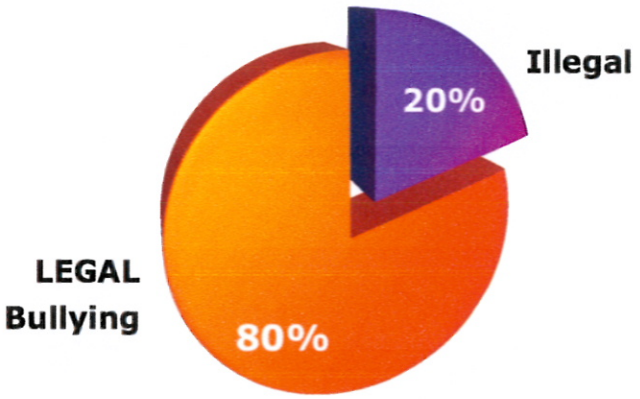
The Phenomenon

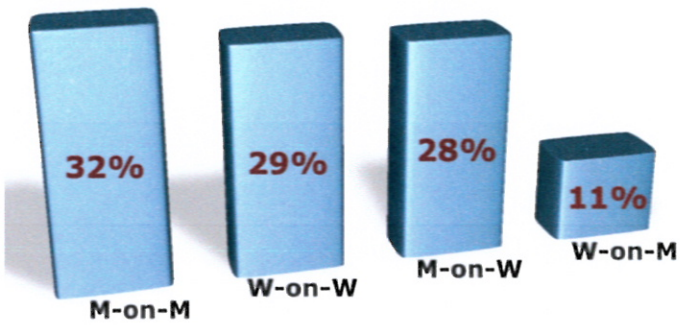
The Workplace Bullying Institute (WBI) introduced the British term to Americans in 1997. It is defined as repeated, health-harming mistreatment that comes in the form of any one or some combination of the following categories: work sabotage, verbal abuse, or conduct that is threatening or intimidating or humiliating. It is a non-physical form of workplace violence.

In September, 2007, WBI and Zogby International queried the largest-ever representative sample of American adults (7,740) about Workplace Bullying. Results showed that
37% of workers (est. 54 million) directly experienced bullying, 12% witnessed it, while 45% had no experience.

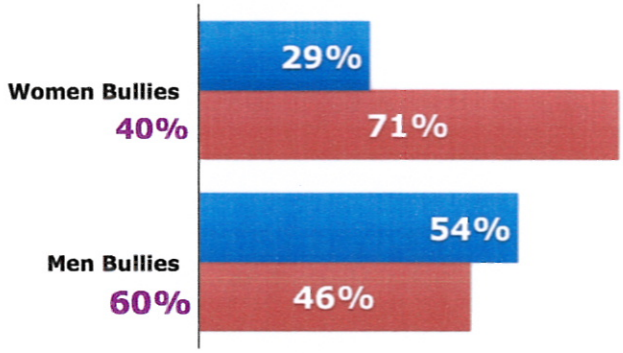
In 20% of bullying cases the harassment was potentially illegal. **Bullying is 4 times more prevalent than illegal harassment.**



Bullying is legal primarily because its majority (61%) is same-gender harassment.

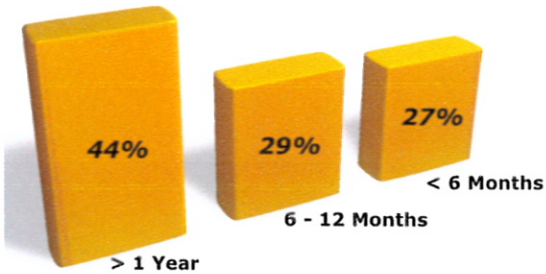


Women and men are both bullies but they bully differently Women are the cruelest towards other women, targeting other women 71% of the time. Men split targets across gender nearly evenly.

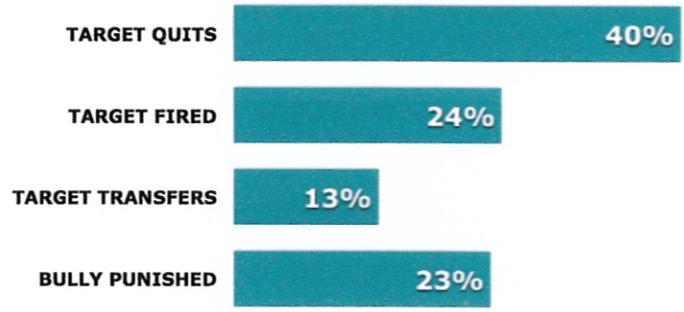


Bullying Damages People

Bullying impacts health by causing a host of stress-related problems (for 45% of respondents in the WBI-Zogby survey). Effects range from depression and PTSD to cardiovascular diseases and neurological compromises. Harm comes from prolonged exposure. 44% suffered for more than 1 year.

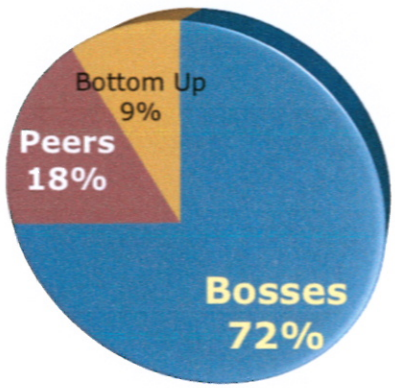


In the vast majority of cases, bullying only stops when the target loses the job she or he once loved, either by quitting, being forced out, or transferring to stay employed. The bully rarely endures negative consequences.



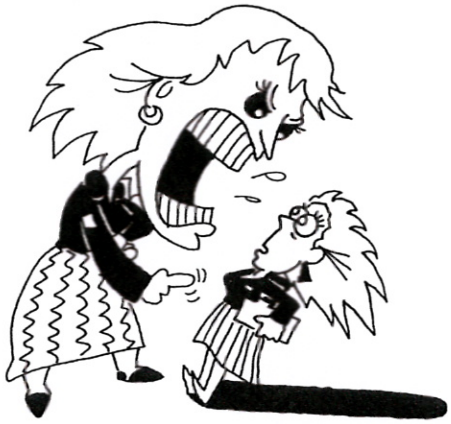
The Bullies

Not all bosses are bullies, but most bullies are bosses. The stereotype is real. It takes title power to threaten to take away another person's livelihood and economic security.



Bullies bully because (1) the work environment provided opportunities to behave in a cutthroat, zero-sum, manner, (2) there was a pool of exploitable targets (typically with a prosocial, helping orientation), and (3) negative personal consequences were few to non-existent, they were rewarded for it.

We describe four categories of bullying tactics. Public screaming, behind-closed-doors criticizing, back-stabbing snake & hyper-controlling gatekeeper through whom everything flows.

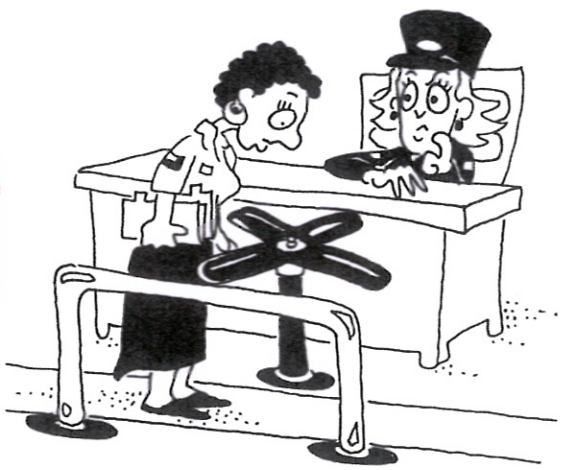


Screaming Mimi

Bully Types from the book *The Bully At Work* by Namie & Namie (Sourcebooks, 2003)

Constant Critic

Two-Headed Snake



Gatekeeper

Why Bullying I$ An Employer'$ I$$ue

Employers establish the work environment, its culture, and are responsible for its health or toxicity. According to WBI-Zogby, employers worsen or ignore the bullying in 62% of cases when notified about the incidents.

Here are several reasons for employers to address workplace bullying:

1. It is 4 times more prevalent than sexual harassment. Employers already know what to do about harassment.

2. It is costly: Turnover is expensive. The loss of an estimated 21 million workers who quit because of bullying could have been prevented.

3. It damages employee health. Of those individuals bullied, 45% reported stress-related health complications.

4. Witnesses know when bullying happens -- 12% of the workforce sees it. Fear-driven workplaces have poor morale and low productivity.

5. Employee recruitment and retention are made more difficult.

A Legislative Solution

A 1998 Washington Post newspaper editorial, while reacting to a US Supreme Court decision called on Congress to write specific anti-harassment laws without restriction to discrimination against protected groups. The editorial stated, "what bothers people about abusive workplace conduct, after all, is not the fact that it may be discriminatory but that it is abusive in the first place."

Through the network of volunteer State Coordinators across the U.S., the WBI Legislative Campaign has circulated the anti-bullying Healthy Workplace Bill is designed to protect all individuals against "status-blind" harassment at work. California in 2003 was the first U.S. state to introduce the bill. Several states have since followed. Consult bullybusters.org for the list of current active and past bills. Lawmakers may request a copy of the draft language.

The real value of having a law in place for bullied employees is to compel employers to correct and prevent health-impairing abusive misconduct as they now act against discrimination. Employers can voluntarily stop bullying, but it may take a law to convince them to look at the bottom line and to do the right thing.

The definitive U.S. resource for workplace bullying information, The Workplace Bullying Institute-Legislative Campaign, Bellingham, WA, is on the web at

healthyworkplacebill.org • workplacebullyinglaw.org
workplacebullying.org

Work Shouldn't Hurt!

Bullying is Costly for Employers
The Healthy Workplace Bill Saves Employers $$$$

Workplace Bullying Kills COMPETITIVENESS

• Unwanted Turnover

Despite layoffs, the best & brightest employees are the ones who flee or are driven out. The cost to replace lost talent includes -- recruitment, interviewing managers' time, training, & reduced proficiency -- the equivalent of 2-3 times the former worker's salary.

• Absenteeism/Presenteeism

Productivity is made impossible when workers take necessary sick leave. Presenteeism happens when workers respond to mistreatment with disengagement. Sabotage may result.

• Litigation/Defense Costs

Most bullying does not qualify as illegal harassment. However, in 20% of bullying incidents, discrimination plays a part. And frustrated workers will file lawsuits. Each case must be defended or settled, costing 6-figure legal bills. Frequent defendants pay higher employment practices liability insurance premiums.

• Increased Healthcare Utilization

Stressed workers become ill workers. Stress-related diseases due to workplace mistreatment (well documented in the scientific literature) require medical & mental health attention. Higher use raises employer insurance premiums.

• Compromised Worksite Safety

Stressed workers are fatigued workers who cause costly accidents. The most highly stressed, traumatized workers can resort to violence. Headline grabbing suicides, as well as on-site massacres, pose risks to employers who treat bullying with indifference.

Workplaces Free of Abuse, Bullying & Disrespect:

- Foster Innovation
- Have Loyal & Engaged Workers
- Are Healthier with Stress-Free Workers
- Have Low Litigation Risk
- Have Low Violence Risk

Employers should care enough to reduce their own costs & erradicate preventable bullying. However, U.S. employers historically treat bullying with indifference, denial, or encouragement. The HWB is a gentle prod to employers to do what they should already be doing voluntarily.

The HWB is Pro-Employer, it:

- Rewards Proactive Action with an Avoidance of Vicarious Liability
- Requires Abuse to be Repeated, Malicious & Health-Harming
- Defines High-Threshold Abusive Conduct
- Preserves Managerial Rights

Current discrimination and harassment laws rarely address bullying concerns. Bullying is four times more prevalent than illegal discrimination, but is still legal in the U.S. People deserve protection against arbitrary cruelty that has nothing to do with work.

Healthy Workplace Bill

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Estimating Employer Cost Saving from Turnover

By Having a Law

Assumptions

- 7% of workforce is currently bullied
- Bullying accounts for 60% of preventable workforce loss of targets
- Replacement cost = 2 x salary

2013 Data

- Utah workforce population 1,100,000
- Median income = $58,000

Calculations

- Population being bullied = 46200
- Turnover cost = $5,359,200,000

Utah's Cost Saving for Having a Law

$5.4 billion annually

U.S. Workplace Bullying Survey

Workplace Bullying Defined

as repeated mistreatment manifested as either

- verbal abuse, or
- conduct which is threatening, humiliating, intimidating, or
- sabotage that interferes with work or some combination of the three

The Largest Scientific Survey of bullying in the U.S.

Research Partners

WORKPLACE BULLYING INSTITUTE AND Zogby International

Zogby International conducted **7,740** interviews to create a representative sample of all American adults in August, 2007. The margin of error was +/- 1.1 percentage points.

Key Findings

- 37% of workers have been bullied
- Most bullies are bosses (72%)
- Most Targets (57%) are women
- Bullying is 4 times more prevalent than illegal harassment
- 62% of employers ignore the problem
- 45% of Targets suffer stress-related health problems
- 40% of bullied individuals never tell their employers
- Only 3% of bullied people file lawsuits

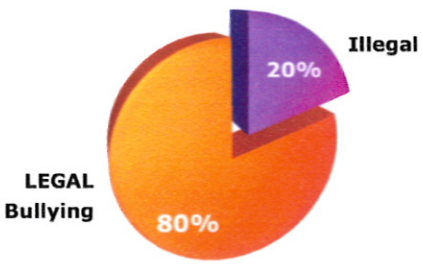
The complete results of the 2007 WBI-Zogby survey can be found online at bullyinginstitute.org.

Prevalence

37% of the U.S. workforce (an est. 54 million Americans) report being bullied at work; an additional 12% witness it. **49% of workers.** Simultaneously 45% report neither experiencing nor witnessing bullying. Hence, a "silent epidemic."

A Different Kind of Harassment

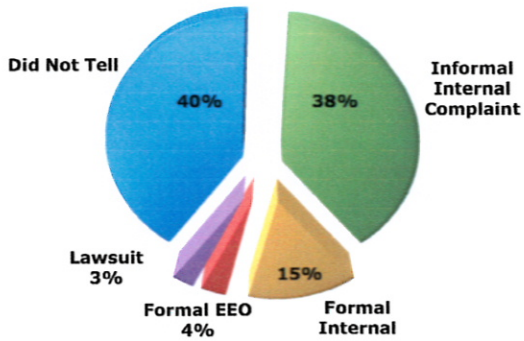
Bullying is 4 times more common than harassment (based on illegal discrimination). In only one of five bullying cases does discriminatory conduct play a role.



Bullying Damages Employees' Health

The mythology surrounding bullying is that targets complain and litigate frequently. **However, 45% of targets had stress-related health problems.** Past research found that targeted individuals suffer debilitating anxiety, panic attacks, clinical depression (39%), and even post-traumatic stress (PTSD, 30% of women; 21% of men). In addition once targeted, a person has a 64% chance of losing the job for no reason.

Despite the health harm, **40% never report it. Only 3% sue and 4% complain to state or federal agencies.**



Bullying Cot Employer$

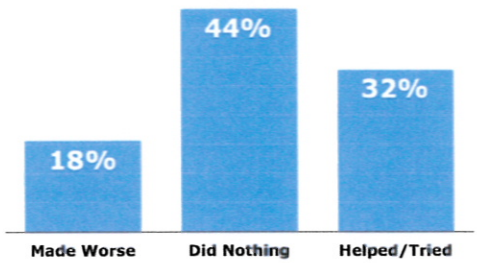
Tangible Costs

- Turnover: recruitment, interviewing, hiring
- Absenteeism/ Lost Productivity
- Workers' Compensation
- Disability Insurance: Short- & Long-Term

Intangible Costs

- Employee Sabotage
- Difficult Recruitment & Retention
- Tarnished Reputation: "Worst Place to Work"

When they are informed about the bullying, U.S. employers either worsen the problem or do nothing. Doing nothing is not a neutral act. But bullying is mostly legal and can be ignored by law.



It might take a law to compel employers to look after their self-interest.

WBI-Zogby Survey
Sponsored by
WAITT INSTITUTE FOR VIOLENCE PREVENTION

WORKPLACE BULLYING INSTITUTE

2010 U.S. Workplace Bullying Survey

About the Survey

The Workplace Bullying Institute (WBI) wrote the survey and commissioned Zogby International to collect data for the second representative study of all adult Americans on the topic of workplace bullying. WBI conducted the first national study in 2007.

There were two 2010 surveys - one with several items and 4,210 survey respondents (MOE +/- 1.5 percentage points), and one single-item survey with 2,092 respondents (MOE +/- 2.2 percentage points). Each sample was representative of all American adults in August, 2010.

What is Workplace Bullying?

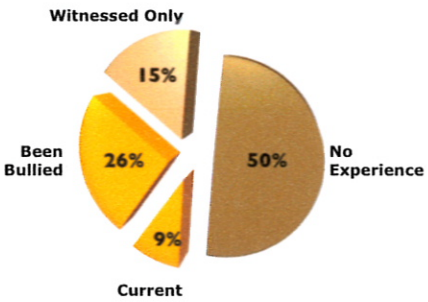
In Survey 1, Workplace Bullying was defined as "repeated, health harming abusive conduct committed by bosses and co-workers." In the single-question survey (Survey 2), Workplace Bullying was defined as "repeated mistreatment: sabotage by others that prevented work from getting done, verbal abuse, threatening conduct, intimidation, & humiliation" in order to make the direct comparision to the 2007 WBI-Zogby prevalence question.

Key Findings

- 35% of workers have been bullied (37% in 2007)
- 62% of bullies are men; 58% of targets are women
- Women bullies target women in 80% of cases
- Bullying is 4X more prevalent than illegal harassment (2007)
- The majority (68%) of bullying is same-gender harassment

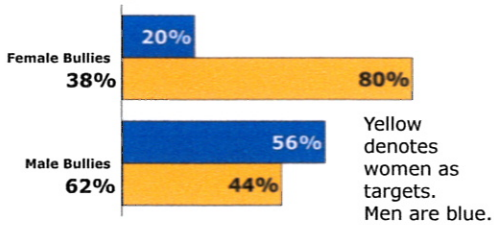
Prevalence of Workplace Bullying

35% of the U.S. workforce **(an est. 53.5 million Americans)** report being bullied at work; an additional 15% witness it. Simultaneously, 50 % report neither experiencing nor witnessing bullying. Hence, a "silent epidemic."



Gender and Workplace Bullying

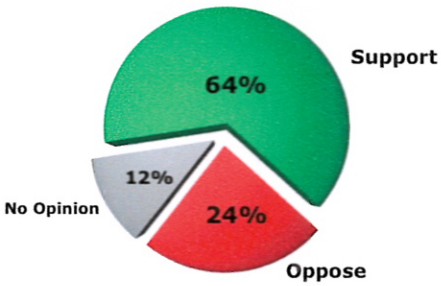
Both men and women bully, but the majority of bullying is same-gender harassment, which is mostly legal according to anti-discrimination laws and workplace policies. Women target women.



Yellow denotes women as targets. Men are blue.

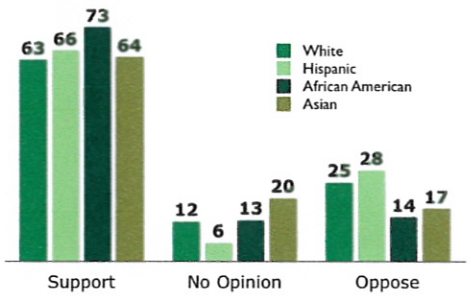
Public Support for the Healthy Workplace Bill

Survey 1 respondents were asked if they supported or opposed workplace bullying legislation to protect workers from "abusive conduct" as contained in the original HWB language. Support is 2.5 times the level of opposition.



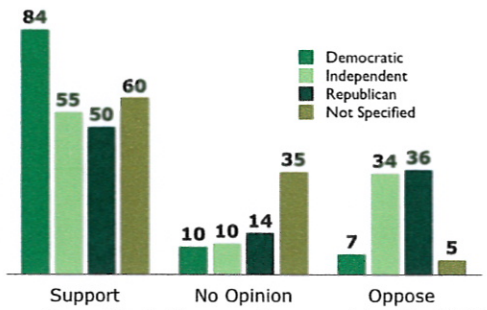
Support and Race

The strongest support comes from groups which enjoy protected status under current civil rights laws. Support from African Americans (73%) and Hispanics (66%) shows that current laws are inadequate when workplace cruelty is the issue. In fact, in 2009 the NAACP endorsed HWB as a necessary law.



Political Party Affiliation and Support

Since 2003, the HWB has enjoyed bipartisian support in several state legislatures. Both Republicans and Democrats have been prime sponsors of the bill. In the 2010 WBI-Zogby survey, people identified themselves as members of the Democratic or Republican parties, or as Independents or not specified. Strongest support for the HWB came from Democrats (84%), Not Specified (60%), followed by Independents (55%) and half of Republicans. Thus, constituents of both parties want elected officials to address workplace bullying.



For more information about the survey please contact WBI
workplacebullying.org
info@workplacebullying.org

To sponsor the Healthy Workplace Bill please contact the HW Campaign
healthyworkplacebill.org info@healthyworkplacebill.org
Your State Coordinator will contact you
National Office: 360.656.6630

HEALTHY WORKPLACE Bill

2014 WBI U.S. Workplace Bullying Survey

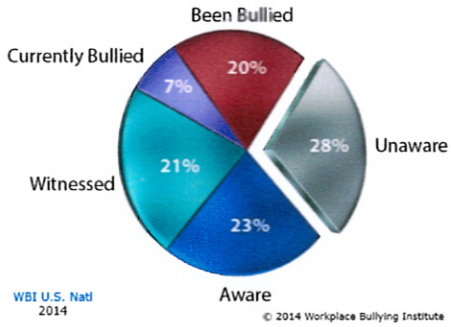
Psychological Violence • Emotional Abuse at Work • Mobbing

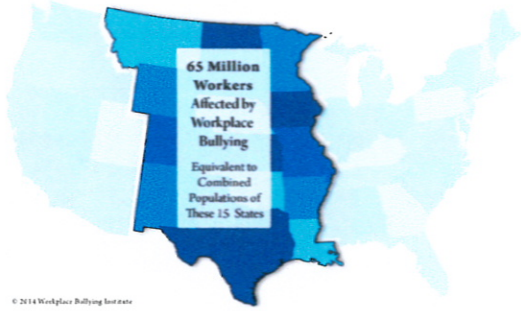
Workplace Bullying remains an American epidemic. In the absence of legal prohibitions against it, employers are failing to take responsibility for its prevention and correction. Bullied individuals pay dearly with the loss of their economic livelihood to stop it.

Prevalence

Workplace Bullying was defined as repeated mistreatment; abusive conduct that is: threatening, humiliating, or intimidating, work sabotage, or verbal abuse.

This definition is the one used in the Healthy Workplace Bill. Bullying is "abusive conduct," referring to its most serious forms only. By comparison with the rate of any disease or malady. bullying is an epidemic.





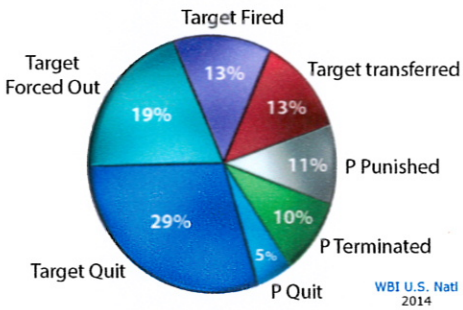
The number of U.S. workers who are affected by bullying – summing over those with direct bullying and witnessing experiences – is 65.6 million, the combined population of 15 states.

Employers

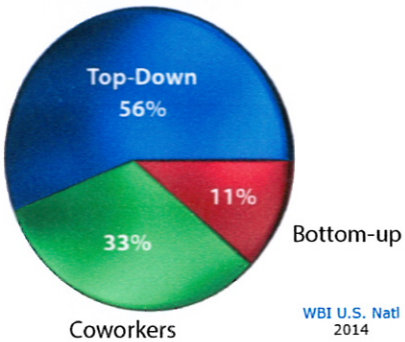
Employers fail to appropriately react to abusive conduct much more frequently than they take positive steps ameliorate bullying. Denial and discounting were the most common reactions by employers.

This led to 61% of the targets losing their jobs as the only way to stop the bullying.

What Stops It



Bully's Rank



Key Findings

- **27% have current or past direct experience with abusive conduct at work**
- **72% of the American public are aware of workplace bullying**
- **Bosses are still the majority of bullies**
- **72% of employers deny, discount, encourage, rationalize, or defend it**
- **93% of respondents support enactment of the Healthy Workplace Bill**

Support For HWB

*72% OF ALL AMERICANS ARE AWARE OF ABUSIVE

2014 WBI U.S. Workplace Bullying Survey

HEALTHY WORKPLACE Bill

healthyworkplacebill.org

Gary Namie, PhD, Research Director
Workplace Bullying Institute
National Office: 360.656.6630

WORKPLACEBULLYING.ORG

Incidence and types of adverse events and negligent care in Utah and Colorado.

Thomas EJ, **Studdert DM**, **Burstin HR**, **Orav EJ**, **Zeena T**, **Williams EJ**, **Howard KM**, **Weiler PC**, **Brennan TA**.

Department of Medicine, Brigham and Women's Hospital, Boston, Massachusetts, USA. ethomas@heart.med.uth.tmc.edu

BACKGROUND: The ongoing debate on the incidence and types of iatrogenic injuries in American hospitals has been informed primarily by the Harvard Medical Practice Study, which analyzed hospitalizations in New York in 1984. The generalizability of these findings is unknown and has been questioned by other studies. OBJECTIVE: We used methods similar to the Harvard Medical Practice Study to estimate the incidence and types of adverse events and negligent adverse events in Utah and Colorado in 1992. DESIGN AND SUBJECTS: We selected a representative sample of hospitals from Utah and Colorado and then randomly sampled 15,000 nonpsychiatric 1992 discharges. Each record was screened by a trained nurse-reviewer for 1 of 18 criteria associated with adverse events. If > or =1 criteria were present, the record was reviewed by a trained physician to determine whether an adverse event or negligent adverse event occurred and to classify the type of adverse event. MEASURES: The measures were adverse events and negligent adverse events. RESULTS: Adverse events occurred in 2.9+/-0.2% (mean+/-SD) of hospitalizations in each state. In Utah, 32.6+/-4% of adverse events were due to negligence; in Colorado, 27.4+/-2.4%. Death occurred in 6.6+/-1.2% of adverse events and 8.8+/-2.5% of negligent adverse events. Operative adverse events comprised 44.9% of all adverse events; 16.9% were negligent, and 16.6% resulted in permanent disability. Adverse drug events were the leading cause of nonoperative adverse events (19.3% of all adverse events; 35.1% were negligent, and 9.7% caused permanent disability). Most adverse events were attributed to surgeons (46.1%, 22.3% negligent) and internists (23.2%, 44.9% negligent). CONCLUSIONS: The incidence and types of adverse events in Utah and Colorado in 1992 were similar to those in New York State in 1984. Iatrogenic injury continues to be a significant public health problem. Improving systems of surgical care and drug delivery could substantially reduce the burden of iatrogenic injury.

PMID: 10718351 [PubMed - indexed for MEDLINE]

Educating the healthcare community about safe medication practices

ISMP MedicationSafetyAlert!® Acute Care

A federally certified Patient Safety Organization

INTIMIDATION: PRACTITIONERS SPEAK UP ABOUT THIS UNRESOLVED PROBLEM (PART I)

From the March 11, 2004 issue

All too often, seasoned healthcare providers feel compelled to warn new staff members about a particularly difficult physician, and perhaps even shield them from this person for as long as possible. It's a telling sign of a culture that tolerates, even fosters, intimidation. More than 2,000 (N=2,095) healthcare providers from hospitals (1,565 nurses, 354 pharmacists, 176 others) responded to our November 13, 2003, survey on this subject. Sadly, they clearly confirmed that intimidating behaviors continue to be far from isolated events in healthcare. What's more, these behaviors are not necessarily limited to a few difficult physicians, or for that matter, to physicians alone. In Part I of our report, learn what respondents had to say about workplace intimidation. Recommendations to address this longstanding problem will be presented in Part II of our report, in the March 25, 2004, edition of the newsletter.

Healthcare providers feel the sting of intimidating behaviors. Regardless of the source of intimidation (physicians or others), respondents reported that subtle yet effective forms of intimidation occurred with greater frequency than more explicit forms. For example, during the past year, 88% of respondents encountered condescending language or voice intonation (21% often); 87% encountered impatience with questions (19% often); and 79% encountered a reluctance or refusal to answer questions or phone calls (14% often). Almost half of the respondents reported more explicit forms of intimidation during the past year, such as being subjected to strong verbal abuse (48%) or threatening body language (43%). Incredibly, 4% of respondents even reported physical abuse.

Physicians clearly intimidate, but it's not just physicians. According to respondents, physicians and other prescribers engaged in intimidating behaviors more frequently than other healthcare providers (e.g., pharmacists, nurses, supervisors). For example, respondents reported that physicians/prescribers often used condescending language, were reluctant to answer questions or return phone calls, and were impatient with questions at least twice as often as other healthcare providers. Sixty-nine percent of respondents told us that physicians/prescribers had often (12%), or at some time during the past year (57%), stated: "Just give what I ordered;" whereas 34% of respondents encountered similar pressure from other healthcare providers to give what the prescriber had ordered. Likewise, physicians and prescribers more frequently exhibited strong verbal abuse and threatening body language than other healthcare providers.

Intimidating and abusive behavior should never be tolerated in healthcare. Such intolerance should not be misconstrued to represent punishment for those who make errors. The issue is not whether such behavior resulted in an error, rather that it is egregious and unacceptable under any circumstances. It promotes stress, job dissatisfaction, employee turnover, resentment, and miscommunication, all of which can only result in poor outcomes for patients. As such, the topic should be covered fully in policies and bylaws, discussed during all staff orientation (including physician orientation) and addressed immediately if it occurs.

In other complex industries with better safety records than healthcare, all uncertainty about safety is presumed to be a serious problem without putting the person who expresses the concern on the defensive to prove he is right.1 Simply put, if someone thinks it may be unsafe, it is considered unsafe. Equally important, these highly reliable industries follow a "two challenge rule" where the person who is concerned about safety communicates the problem and its rationale twice. If no resolution occurs, the matter is automatically referred to others for resolution. This review process does not imply that the person concerned about safety "wins," it just means that the situation must be reviewed quickly by at least one other person before a final decision is made. It would be wise to follow this example to help counteract intimidation.

Reference 1: Gifford BJ, Morey J, Risser D, et al. Enhancing patient safety through teamwork training. Journal Healthcare Risk Management. 2001; 21(4):57-65.

Editor's note: We thank John Gosbee, MD, MS, National Center for Patient Safety, US Department of Veterans Affairs, for his contribution to this article.

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) “Any behavior which impairs the health care team’s ability to function well creates risk,” says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. “If health care organizations encourage patients and families to

speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk."

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with "blowing the whistle" on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are "let off the hook" for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
    - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
    - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
    - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
    - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
    - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families

who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.

8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

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* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

5 Reasons Abusive Work Environment Cases Belong in Civil Court

Save State $$$ • More Justice for Bullied Workers

1. Our State is broke.

This is not the time to dump additional work on budget-constrained state agencies (e.g., the Labor Dept.). If complaint handling, investigations, resolution & enforcement in matters of abusive work environment (bullying) claims, it would be a budget buster. Not now. Not for our state. The HWB is revenue neutral, will not cost the state money.

2. Free complaint filing by the State leads to frivolous complaints.

Complainants who hire private attorneys will have stronger cases given their personal investment. Attorneys & Courts will weed out weak cases and stop them before they begin. Free services are abused. Bullies will exploit the state.

3. State investigatory procedures languish for years.

Too much to do by too overwhelmed State employees leads to prolonged cases. It takes years for resolution. People harmed at work seek justice the state can't deliver. Justice prolonged is justice denied.

4. State OSH regulation violation penalties don't change employers.

Courts can levy harsher financial penalties for real and punitive damages in civil cases than the State can. Employers will change their internal policies & staff when jury verdicts grab headlines. Stiff penalties get attention.

5. Justice for aggrieved workers = employer accountability.

Bad employers hide behind cloak of "confidential" procedures. Court filings are public and transparent. Abusive employers identified as harboring abusive workers risk negative media attention. Outed employers will do everything to restore their damaged reputations. Public awareness of employer misconduct often defines justice.

The Anti-Bullying/Anti-Abuse Healthy Workplace Bill calls for 'private right of action' requiring civil lawsuits by private attorneys, not the State.

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HEALTHY WORKPLACE Bill

The National Healthy Workplace Campaign on the web at healthyworkplacebill.org

Why Mediation Doesn't Work for Workplace Bullying

By Esque Walker, PhD, Certified Distinguished Mediator and Texas HWB State Coordinator

The mediation process assumes that all parties involved in the mediation are "sufficiently capable" of negotiating and reaching a mediated agreement with each other as equals in the process. In cases involving workplace bullying, or any type of family violence, this is a false assumption; individuals experiencing abuse, violence, or similar interactions are disempowered. Their ability to deal effectively with their abusers are diminished.

The Most Common Reasons Mediation Fail Are:

- Retribution
- The imbalance of power between conflicting parties
- Forced or coerced mediations and/or settlements
- Fear of subsequent intimidation and abuse post-mediation
- Increased threats to personal safety post-mediation
- Fear of the bully
- The complexity of workplace bullying
- Diminished psychological status of the complainant
- Undiagnosed depression or PTSD and suicidal complainants
- The mediated agreement will not be honored
- Limited power of a mediator and the process
- Duress of the complainant
- Attempts of the mediator to mediate the actual abuse
- Attempts of the mediator to minimize the abuse
- Inexperienced or poorly trained mediator (no knowledge of workplace bullying or family violence issues)
- Misunderstanding the differences between workplace bullying and interpersonal conflict
- Complainants acting as their own legal representative
- Perpetrator fabricating information against the complainant
- Perpetrator portraying him/herself as the victim in the situation
- Character assassination and demeaning comments and references about the complainant during the mediation to keep the complainant off balance and emotional
- Unreasonable expectations of the mediation process by the complainant
- The inability of the complainant to enter into an agreement
- Extremely emotional complainant unable to articulate the real issue(s)
- Mediation does not cover prior behavior or abuse
- Multiple party involvement (more than one perpetrator)
- In some situations, the complainant will assume the role of protector for the perpetrator by minimizing the situation and behaving in a way or saying the things they feel is appropriate to please the perpetrator (learned abuse behavior: the same behavior demonstrated by victims of family violence) and fear of the aftereffect of the mediation
- Inappropriate body language or gestures directed at the complainant
- Inappropriate outbursts and interruptions by the perpetrator to disrupt the process (demonstrating to the complainant that s/he is in control)
- The perpetrator does not see his/her actions as abusive or inappropriate

Current discrimination and harassment laws rarely address bullying concerns. Bullying is four times more prevalent than illegal discrimination, but is still legal in the U.S. People deserve protection against arbitrary cruelty that has nothing to do with work.

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healthyworkplacebill.org

Public Sector (Government) Organizations

Mediations in government organizations present additional challenges.

External mediators (paid by another government agency) are given a sheet with the complainant's name and type of case (i.e. discrimination, harassment etc…) no other information is provided. All contact with the complainant is made by EEO or HR before and after the mediation. Internal mediators (paid by the organization) are selected by EEO or HR to settle the case; these are usually managers, other executives, or an employee who outranks the complainant.

The Workplace Bullying Institute conducted an online survey to described the outcomes after mediation. The results, 33% of targets were terminated or quit, 52% of perpetrators faced zero consequences, and negative consequences for the offender followed mediation in only 7% of cases.

Because cases slated for mediation are identified as cases of discrimination, harassment, violations of one of the protected statues or problem employees, and not workplace bullying, traditional institutions and systems have not been recording success or failure of mediation to stop bullying.

- All mediated agreements must be approved by HR and EEO administrators (forces outside the mediation dictating the outcome).
- Government trained mediators take a one week 40-hour course and are termed mediators (poorly trained)
  Note: government mediators may mediate one case prior to your case, or your mediation may be their first case with no supervision or additional training. It is not unusual for a government-trained mediator to be trained and not get their first case for 12 or more months after training.
- Managers and other executives are used as mediators
- Internal ties to other managers and employees
- Organization has a skewed view of the complainant (labeled as a trouble maker)
- Mediator is aware of the rumors and gossip about complainant
- Family clusters (parents, siblings, other family members, close friends, church members) you never know the dynamics of whom you're dealing with.
- Ineffective zero tolerance polices applied to the abuse
- Notifying the complainant with less than 24 hours that they will be going to mediation (no available union representative or attorney, no prep time for the complainant)

Mediation is not the end of the bullying experience for the target; especially if the target remains employed in the organization.

Due to the structure of public sector organizations, it is very difficult to totally impossible to make organizational changes. Each federal agency is operated by federal mandates and must go through the parent organization. In Washington D.C., these mandates are implemented nationally for that particular agency and may be 10 plus years old (mandates are updated about every 20 years).

Current discrimination and harassment laws rarely address bullying concerns. Bullying is four times more prevalent than illegal discrimination, but is still legal in the U.S. People deserve protection against arbitrary cruelty that has nothing to do with work.

HEALTHY WORKPLACE Bill

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Bully Apologists Will Say Anything, Here's the Truth

Business Lobbyists Will Argue	But the truth is. . .
A hostile workplace is already illegal for everyone. Anti-discrimination and anti-harassment laws apply. No new laws are needed.	Current laws apply to only 20% of bullying cases. Legal protections apply when the target is a member of a protected status group, except in same-sex and same- race harassment which accounts for 61% of bullying. The Bill closes the legal loophole.
More regulations make businesses in our state less competitive and less likely to keep jobs here.	The Bill affords the aggrieved employee redress only by pursuing private legal action, bearing all expenses. No State regulatory function or departments are involved, no fiscal impact. Employers won't leave just because of this Bill.
Bullying is too subjective. Employers lose the right to criticize poor performers. This law undermines managerial prerogative.	The Bill prohibits only extreme, health-harming abusive misconduct, precisely defined, as confirmed by health professionals. Managers' rights are preserved. Only abuse is addressed by the Bill.
Compliance with enacted legislation will be costly. Risk of exposure to vicarious liability is high. The employer will be blamed for the bully's conduct.	Bullying is already costly and eroding productivity through turnover and absenteeism. Bullies are too expensive to keep! The Bill contains generous affirmative defenses for employers. Compliance is simple, a process familiar to Human Resources. Create an explicit policy prohibiting an abusive work environment, faithfully enforce it, then only the abusive individual will be accountable. Responsible employers with correction procedures in place will not be liable.
It's "Job Killer" legislation.	Bullies are the actual job killers. They terrorize co-workers & subordinates which creates stress, PTSD & endangers employee health. Bullying threatens health, careers, witnesses, and affected families.
Americans are not afraid of aggression. Sometimes a little bit of bullying motivates workers and does them good!	A shameless argument. If an employer needs to be abusive at work, perhaps the company should not be in business! Government employers have a stronger ethical obligation. Partner violence, student bullying, workplace violence have all been outlawed. The rest of the industrialized world has declared war on work-place bullying. Bullying makes our society uncivilized!

Current discrimination and harassment laws rarely address bullying concerns. Bullying is four times more prevalent than illegal discrimination, but is still legal in the U.S. People deserve protection against arbitrary cruelty that has nothing to do with work.

HEALTHY WORKPLACE Bill

healthyworkplacebill.org

The
HEALTHY WORKPLACE Bill

11 states with 16 current bills

September 2013

Healthy Workplace Bill Legislative History in the United States - Introduced in 25 States Since 2003

NEW YORK *9th introducing state*
2013 -- **CURRENT BILLS** A 4965 & S 3863
2011-12 -- A4258 & S 4289
2010 -- S 1823-B **PASSED SENATE**, 45-16-1
A 5414-B & A 6207
2009 -- Study-only bills: A 2247 & S 1948
2008 -- A 10291 & S 8793
2007 -- A 7801-A, S 2715 & A 4921
2006 -- S 8018 & A 11565

MASSACHUSETTS *6th introducing state*
2013 -- **CURRENT BILL** HB 1766
2011-12 -- H 2310 & S 916
2009-10 -- SB 699; 2005 -- H 3809
2004 -- Public Policy Question District 3 (68% yes)

WEST VIRGINIA *19th introducing state*
2013 -- **CURRENT BILL** HB 2054
2011 -- HB 3015

FLORIDA *23th introducing state*
2013 -- **CURRENT BILLS** SB 308 & HB 149

NEW MEXICO *22th introducing state*
2013 -- **CURRENT BILL** HB 234

VERMONT *13th introducing state*
2013 -- **CURRENT BILL** S 34
2011 -- S 52
2009-10 – S 87; 2008 -- S 312; 2007 -- H 548

NEW JERSEY *10th introducing state*
2012 -- **CURRENT BILL** S 333
2010-11 – A 673 & S 2515
2008 -- A 1551; 2006 -- A 3590

NEW HAMPSHIRE *18th introducing state*
2013 -- **CURRENT BILL** HB 591
2010 -- HB 1403

WISCONSIN *17th introducing state*
2013 -- **CURRENT BILLS** AB 245 & SB 233
2011-12 -- AB 364 & SB 277; 2010 -- AB 894

HAWAII *3rd introducing state*
2013 -- **CURRENT BILLS** HB 196 & SB 272
2012 -- SB 2847; 2010 -- Res. SR 100 Passed;

PENNSYLVANIA *25th introducing state*
2013 -- **CURRENT BILL** HB 1179

MAINE *24th introducing state*
2013 -- HB 1766

ILLINOIS *15th introducing state*
2011-12 -- HB 942
2010 -- SB 3566 **PASSED SENATE**
2009 -- HB 374 & HJR 40

WASHINGTON *4th introducing state*
2011-12 -- HB 1928 & SB 5789
2008 -- SB 6622; 2007 -- HB 2142; 2005 -- HB 1968

CONNECTICUT *12th introducing state*
2012 -- SB 154; 2010 -- HB 5285; 2009 -- SHB 6188
2008 -- SB 60; 2007 -- SB 371

NEVADA *16th introducing state*
2011 -- AB 90; 2009 – AB 166

OKLAHOMA *2nd introducing state*
2009-10 -- HB 1685; 2007 -- HB 1467; 2004 -- HB 2467

KANSAS *8th introducing state*
2009-10 -- HB 2218; 2006 -- HB 2990

OREGON *5th introducing state*
2009 – SB 727; 2007 - SB 1035; 2005 -HB 2410 & HB 2639

MONTANA *11th introducing state*
2009 -- SB 494; 2007 -- HB 213

MISSOURI *7th introducing state*
2006 -- HB 1187

MINNESOTA *21st introducing state*
2011 -- SF 1352 & HF 1701

UTAH *14th introducing state*
2011 -- HB 196; 2011 -- HB 292; 2009-10 – HB 224

MARYLAND *20th introducing state*
2012 -- SB 999 ; 2010 -- SB 600

CALIFORNIA ***1st state to introduce;*** 2003 -- AB 1582

New York Law Journal

Office Bully Takes One on the Nose: Developing Law on Workplace Abuse

by Jason Habinsky and Christine M. Fitzgerald

January 21, 2011

For years the law has been stacked against an employee claiming that he or she was abused or bullied by a co-worker. Generally, the law offers no protection to such a victim as long as the alleged bully can show that his or her actions were not motivated by the victim's status as a member of a protected class. Currently, there are no federal, state or local laws providing a cause of action for an individual subject to a non-discriminatory abusive work environment. However, with bullying becoming front-page news across the nation, it is just a matter of time before the law adapts. Since 2003, 17 states have considered legislation designed to protect employees from workplace bullying. Indeed, this year New York came very close to a floor vote on a bill that would provide a cause of action to an employee subjected to an abusive work environment.

Proponents of anti-bullying legislation contend that it is necessary given the prevalence of abusive conduct in the workplace. The proposed New York legislation noted that "between sixteen and twenty-one percent of employees directly experience health endangering workplace bullying, abuse and harassment" and that "[s]uch behavior is four times more prevalent than sexual harassment." **...**

"with bullying becoming front-page news across the nation, it is just a matter of time before the law adapts"

Existing Legal Framework

Currently, employers have little to worry about with respect to facing substantial liability as a result of workplace bullying. The existing legal framework provides very limited recourse to an employee who is bullied at work. While some types of harassment are outlawed under Title VII of the Civil Rights Act of 1964, Title VII's reach is narrow. Title VII prohibits employment discrimination based on an individual's race, sex, color, religion, or national origin. It is well-settled that "Title VII does not prohibit all verbal or physical harassment in the workplace" but rather only discrimination because of race, sex, color, religion or national origin. **...**

Likewise, the extreme behavior that gives rise to the tort of intentional infliction of emotional distress does not encompass most workplace bullying. In order to prove a claim for the intentional infliction of emotional distress a plaintiff must prove that the defendant acted intentionally or recklessly, the defendant's conduct was extreme and outrageous, and the conduct caused severe emotional distress. Restatement (Second) of Torts §46.

Courts have found that extreme or outrageous conduct is "'so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community'…but does not extend to 'mere insults, indignities, threats, annoyances, petty oppressions, or other trivialities.'" **...**

Legislation Campaign

The HWB provides legal redress for employees who are subjected to an abusive work environment, by allowing employees to sue both their employer and the alleged bully for monetary damages. The Workplace Bullying Institute contends that the bill is employer friendly since it sets a high standard for misconduct, requires proof of harm by a licensed health professional in order for an individual to collect damages, and protects employers with internal correction and prevention mechanisms from liability.

"it seems inevitable that some form of the HWB will become law"

In 2003, California became the first state to introduce some form of the HWB. Subsequently, anti-workplace bullying legislation has been introduced in sixteen other states. In 2010, the New York State Senate passed the bill. However, the New York Assembly Labor Committee stalled the passage of this ground breaking legislation when it voted to hold the bill, rather than vote on it.

Abusive conduct is defined as "conduct, with malice, taken against an employee by an employer or another employee in the workplace, that a reasonable person would find to be hostile, offensive and unrelated to the employer's legitimate business interests." The severity, nature and frequency of the conduct should be considered in determining liability. **...**

The bill provides employers with an affirmative defense when the employer "exercised reasonable care to prevent and promptly correct the abusive conduct which is the basis of such cause of action and the plaintiff unreasonably failed to take advantage of the appropriate preventive or corrective opportunities provided." **...**

Therefore, it appears that we may be on the cusp of a new era of legislation and legal precedent targeted at preventing and punishing workplace bullying. Indeed, it seems inevitable that some form of the HWB will become law, whether in New York or elsewhere, and that once the first state adopts an anti-bullying statute others will shortly follow. **...** We suggest that employers become proactive and take immediate steps to prevent workplace bullying. This will ensure that employers are better prepared to defend against a cause of action for workplace bullying. **...**

Excerpted from the original article by Jason Habinsky, *counsel* & Christine M. Fitzgerald, *associate at Hughes Hubbard & Reed, New York office*.

Deseret News

Abusive bosses in medical fields targeted

By James Thalman
Deseret News

Published: February 4, 2009

Hospitals would become bully-free zones and bad-boss behavior prohibited in state statute under a bill that a legislative review committee on Tuesday earmarked for interim study.

Despite opposition to the bill by the head of the state Division of Risk Management, former district Judge Roger Livingston, counter testimony from disgruntled health-care workers who support HB224 was too compelling for lawmakers to ignore.

They heard and were given written accounts of ostensibly competent, caring medical providers being driven from their jobs and even out of the state by supervisors who induce stress in an already high-stress occupation. The hyper-patrolling and controlling oversight — which included employees having to ask to go the bathroom — are far from uncommon and are adding injury to the insult in the form of serious mistakes and harm to patients, committee members were told.

Laura Sorensen, a registered nurse with critical care certification and a former Air-Med flight nurse and a state Emergency Nurse of the Year, said workplace bullying is the not the joke opponents try to make of it. She said that after immediately divulging to a supervisor that she had been diagnosed with multiple sclerosis 15 years ago, the University of Utah began a systematic effort to have her fired, effectively "disabling me well before I had any signs of being 'crippled up' by the disease." She said U. attorneys immediately considered her a potential liability as a flight nurse and proceeded to keep her from working, despite her filing an Americans With Disabilities Act lawsuit and court-directed mediation in which she told U. lawyers all she wanted was her job back until her health literally — not potentially — precluded it.

Nurse Sharlene Watson said she was driven out of her labor and delivery job at the U. for delivering a baby before the attending doctor arrived and to ease an ongoing disagreement between her boss and another nurse. She was immediately placed on leave without pay. She said in subsequent hearings she was verbally and physically abused.

"People think government immunity doesn't prevent actions in court, but I can tell you they do," Watson said.

Livingston said if state employees feel aggrieved, "we have methods to ensure that we are as progressive and open and fair."

He added that he didn't want to come off as denigrating testimony before the committee, but said "in the strongest possible terms, this would be a giant step backward."

To illustrate his point, he mentioned a 1977 citizen petition in Arizona against Daylight Savings Time in which a reason cited by signers was that "the extra hour of sunlight would burn their lawns."

Dave Gessel, vice president of government relations and legal counsel for the Utah Hospital Association, said HB224 is "well-intended but off the mark," noting that behavior at any workplace has never been made a cause of legal action. "This is a Grand Canyon change. To single out health care or go across that

chasm is huge" in part because Utah is a right-to-work state in which 89 percent of all employees can be let go from their job for no good reason.

"Employers would see a problem and think they better fire that person right now," he added. "This would backfire."

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No More B.U.H.L.!
(Bullies Under Healthcare Leadership)

As nurses, we know just what "bully" means. But a thesaurus easily illustrates the behavior of some of the nurses we have worked with: "intimidate," "persecute," "oppress," "browbeat." And we know as nurses we don't only "eat our young" either. It is very important that we as a profession learn to stop this destructive behavior. The quality of patient care suffers. The financial status of healthcare organizations diminishes. And the lives of nurses are disrupted, resulting in physical and mental health problems and economic consequences that can even end in suicide. Professionals are better than that.

According to the Workplace Bullying Institute (2000), bullies target the better skilled both technically and socially, most honest coworkers because they are a threat to the bully. This source also found that most targets are females. There are various theories about why bullies bully, but perhaps more relevant, is what can be done to end the problem. To solve any dilemma, it is necessary to acknowledge and confront the issue directly. Bullying behavior needs to be tackled both at the strategic, organizational, and personal levels. Organizations and individuals within those organizations must confront bullies and ensure they are aware that their behavior will not be tolerated.

Confronting the issue on the strategic level is imperative. In the beginning of 2009, The Joint Commission will require facilities to take on "disruptive and inappropriate behaviors." In a "Sentinel Event Alert" the entity acknowledged that these behaviors contribute to medical errors, adverse outcomes, and the costs of care (2008).

Organizations have often been tolerant of bullies. If it is widely understood that bullying negatively impacts patient outcomes and drives up costs, why have organizations been slow to deal with the problem? Angie Panos, Ph.D., expert in Prevention of Workplace Violence explains, "Bullies make themselves look great to their superiors, as they are usually quite adept at explaining away their behavior. They can appear so reasonable that superiors often think the one being bullied is just a whining, weak person. Usually the bully will lie or exaggerate their reasons for their behavior. Often these bullying behaviors are not witnessed directly by others either" (2008).

An organization's Mission and Vision Statements and Code of Conduct should support a culture that makes patient well-being and a spirit of team work a priority. To ferret out problems, organizations can scrutinize such indicators as vacancy and turnover rates. Many targets will leave their position or be ousted by bullying superiors. Nurses within an organization will tend to avoid a unit or a shift they know is staffed with bullies. Turnover, and to some extent, vacancy rates can be helpful in identifying trends of trouble.

On the personal level, individuals that would like to improve their organization, relationship with coworkers, and working environment, need to learn to confront bullying. Many people don't like confrontation. A majority of people are ill-equipped to confront and never learned this skill. In childhood, too many people were advised by parents to employ ineffective strategies. Parents often urge children to "just walk away" or "ignore" bullies. A target of a bully that "ignores" the tormentor will continue to be the target. But confrontation is a skill that can be taught and learned.

Angie Panos, PhD shares that when confronting a bully, "ultimately the nurse has to be professional, but assertive. At times, the bully is in a position of leadership. Confrontation can still work. Bullying behavior will only stop when confronted with strength (no whimpering or it will encourage more bullying)." At times it may be better if a target leaves the organization. Panos goes on to explain, "Sometimes a culture or group can target a certain individual or turn them into a scape-goat, and that is much more challenging to confront. It sometimes can be turned around, but more often the nurse needs to move to a different department or hospital to escape what would be a losing battle."

If nurses do find a need to leave their jobs as a result of bullying, nursing in Utah offers many opportunities. Organizations that wish to retain good nurses will confront their bullies.

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www.utahnursesassociation.com

Utah Nurse

November, December 2009, January 2010 Volume 18 • Number 4

Public Forum on Health Care Provider Abuse Prevention Act

Submitted by Denise Halverson, Michelle Swift, Dorothy Soloman and Gary Namie

The safety of all citizens depends on ethical practice in the medical workplace. This quintessence applies to patient care, of course. And it also applies to the way managers, supervisors, and colleagues treat medical practitioners. The preservation of ethics in the medical workplace depends on an environment which inhibits intimidating and disruptive behaviors.

On Tuesday, October 20th, 2009, a public forum on "Health Care Provider Abuse Prevention" will wrestle with issues surrounding the abuse of those who heal and care for others. Health care workers often bring an extraordinary degree of compassion and sensitivity to their work, which makes them particularly susceptible to harassment and bullying by exploitative and manipulative personalities. This catalyzes confusion in the workplace, discouragement and despair among our most gifted providers, the replacement of particularly adept caregivers by those less empathic and perhaps less talented. The distressing results include a decline in the overall quality of patient care and the disintegration of professional ethics.

Doors to Room 030 House Building will open at 6:30 PM and the meeting runs from 7:00-8:30 PM. The general public is invited to attend and ask questions following a panel discussion featuring Gary Namie, author of "The Bully at Work" and leading expert on workplace bullying; Michelle Swift, R.N, attorney, and former UNA president; Utah nurses Sharlene Watson and Laura Sorenson; and Representative Stephen Sandstrom of Utah District 58.

The forum seeks to illuminate and inform in conjunction with the Health Care Provider Abuse Prevention Act, sponsored by Representative Stephen Sandstrom. Legislators anticipate that the Health and Human Services Interim Committee will hear the bill the following morning, October 21, 2009, in room 250 State Capitol.

Individuals who have personal workplace experiences of verbal abuse, threats, intimidation, humiliation or sabotage of their work are invited to attend and share that story at either the public forum or the Health and Human Services Interim Committee hearing or both events.

Most people don't realize the prevalence of the conducted by the Institute for Safe Medical Practices, 49% of all respondents reported that their past experiences with intimidation had altered the way they handled order clarifications or questions about medication orders. A remarkable 40% of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator [3]. In response to this survey and years of reported abusive conduct, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) issued a Sentinel Event Alert in 2008 establishing a zero tolerance policy for intimidating and disruptive behaviors in the medical workplace, effective January 2009 [1].

JCAHO leadership stated in a Sentinel Event Alert issued July 9, 2008, "Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team . . . There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care. Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it." [2]

Adverse events in medical care are not uncommon, even in Utah. In a 1992 study, based on an examination of a representative sampling of medical records from hospitals in Utah, it was estimated that adverse events occurred in 2.9% of hospitalizations and 32.6% of these adverse events were due to negligence [6]. More detailed studies suggest that the 2.9% of adverse events based on medical records may in actuality be as high as 8-10% [7].

According to the Workplace Bullying Institute (WBI), Gary Namie, "Bullying at work is repeated, health-harming mistreatment of a person by one or more workers that takes the form of verbal abuse; conduct or behaviors that are threatening, intimidating, or humiliating; sabotage that prevents work from getting done; or some combination of the three...The bully puts her or his personal agenda of controlling another human being above the needs of the

Public Forum continued from page 1

Based on research conducted by the WBI in 2003, the top reasons bullied individuals gave for being targeted were:

1. The Target's refusal to be subservient, to no go along with being controlled (58%)
2. The Target's superior competence or technical skill (56%)
3. The Target's social skills: being liked, positive attitude (49%)
4. Ethical, honest reporting of fraud and abuse (46%)

Targets of bullying are generally ethical, service oriented, highly-skilled, and non-political individuals. Bullying is a result of the bully's inadequacies, not the Target's. According to the first national scientific survey of workplace bullying conducted by WBI, 37% of adult Americans have personally experienced bullying at work. Research and anecdotal evidence suggest that what makes a Target a target is an inability to defend him- or herself when assaulted. Thus, legal protections are warranted.

Workplace bullying, mobbing, and harassment can inflict serious harm upon targeted employees, including feelings of shame and humiliation, severe anxiety, depression, suicidal ideation, impaired immune systems, hypertension, increased risk of cardiovascular disease, and symptoms consistent with post-traumatic stress disorder.

Abusive work environments also have serious consequences for employers, including reduced employee productivity and morale, higher turnover and absenteeism rates, and increases in medical and workers' compensation claims. In healthcare specifically, bullying-induced errors can contribute to patient morbidity and mortality.

When abusive behavior is tacitly or explicitly rewarded by an organization medical practitioners are vulnerable to being targeted for devastating health-harming workplace abuse which may cost them their careers, their social support system, and their physical and psychological health. Damages permeate through the targets families, the workplace and the greater community.

If mistreated employees who have been subjected to abusive treatment at work cannot establish that the behavior was motivated by race, color, sex, sexual orientation, national origin, or age, there are likely no protections by the law against such mistreatment. According to the WBI national survey, workplace bullying is approximately four times more prevalent than illegal forms of harassment and discrimination. Existing workers' compensation plans and common-law tort actions are inadequate to discourage this behavior or to provide adequate relief to employees who have been harmed by abusive work environments. Thus current laws are largely ineffective in dealing with workplace abuse.

The purpose of the Health Care Provider Abuse Prevention Act is three-fold:

(1) To provide legal incentive for employers to prevent and respond to abusive mistreatment of employees in the medical workplace.

(2) To provide legal relief for employees who have been harmed, psychologically, physically, or economically, by being deliberately subjected to abusive work environments in the medical workplace.

(3) To protect the citizens of the State of Utah against the dangerous consequences of perpetuating a culture of intimidation and abuse in the medical workplace by allowing such behavior to go unchecked.

It is hoped that the Public Forum will begin to open discussions about a very critical and prevalent problem that has flourished through an epidemic of silence. Individuals, both inside and outside the health care industry, should contact their State legislators to let them know that the public is interested in this issue. It is impossible for individuals in the health care system to address this problem unless we as a society support them in doing so, by setting appropriate standards and providing effective legal protections for those on the battle front. It is a problem that affects every member of our community and we need to address it before we lose any more of our most highly qualified and most highly ethical health care practitioners.

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Workplace Abuse in the Medical Workplace: Fact vs. Myth

A physician demands that a prescription be filled despite proof that it has been prescribed from faulty information; an intimidated ER nurse doesn't dare speak up when a life-threatening condition is overlooked; a surgical team stands knowingly, yet silently by as a surgeon makes a life-threatening error ; despite the plea of a mother, a knowledgable nursing staff refuses to challenge the doctor's written order resulting in the senseless death of a toddler; a senior nurse refuses to assist a junior nurse as a critically-injured patient slips away. What is the common factor in these, and other similar and actual situations? Workplace bullying. In medical environments, personnel often couch it in more benign language: intimidating and disruptive behavior.

Workplace bullying involves repeated health-harming mistreatment usually directed toward underlings or peers, but affecting the quality of patient care and life in general. Workplace bullying falls into one or more of the following categories: work sabotage, verbal abuse, or conduct that is threatening or intimidating or humiliating. Conduct that is in opposition to the employer's legitimate business interests, workplace bullying levies real costs, financially, emotionally, physically, and in every other way. In the medical work place it contradicts professional ethics, including the Hippocratic Oath, for it severely compromises patient safety and quality care.

Bullying is about the bully, not the target. The bully puts his/her personal agenda of controlling another human being above the interests of patients and the employing medical organization. A bully's weapons of choice often include deliberate humiliation, the withholding of critical resources or information, social manipulation, and professional sabotage.

What are the myths that allow the destructive behaviors to continue and thrive?

Myth 1: Bullying behavior is not prevalent.

Intimidating behaviors are increasing at an alarming rate. A survey conducted by the Institute for Safe Medical Practices (ISMP) found that 88 percent of the medical practitioners surveyed encountered condescending language or voice intonation, 87 percent encountered impatience with questions, 79 percent dealt with reluctance or refusal to answer questions, 48 percent were subjected to strong verbal abuse, 43 percent experienced threatening body language, and 4 percent reported physical abuse. Intimidating and disruptive behavior involves more than one or two offending individuals in a given medical organization. Thirty-eight percent of respondents reported that three to five individuals were involved in negative encounters and 19 percent reported that more than five individuals were involved in negative encounters. Moreover, only small differences between male and female respondents showed up in reports, with male respondents somewhat more reluctant to confront a known intimidator, and female respondents somewhat more willing to ask for help in dealing with a known intimidator.

Myth 2: Targets deserve or ask for abuse. Smart people don't become targets.

Individuals most often targeted by bullies prove to be independent, skilled, bright, cooperative, nice, ethical, just and fair people. In fact, targets are often amongst the most highly skilled, competent, and altruistic individuals. Bullies, seem driven by their own personal insecurities, perceive skilled and competent coworkers as a threat. Bullies tend to thrive in environments in which (1) there are opportunities to behave in a cutthroat, zero[1]-sum, manner, (2) there is a pool of exploitable targets (typically those people with a pro-social helping orientation), and (3) negative personal consequences are negligible, and (4) perpetrators are rewarded for their bullying behavior by those who collude with the intimidation, or those who are afraid to challenge the bully.

Myth 4: Bullies are worth keeping around.

Bullies are exhorbitantly expensive. Conservative estimates and prevalent data indicates that bullying medical practitioners cost organizations over a million dollars per 50 employees per year in turnover costs alone. Damages to organizations also include poor morale, low productivity, and difficult recruitment and retention of quality workers. The ability of health care workers to work as a team is compromised, the quality of patient care is diminished, and lives are needlessly lost. Medical lawsuits invariably accompany the substandard medical care produced by such sabotage, and the cost in this regard may be incalculable[2].

Negative impacts specifically on Targets and their families include damages to psychological and physical health, financial stability, social support systems, and professional growth opportunities. In a survey conducted by Zogby International, 45 percent of targets reported stress-related health complications, ranging from depression and PTSD to cardiovascular diseases and neurological compromises. The greatest harm comes from prolonged exposure and 44 percent reported suffering from workplace abuse for more that 1 year.

Myth 5: Employers generally recognize the harm done to their organization and deal effectively with bullying behavior.

In the vast majority of cases, bullying stops only when the target loses his/her job either by quitting, being forced out, or transferring to stay employed. But it's only a matter of time before the bully identifies a new target. The bully infrequently[3] endures negative consequences. According to the Zogby International survey, the Target quits 40 percent of the time, the Target gets fired 24 percent of the time, and the Target transfers 13 percent of the time. The Bully is punished only 23 percent of the time. And 62 percent of employers ignore the problem altogether. According to the ISMP survey, only 39 percent of medical practitioners felt that their organization dealt effectively with intimidating behavior. Medical corporate cultures

Myth 6: There are legal protections against workplace bullying in the United States.

The United States remains the last among western democracies—to have no anti-bullying laws for the general workforce. If mistreated employees who have been subjected to abusive treatment at work cannot establish that the behavior was motivated by race, color, sex, sexual orientation, national origin, or age, they will likely find no legal protections against such mistreatment. According to the Zogby survey, workplace bullying is four times more prevalent in the United States than illegal harassment.

Myth 7: Bullying is just part of the medical culture necessary to maintain quality patient care.

According to the ISMP survey, a remarkable 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator. Forty-nine percent of respondents reported that intimidation had altered the way they handle order clarifications or questions about medication orders. Forty percent simply assumed that a questionable order was correct or asked another professional to speak with an intimidating prescriber. Seven percent reported being involved in a medication error in which intimidation clearly played a role.

At the release of a Sentinel Event Alert by the Joint Commission establishing a zero tolerance policy, Dr. Mark Chassin, President of JCAHO, stated: "The Joint Commission has maintained a database of serious adverse events for many years and in continuously analyzing those data, we find that failures of simple communication among caregivers underlie many, many of these adverse events. One of the most important barriers to good communication is the intimidating and disruptive behaviors we're talking about today.

The ignoble history of tolerance and indifference to intimidating and disruptive behaviors allows this type of behavior to go unchecked. By giving tacit permission, health care organizations are condoning workplace bullying. At last, the Joint Commission has insisted that enough is enough[4]. Safe patient care is dependent on trust, teamwork and a collaborative work environment among caregivers. The space for intimidating and disruptive behaviors shrinks daily for workplace bullies, no matter what their reasons and no matter who they are. Some have argued that the stress of delivering health care in life or death situations excuses the behavior of bullies. Yes, there are very real stresses in health care because the stakes are high, and health care professionals are often pushed to the breaking point mentally and physically. But responsible professionals agree that there's a right way and a wrong way to manage that stress."[5]

Intimidating and disruptive behaviors in no way contribute to quality patient care. Rather, they undermine patient safety and devastate staff morale.

Myth 8: There is nothing that can be done about bullying in the medical workplace.

Don't fall into the trap of believing that abuse in the medical workplace is a necessary evil that cannot be addressed. Each of us can make a difference: First, we can support laws that make health-harming workplace violence illegal. Second, we can support organizations in establishing and enforcing appropriate policies. Third, we can pay attention to those around us. There is safety in numbers and in unity. Bullies try to divide and conquer in order to exert their will. We can refuse to participant in their social manipulation tactics. We can ask questions, insist on answers, and verify facts when coworkers appear to be targeted. We can support ethical behavior. We can treat all of our fellow coworkers with the dignity and respect that they deserve. We as a community can and must demand that our medical workplaces become bully free zones.

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