

SENATE BILL 494**"An Act Providing for Remedies for Hostile Work Environments ..."**
Introduced by Representative J. Windy Boy

The level of physical, psychological and sexual abuse and intimidation in health care settings is alarming. The need for the violence prevention is well documented with research supporting that violence in health care settings is increasing and "may affect more than half of all workers" in the world's health systems. (DiMartino 2002) In 1998, OSHA reported assaults to workers in healthcare and social service industries were greater than any other industry. The Bureau of Labor Statistics reports an incident rate of 9.3 for health service workers from assaults or violent acts compared to a private sector rate of 2. The Bureau of Labor Statistics only includes fatal assaults and non-fatal assaults when injuries result in lost time from work. *Psychological violence is not reportable yet it is insidious and pervasive in the health care setting. The emerging studies on workplace safety are confirming that psychological violence is an even greater problem than physical assaults in the workplace.*

- The challenge for health care workers in rural and remote settings to address workplace violence and secure a healthy work environment is additionally challenged by factors such as isolation, lack of anonymity, lack of replacement staff, lack of privacy, and inadequate communication systems.
- Non-physical behaviors like bullying can be obscured and discounted; yet, the impact of threats and verbal abuse are profound and contribute to decreased productivity and psychological responses, including emotional distress and anxiety. The victimized worker experiences the aftermath of abuse as do clients, colleagues, family and friends.
- "The pressures on victims to remain silent are great. Traditionally, many cultures have covertly accepted physical violence, sexual harassment or verbal abuse against women. Also, nurses often passively accept abuse and violence as "part of the job"--an attitude sometimes shared by the public and judiciary. This has all led to underreporting and hampered the development of effective anti-violent strategies." (The International Council of Nurses 2000)
- The effects of workplace violence are observed on individual workers and their families and friends, organizations and business, government agencies, and the community at-large. The costs of violence and stress in the workplace are estimated to be 1% to 3.5% of the gross domestic product. (Hoel, Sparks and Cooper, 2001)
- "Workplace violence affects the dignity of millions of people worldwide. It is a major source of inequality, discrimination, stigmatization and conflict at the workplace. Increasingly, it is becoming a central human rights issue. At the same time, workplace violence is increasingly appearing as a serious, sometimes lethal threat to the efficiency and success of organizations. Violence causes immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment." (ILO/ICNC/WHO/PSI, 2002)
- The level of violence in health care "for those who deliver care and those who seek care constitutes an epidemic public health concern" (Kingma 2001, Hesketh 2003). The consequences of violence impacts heavily on the delivery of health services, the quality of health services, the decision of health care workers to leave their place of employment, increased cost of health care services, and the ability to recruit into professions.
- In 2002 and 2004 National Survey of RNs, 28% of nurses reported personally experiencing violence in the past year. This is a serious number especially when considered in light of additional studies that indicate 80% of assaults on RNs are not reported. According to OSHA "Incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the health care industry that assaults are part of the job".

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Lateral violence: Calling out the elephant in the room

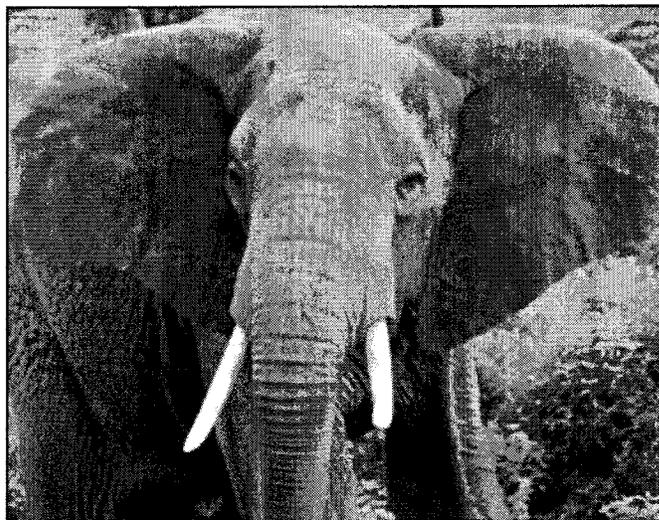
By Ann Kettering Sincox and Michelle Fitzpatrick, RN, MS, CPNP

For the last eight years, I've had the pleasure of being the MNA Consultant to the Michigan Nursing Students Association (MNSA) Board. Although each Board has had its own personality, there are some similarities. Individual members are all swamped with schoolwork. They are all amazed at what it takes to plan an annual convention. And, they all have horror stories of verbal abuse from some of the nurses they've met during clinical rotations.

And with good reason. Nursing students are one of the primary recipients of lateral violence, or nurse-to-nurse aggression. Whether it's considered hazing, or a rite of passage, ("This happened to me when I was a new nurse so I'm just passing it along.") or the real or perceived imbalance of power, nursing students are frequent targets of lateral violence. Cynthia Clarke PhD, RN notes that the consequences of lateral violence or incivility in nursing education include disrupted student faculty relationships, problematic learning environments, and increased student stress, as well as the potential for violence. In addition to nursing students, newly licensed nurses, along with newly hired nurses, temporarily assigned nurses, float nurses, and nursing assistants or aides also commonly experience the backlash of lateral violence.

In a recent presentation on lateral violence called "Incivility and Interactive Workplace Violence: Addressing Lateral Violence in Nursing," co-author Michelle Fitzpatrick, RN, MS, CPNP, noted that, "Lateral violence continues in nursing, because it can." Like "the elephant in the room," nursing

A new page has been added to the MNA website as a resource for those wishing to learn more about lateral violence. It can be accessed at www.minurses.org by clicking on "MNA Programs," then "Nursing Practice." Please send any resources that you find to Ann Kettering Sincox, Editor, at ann.sincox@minurses.org. Resources already posted include a master's thesis on lateral violence "Adult Bullying Within Nursing Workplaces: Strategies to Address a Significant Occupational Stressor" by Michele R. Haselhuhn, RN, BSN, MSN, CCRN, CEN, EMT-P and a link to a continuing education module on lateral violence from the American Nurses Association. An extensive biography used with this article is also available.



generally fails to acknowledge its existence. Some experts on the topic of lateral violence in nursing have even referred to the phenomenon of lateral violence as "nursing's dirty little secret." Educational institutions and healthcare organizations may also fail to acknowledge lateral violence, and frequently do not have measures in place to address it. Additionally, too often, there is a tendency to 'blame the victim'.

Lateral violence in nursing can consist of a variety of behaviors; from unintentional, thoughtless acts to purposeful, intentional, destructive acts meant to harm, intimidate or humiliate another group or individual(s). Lateral violence can range from random instances to a pattern of repeated behaviors. Collectively, these behaviors have the effect of creating an environment of hostility. Any time there exists a 'we versus they' attitude, or an imbalance of power, conditions are 'prime' for lateral violence to occur.

In its extreme form, lateral violence can manifest itself as bullying. Bullying, as defined by Barbara Coloroso (2003), is "a conscious, willful, and deliberate, hostile activity intended to harm, induce fear through threat of further aggression, and create terror" (p.13). Regardless of how bullying masquerades itself, three elements will always be present. These include an imbalance of power, an intent to harm, and the threat of further aggression. When bullying is left unchecked, a fourth element comes into play; terror in, or intimidation of the target.

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Lateral violence: Calling out the elephant in the room

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Martha Griffin, RN, PhD, a nationally recognized expert on lateral violence, has identified ten of the most common forms of lateral violence in nursing. These include:

- 1) Nonverbal innuendo
- 2) Verbal affront
- 3) Undermining actions; unavailability
- 4) Withholding information
- 5) Sabotage; "setting up to fail"
- 6) Infighting
- 7) Scapegoating
- 8) Backstabbing
- 9) Failure to respect privacy
- 10) Broken confidences

A recent editorial in *Critical Care Nurse* (June, 2007) also identified inequitable assignments, belittling gestures, unwarranted criticism, fault finding, segregation, isolation, and elitist attitudes regarding work area, education, and experience as additional expressions of lateral violence which denigrate an individual nurse's professional identity.

Lateral violence is tough on the body, too. The stress it creates can result in a number of physiological and psychological symptoms including: headache, stomach disorders, weight changes, hypertension, cardiovascular disease, stress, anxiety, panic, anger, embarrassment, depression, insomnia, fatigue and rumination. Post traumatic stress disorder (PTSD) can occur not only as the result of being a recipient of lateral violence, but also secondary to observing aggression being inflicted on to other nurses. Nurses suffering from lateral violence can have conflicts in intimate relationships, engage in substance abuse and experience social isolation and phobias. Ultimately, there may be a loss of income and career damage and in extreme cases, suicidal or homicidal thoughts and behaviors.

Lateral violence takes its toll on the workplace as well. In an article in *NurseWeek* (November 2006), Griffin stated that her "research shows that 60% of nurses new to practice leave their first positions within six months because of some form of lateral violence being perpetrated against them." Feelings of frustration and dissatisfaction contribute to decreased organizational commitment, and increased staff turnover and nursing shortages. Oftentimes there is increased absenteeism and stress related illnesses and, of course, decreased job satisfaction.

Patients are also harmed by unchecked lateral violence. Nurses stressed by the effects of a hostile environment are more likely to make errors. Dissatisfied nurses projecting their feelings onto others can also negatively impact patient satisfaction. When negative interactions among nurses are

witnessed or sensed by patients, lateral violence ultimately undermines patient trust in the health care team.

Calling Attention to the Elephant

In order to address and resolve lateral violence in nursing, we need to stop pretending that it doesn't exist. We must develop and implement measures to deal with the problem. Both short term interventions directed at problem resolution, as well as long term interventions directed at changing organizational culture are necessary. Griffin (2007) noted that a "zero tolerance", "top down-bottom up" approach is necessary to effectively address lateral violence in nursing. Nurse executives and nurse educators must set the example for respectful behavior. Furthermore they must hold individuals accountable for demonstrating respectful behavior both in the workplace, and in the academic and clinical learning environment. Staff nurses also must be empowered to speak up and help each other out. Too frequently individuals become bystanders, passively observing, or even ignoring the interactions going on around them. Nurses must seek support for each other.

The present generation of nurses is responsible for stopping the cycle of lateral violence from continuing into the next generation of nurses. Formal education sessions to increase awareness of the problem are necessary. First, we must name the problem and acknowledge its existence. But eventually, what must change are the group norms and values. Each nurse who feels they are a victim of lateral violence should keep accurate records to help document and track the problem. However, it's not enough just to keep good records. If there are institutional policies about lateral violence, those should be found and utilized if necessary. Workplaces must develop and formalize a system for reporting. Additional options to address lateral violence include creating workplace violence teams and developing or updating institutional policies.

A culture of safety is the ultimate goal; one which is characterized by a healthcare environment which encourages and permits open and respectful communication in order to ensure the provision of safe patient care.

"The myths that abound in our society about targets – weak and pathetic, frail, insecure, loner, in a 'dance' with the bully, asking to be bullied, had it coming, deserving of what they got, 'losers deserve to lose' – all feed into the rationalizations kids (and many adults) make for not putting the onus for the bullying on the bully, for joining in, for turning away from targets, or worse, for blaming the targets for what happened to them. No one deserves to be bullied." (Barbara Coloroso, *The Bully, the Bullied, and the Bystander*, 2003, p. 42) *

Bad behavior no longer acceptable

For every time you had to listen to a physician raise their voice in angry displeasure, for every time an upset patient complained to you that they overheard a doctor and a nurse were fighting in the hall, for every time you have lost your temper towards a co-worker – this article is for you. Change is around the corner - for everyone!

Recently the Joint Commission has taken a serious step towards controlling bad behavior among health care professionals. “Most health care workers do their jobs with care, compassion and professionalism,” said Mark R. Chassin, MD, MPP, MPH, president of the Joint Commission. “But sometimes professionalism breaks down and caregivers engage in behaviors that threaten patient safety. It is important for organizations to take a stand by clearly identifying such behaviors and refusing to tolerate them.”

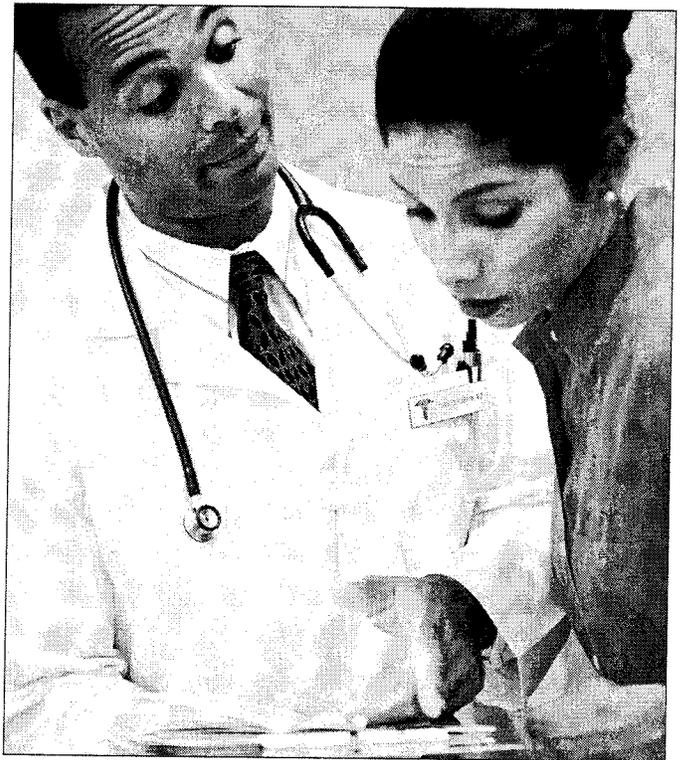
The Joint Commission is primarily concerned with what it defines as intimidating and disruptive behaviors: verbal outbursts, physical threats, reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. The preponderance of these behaviors creates an unhealthy and potentially hostile work environment. In the high stress area that is modern health care, allowing bad behavior can make pressure situations even tenser and lead to a general disintegration of professionalism.

The Joint Commission also points out the lack of comfort most health care professionals feel in whistleblowing. Physicians, especially those who bring in the higher dollars, seem to be “let off the hook” in many institutions. The Joint Commission Sentinel Alert points out that “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.’

All this has led to the Joint Commission issuing this standard: as of January 1, 2009, hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities, and behavioral health care facilities must have a code of conduct in place that determines which behaviors are tolerated and which are not, and creates a formal procedure for managing any unacceptable behavior.

The new code of conduct will cover 11 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



By January 1, 2009, hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities, and behavioral health care facilities must have a code of conduct in place that determines which behaviors are tolerated and which are not, and creates a formal procedure for managing any unacceptable behavior.

- and education should emphasize respect, include training in basic business etiquette (particularly phone skills) and people skills.
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.
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
 - a. “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.
 - b. Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive

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Bad behavior no longer acceptable

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- of the policies that are present in the organization for non-physician staff.
- c. Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
 - d. 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.
 - e. 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 that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.
 5. Provide skills-based training and coaching for all leaders and managers in relationship-building and resolution. Cultural assessment tools can also be used to measure whether or not attitudes changes 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.
 7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, 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. 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. 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. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.
 9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, 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.
 11. Document all attempts to address intimidating and disruptive behaviors.

Be sure to note number four, which requires nursing involvement! This new standard will affect more than 15,000 accredited health care organizations and there is every possibility that yours will be one of them. If you have been the victim of bad behavior perpetuated by co-workers or seen it in evidence, get involved with the process of implementing the new code of conduct at your workplace. This IS going to affect accreditation and it IS going to be taken seriously by health care organizations. Time is short - less than six months remain before the new standards must go "live" and every minute counts. Find out the personnel involved in this process, point to number four on the list of actions, and get involved! ❄

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