CE 1.5 ANCC Contact Hours

Professional Case Management
Vol. 23, No. 6, 294-306

The New Age of Bullying and Violence in Health Care: Part 4

Managing Organizational Cultures and Beyond

Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP

ABSTRACT

Disrespect among the health and behavioral health workforce may have reached the point of no return. The industry is on heightened alert, as the disruptive behaviors of bullying and lateral violence, plus escalating incidents of workforce harassment and workplace violence incidents, impact every practice setting. These behaviors contribute to concerns around client and professional safety, quality-of-care processes, as well as workforce retention and mental health.

Purpose/Objectives:
This article:

1. Defines a hostile workplace;
2. Identifies types of toxic employees;
3. Discusses types of workplace harassment;
4. Reviews the impact of organizational culture on these disrupters; and
5. Explores strategies and legislation to manage workplace violence across practice domains.

Primary Practice Setting(s): Applicable to all health and behavioral health settings where case management is practiced.

Findings/Conclusions: Despite glaring improvements in how care is rendered and an enhanced focus on quality delivery of care, organizations must address cultures that support as opposed to negate disruptive workplace behaviors. The emerging regulatory and organizational initiatives to reframe the delivery of care will become meaningless without consistent attention to enforcement of regulatory, policy, and prevention actions.

Implications for Case Management Practice: Professionals who hesitate to confront and address incidents of disruptive and oppressive behavior in the health care workplace potentially practice unethically. Bullying has fostered a dangerous culture of silence in the industry, one which impacts client safety, quality care delivery, plus has longer term behavioral health implications for the professionals striving to render care. Add the escalating numbers specific to workplace violence and the trends speak to an atmosphere of safety and quality in the health care workplace that puts clients and professionals at risk.

Key words: *bullying, earned respect, hostile work environment, mobbing, owed respect, toxic employees, sexual harassment, workplace harassment, workplace violence*

The final installment of "The New Age in Bullying and Violence in Health Care" series was originally targeted to focus only on managing an organizational culture of bullying, plus offer further strategies on workplace violence (WPV). Sixty-eight percent of executives identify bullying as a serious problem in their organizations, though, only about 5.5% actively do anything about it (Smith, 2013). Those persons exposed to bullying in the workplace, whether as target or victim, are twice as likely to commit suicide (Falzoi, 2016). Workplace homicides, in tandem, have risen significantly as high as 600% between 2015 and 2016 (Bureau of Labor Statistics, 2017). Increasingly brazen acts of WPV quickly appear over social media and then throughout the world. These are concerning numbers that mandate further attention by all professionals and organizational leaders.

However, workplace bullying and violence are not the only disruptive behaviors to invade the health care industry. A new generation of negative actions has arrived on the scene, pushing where that line in the sand marks a clear and present "no crossing" zone. The year of 2018 has seen the rise of the #MeToo movement across work sectors, especially health care.

Address correspondence to Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP, EFS Supervision Strategies, LLC (efssupervision@me.com).

The author reports no conflicts of interest.

DOI: 10.1097/NCM.0000000000000324

Despite glaring improvements in how care is rendered and an enhanced focus on quality delivery of care, organizations must address cultures that support as opposed to negate disruptive workplace behaviors. The emerging regulatory and organizational initiatives to reframe the delivery of care will become meaningless without consistent attention to enforcement of regulatory, policy, and prevention actions.

The literature is quickly amassing surveys and research that reveal no profession is immune from harassment, especially that which is sexual in nature. Other terminology has hit the workplace radar, that of mobbing, hostile work environment, and toxic employees. Understanding where bullying fits in the scope of these fresh framings is vital. To round out our scope, health and behavioral health settings are balancing state laws that secure the rights of persons to carry weapons with WPV safety and prevention protocols.

This Part 4 article goes far beyond the original scope to focus on the current and emerging landscape of workplace bullying and violence. Attention is on defining and distinguishing between hostile environments and toxic employees, the increased recognition and management of the types of harassment, naming organizational cultures and their relationship with harassment and bullying, as well as WPV and requisite legislation. Considerations for case management's interprofessional workforce are also discussed.

The New Workplace Landscape: Definitions and Distinctions

The past decade has seen the emergence of workplace challenges that include bullying but are not limited to bullying behaviors. The definition and growth of toxic employees within hostile environments add fury to the already smoldering fire of dysfunctional occupational behaviors. Add the highlighting of sexual harassment and oppression of women across sectors and the landscape has exponentially increased. This section defines and explores these newer trends to infect the industry.

Workplace Harassment

Workplace harassment is unwelcome conduct based on race, color, religion, sex (including pregnancy), national origin, age (40 years or older), disability, or genetic information. It is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967 (ADEA), and the Americans with Disabilities Act of 1990 (ADA). Harassment becomes unlawful where:

1. enduring the offensive conduct becomes a condition of continued employment, or
2. the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

Antidiscrimination laws also prohibit harassment against individuals in retaliation for filing a discrimination charge, testifying, or participating in any way in an investigation, proceeding, or lawsuit under these laws, or opposing employment practices that they reasonably believe discriminate against individuals, in violation of these laws (U.S. Equal Employment Opportunity Commission [EEOC], 2018a). This legislation extends to whistleblowers who initiate dialogues with supervisors, leadership, and human resources about bullying, unethical or related behaviors.

Under the law, employers are automatically liable for harassment by a supervisor that results in a negative employment action such as termination, failure to promote or hire, and loss of wages. Examples that come to mind include when the staff are not promoted on the basis of their professional discipline alone or potentially not judged on the merits of their qualifications for a position (e.g., degree, case management training, certification, Interqual training).

Professionals who hesitate to confront and address incidents of disruptive and oppressive behavior in the health care workplace potentially practice unethically.

Types of Workplace Harassment

Twenty percent of American workers find the workplace hostile or threatening, which includes situations marked by sexual harassment and bullying (Wiseman, 2017). Table 1 presents the two basic types of unlawful harassment, Quid Pro Quo or Hostile Work Environment Harassment (United States Department of Labor, 2018). An employer can be liable for one of the two types of harassment by nonsupervisory employees or nonemployees over whom it has control (e.g., independent contractors or customers on the premises) if it knew, or should have known, about the harassment and failed to take prompt and appropriate corrective action. When a supervisor's

TABLE 1
Types of Workplace Harassment

Types of Workplace Harassment	Definition/Explanation
Quid Pro Quo—"This for That"	• Generally results in a tangible employment decision based upon the employee's acceptance or rejection of unwelcome sexual advances or requests for sexual favors but can also result from unwelcome conduct that is of a religious nature. • Generally committed by someone who can effectively make or recommend formal employment decisions (such as termination, demotion, or denial of promotion) that will affect the victim. *Examples*: • Supervisor who fires or denies promotion to a subordinate for refusing to be sexually cooperative • Supervisor requires a subordinate to participate in religious activities as a condition of employment • Supervisor offers preferential treatment/promotion if subordinate sexually cooperates or joins supervisor's religion
Hostile Work Environment Harassment	• Can result from unwelcome conduct of supervisors, coworkers, customers, contractors, or anyone else with whom the victim interacts on the job, and • The unwelcome conduct renders the workplace atmosphere intimidating, hostile, or offensive *Examples of behaviors that may contribute to an unlawful hostile environment include*: • discussing sexual activities; • telling off-color jokes concerning race, sex, disability, or other protected bases; • unnecessary touching; • commenting on physical attributes; • displaying sexually suggestive or racially insensitive pictures; • using: ◦ demeaning or inappropriate terms or epithets, ◦ indecent gestures, ◦ crude language, • sabotaging the victim's work; and • engaging in hostile physical conduct.

Note. From United States Department of Labor (2018).

harassment results in a hostile work environment, the employer can avoid liability only if it can prove:

1. it reasonably tried to prevent and promptly corrected the harassing behavior; and
2. the employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer. (EEOC, 2018a)

Maintaining accurate documentation is vital strategy in these situations. Prevention is equally identified as a solid tool to minimize and ultimately eliminate harassment in the workplace. The onus is always on the employer to take the necessary steps to prevent and correct unlawful harassment, though therein lies the chronic challenge.

Sexual Harassment

There is agreement across the industry that the focus on sexual harassment by the #MeToo movement has increased awareness, identification, and reporting of incidents. Sexual harassment can include:

- unwelcome sexual advances,
- requests for sexual favors, and
- other verbal or physical harassment of a sexual nature.

One important point that bears addressing involves how harassment does not have to be of a sexual nature, though it can include offensive remarks about a person's sex. For example, it is illegal to harass any woman by making offensive comments about women in general. It is against the law to harass any applicant or employee because of that person's sex (EEOC, 2018b).

A task force convened by the EEOC (2016) filed the *Report of the Co-Chairs of the EEOC Select Task Force on the Study of Harassment in the Workplace*. Approximately one third of the 90,000 charges received by the EEOC in fiscal year 2015 included an allegation of workplace harassment. This included among other things:

- charges of unlawful harassment on the basis of sex (including sexual orientation, gender identity, and pregnancy),
- race,
- disability,
- age,
- ethnicity/national origin,
- color, and
- religion.

The Evidence

Data from the EEOC survey identified 85,257 reports of sexual harassment across workforce sectors from the years 2005–2015 (EEOC, 2016). Of the total number of reports, 4,738 cases alone were in the health care and social assistance field. This number ranked among the largest areas and was only eclipsed by the retail and manufacturing fields, 5,547 and 4,838, respectively (Jewett, 2018). Although the

report focuses on data compiled from across sectors, the findings are universal. Box 1 provides the key findings of the report.

A poll conducted by IPSOS for National Public Radio recently explored to what extent Americans have personally dealt with or encountered harassment in the workplace (IPSOS, 2017). Forty-four percent of Americans think it is inevitable that men will "hit on" women at work. A clear majority (86%) believe that a zero-tolerance policy for sexual harassment is essential to bringing about change in how society addresses the dynamic (IPSOS, 2017; Kurtzleben, 2018).

Despite the popularity of the #MeToo movement and other related initiatives, the health care industry has been slow to acknowledge the prevalence of sexual harassment. Experts cite that this fact is caused by an industry culture steeped in power (Evans, 2018; Fink-Samnick, 2016; Jewett, 2018). However, recent surveys have validated attention to the numbers posed by the EEOC and others, plus the need for attention to the problem. Increasing numbers of lawsuits are being vetted and tackled, juries across the country responding with considerable anger toward these allegations (Evans, 2018). Although one out of four women experience workplace harassment, up to 94% of women never file a complaint (EEOC, 2016).

Most if not all codes of ethics for health care's transdisciplinary workforce explicitly forbid sexual relationships between supervisors and subordinates, citing these dual relationships as potentially exploitive in nature, even if they are consensual (American Medical Association, 2017; American Nurses Association, 2015a, 2015b). Close to 15% of medical students report being subjected to offensive sexist remarks or names, with 4% of them being the victim of unwanted sexual advances. Another 6% of medical students believe they received lower evaluations or grades strictly related to their gender (Murphy, 2018). Fifty-nine percent of respondents in one study reported decreased self-worth and loss of confidence in themselves as professionals when faced with sexual harassment situations (Evans, 2018). These events impact staff health and morale plus client safety, with broader consequences that yield an overall toxic work environment.

Toxic Employees

Toxic employees may include those who are bullies, as well as other types of grueling personalities and behaviors. Employees who are toxic are more than simply rude, but de-energizing, antagonistic, and frustrating. Their behaviors impact each member of any team they serve on and every colleague they interact with. Some experts claim that even the most functional workplaces can have employees whose behaviors have a negative impact on the other staff members and customers (Levin, 2018; Porath, 2016). These behaviors are common and impact every practice setting and are commonplace in health care environments. The case manager who rolls her eyes when colleagues speak at team meetings for longer than she expects can impose a judgmental, if not toxic, influence on team dynamics and processes. Consider the program manager who repeatedly challenges every decision made by the line staff, presenting as overly assertive to the point of aggressive. Table 2 presents the six types of toxic employees (Levin, 2018).

One of the challenges with toxic employees is separating them from other staff members. In this way, the negative behaviors can be isolated rather than infecting anyone and everybody. The toxic energies can be limited to a single employee, with other staff members

BOX 1
Key Findings of the EEOC Select Task Force on the Study of Harassment in the Workplace

- *Workplace harassment remains a persistent problem*: Roughly one third of the approximately 90,000 charges received by the EEOC in fiscal year 2015 included an allegation of workplace harassment.
- *Workplace harassment too often goes unreported*: Roughly *three out of four* individuals who experienced harassment never even talked to a supervisor, manager, or union representative about the harassing conduct. Employees who experience harassment fail to report the harassing behavior or to file a complaint because they fear disbelief of their claim, inaction on their claim, blame, or social or professional retaliation.
- *There is a compelling business case for stopping and preventing harassment*: When employers consider the costs of workplace harassment, they often focus on legal costs. The EEOC alone recovered $164.5 million for workers alleging harassment. Workplace harassment affects *all* workers, and its true cost includes decreased productivity, increased turnover, and reputational harm. All of this is a drag on performance—and the bottom line.
- *It starts at the top—Leadership and accountability are critical*: Workplace culture has the greatest impact on allowing harassment to flourish or, conversely, in preventing harassment. Effective harassment prevention efforts, and workplace culture in which harassment is not tolerated, must start with and involve the highest level of management of the company.
- *Training must change*: Much of the training done over the last 30 years has not worked as a prevention tool—It has been too focused on simply avoiding legal liability. Effective training cannot occur in a vacuum—It must be part of a holistic culture of nonharassment that starts at the top.
- *New and different approaches to training should be explored*: Creative new models that focus on both direct and bystander harassment training.
- *It's on us*: Harassment in the workplace will not stop on its own—It is on all of us to be part of the fight to stop workplace harassment. We suggest exploring the launch of an *It's on Us* campaign for the workplace.

Note. From EEOC (2016).

TABLE 2
The Six Types of Toxic Employees

Six Primary Antagonists	Behaviors
Slacker	• Master procrastinator • Passes responsibilities to others • Makes excuses for work incompletion
Bully	• Overly aggressive with coworkers • Uses power, position, and personality to achieve results
Gossip	• Creates drama via spreading rumors • Tries to be in everyone's business
Lone wolf	• Antithesis of a team player • Often claims "That's not my job", or "I can do it myself"
Emotional mess	• Uses work environment as a therapist's office • Brings emotional baggage into the workplace • Challenges managing stress
Closed-minded know-it-all	• Resistant to learn new work strategies • Sets in ways that may or may not be effective

Note. From Levin (2018).

immunized, if not also protected. Coaching employees on how to minimize their interactions and maintain boundaries from toxic personnel is a vital management strategy (Porath, 2016). Being able to distance oneself from toxic talk in an organization is a necessity.

The Evidence

Toxic employees cost organizations millions of dollars annually. A Harvard Business School study of more than 60,000 employees found that a high-performing hire (e.g., one that models desired values and delivers consistent performance) brings in more than $5,300 in cost savings to a company. Avoiding a toxic hire, or letting one go quickly, delivers $12,500 in cost savings (Houseman & Minor, 2015).

Studies have shown that more than 50% of employees who work with toxic colleagues decreased their work effort and intentionally spent less time at work. Thirty-eight percent of higher functioning staff members intentionally reduced the quality of their work. Another 25% of employees who were exposed to incivility and toxic personalities in the workplace admitted to taking their frustrations out on customers (Levin, 2018). Imagine the implications of this action in health care. A case manager deals with a toxic colleague and then displaces her frustration by yelling at an unsuspecting client or his or her family member.

Toxic staff members alienate colleagues and team members. Interprofessional communication and collaboration are competencies that directly impact the quality outcomes of case management processes. Imagine the impact of any of the following outcomes identified from working with toxic employees:

- Eighty percent lost work time worrying about the offending employee's rudeness.
- Seventy-eight percent said their commitment to the organization declined because of the toxic behavior.
- Sixty-six percent said their performance declined.
- Sixty-three percent lost work time in avoiding the offending employee. (Levin, 2018)

Workplace Mobbing

Mobbing refers to when a group of workers, rather than a single worker, engage in hostile behavior. The perpetrators may be colleagues, superiors, or subordinates of the target(s) and collectively make life difficult in a concerted fashion. The behaviors engaged in by the group are marked by nonsexual harassment and involve individual, group, and organizational dynamics. Ultimately, the actions amount to emotional abuse by coworkers of a fellow employee or employees (Gresham, n.d.; Henshaw, n.d.). With the definitions of bullying and mobbing so closely aligned, there can easily be confusion among the terms. Table 3 provides the opportunity to compare and contrast the definitions of workplace bullying, lateral violence, and workplace mobbing.

Mobbing is witnessed on a daily basis in health care organizations, often prompting high levels of emotion and anxiety in the workplace. Those involved create an atmosphere marked by high levels of harassment and discomfort. Their actions prompt the target(s) to frequently call out sick or leave the workplace permanently. Mobbing can easily take up residence in a department, making the target(s) feel isolated, or potentially feel they can no longer dialogue with others. Examples involve staff spreading rumors about how their manager engaged in an embarrassing argument with the medical director or was "totally ineffective" in advocating for the staff.

Mobbing can easily be triggered by a desire to devalue colleagues, as when groups of case managers of one professional discipline broadcast misinformation about the limited clinical knowledge of other colleagues throughout the facility. Situations involving misunderstanding the unique value of members of the interprofessional workforce easily fuel mobbing. Perhaps, a manager shares "concerns' with a case manager's coworkers about his or her dating patterns or even sexuality preferences. What results is an emotional and psychological terrorism that runs rampant through the department, if not the organization (Yamada, Duffy, & Berry, 2018, p. 3; Gresham, n.d.; Henshaw, n.d.; LegalMatch, 2018).

TABLE 3
Definitions of Workplace Bullying, Lateral Violence, and Workplace Mobbing

Term	Definition
Workplace bullying (Workplace Bullying Institute, 2018)	• The repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. It is marked by abusive conduct that is: ◦ threatening, humiliating, or intimidating, or ◦ work interference—sabotage—which prevents work from getting done, or ◦ verbal abuse.
Lateral violence (US Legal, 2018)	• When two people who are both victims of a situation of dominance turn on each other rather than confront the system, which oppressed them both. • Whether individuals and/or groups, those involved internalize feelings such as anger and rage, and manifest those feelings through behaviors such as gossip, jealousy, putdowns, and blaming.
Workplace mobbing (Yamada et al., 2018, p. 8)	• Nonsexual harassment of a coworker by a group of members of an organization for the purpose of removing the targeted individual(s) from the organization or at least a particular unit of the organization. • Involves individual, group, and organizational dynamics. • Results in humiliation, devaluation, discrediting, and degradation; loss of professional reputation and, often, removal of the victim from the organization through termination, extended medical leave, or quitting. • The results involve financial, career, health, and psychosocial losses or other negative consequences.

Industry Evidence

Numbers from the Workplace Bullying Institute Survey show increasing incidence of mobbing, occurring approximately 37% of the time in organizations (Workplace Bullying Institute, 2017). The prevalence in health care settings is of paramount focus. Concerning implications from mobbing abound for the workforce that include low job satisfaction and morale. Fifty-eight percent of primary care professionals were exposed to mobbing behaviors at least once, as well as one out of five nurses (Erdogan & Yildirim, 2017).

Workplace Disrespect

A recent survey of 20,000 employees throughout the world ranked respect as the most important leadership behavior (Rogers, 2018). Yet, despite this fact, disrespectful behaviors against employees are increasingly reported on an annual basis. The correlation between respect and bullying, or incivility, has received expanded attention in the literature.

Types of Workplace Respect

Two types of respect are named in the literature: owed and earned. *Owed respect* is accorded equally to all members of a work group or an organization; it meets the universal need to feel included. Owed respect is marked by civility and an atmosphere that suggests every member of the group is inherently valuable. Workplaces marked by this type of respect are those most professionals strive to be employed in. Consider the organization that financially supports case management staff attending professional conferences annually. The leadership also budgets for continuing education product subscriptions for the entire department to support licensure and certification requirements. In addition, the department director and the physician advisor model mutual respect through their interactions with every staff members in the organization. Their mantra of "treat others as you wish to be treated" is followed to the letter.

In contrast, *earned respect* recognizes individual employees who display valued qualities or behaviors. This type of respect distinguishes those employees who have exceeded expectations and affirms that each employee has distinctive strengths and abilities. Earned respect meets the need to be valued for doing quality work. Signs that this type of respect is lacking in an environment are when any staff member becomes a credit hog, the supervisor who assumes credit for another colleague or staff member's success or fails to recognize his or her employees' achievements (Rogers, 2018). Imagine the manager for a case management department who takes the time each month to highlight employees who exceed thresholds for their assigned outcomes. These staff members will be more grateful and loyal to their employer, potentially perform better, and be more likely to take direction from their department manager. Workforce retention will also most likely be higher.

In exploring the literature on the types of respect, this quote caught my attention. It eloquently summed up the value of respect as readily as any successful outcomes:

> Respect is like air. As long as it's present, nobody thinks about it. But if you take it away, it's all that people can think about. The instant people perceive disrespect in a conversation, the interaction is no longer about the original purpose—it is now about defending dignity. (Patterson, Grenny, McMillan, & Switzler, 2011, p. 79)

Industry Evidence

Environments with segmented hierarchies and power, such as those in health care, are prone to overmonitoring

or micromanagement (Rogers, 2018). As a result, these settings lend themselves to increased incivility, disrespect, as well as abuse of power, which is akin to bullying (Fink-Samnick, 2016; Porath, 2016). Staff members become viewed as replaceable objects, as opposed to persons with uniquely appreciated skills and talents. Eighty percent of employees treated disrespectfully and uncivilly spend a majority of work time ruminating on the bad behavior. Forty-eight percent of employees will deliberately reduce their efforts when faced with disrespectful colleagues. In addition, discourteous treatment can easily spread like contagion among a department and will be taken out on any and all stakeholders (Rogers, 2018).

Organizational Culture and Implications

The intense challenge of how to best manage an organizational culture of bullying has grasped the attention of the industry. Many professionals view bullying as an extension of a more pervasive organizational culture, one that seeks to enable disruptive behaviors more than negate them (Fink-Samnick, 2015). These behaviors set a tone for the organization that discount case management's ethical tenets of advocacy, beneficence, fidelity, justice, and nonmalfeasance (Case Management Society of America, 2016; Commission for Case Manager Certification, 2015). In contrast, a clear message is conveyed that promotes disregard for the sanctity of the human condition and denigrates personal and professional integrity.

Employers marked by climates that reflect fear, insecurity, and disbelief tend to have a higher incidence of bullying. Corporate cultures and working conditions can easily play a large role in encouraging an atmosphere that enables abuse and endorses bullying and mobbing behaviors. Companies may explicitly reward aggressive behavior by promoting any individuals who bully others; it can simply present to the C-suite that these persons get the job done. However, know that these efforts to move processes forward are fraught with dysfunctional dynamics and relationships. A message is sent that indirectly perpetuates abuse by encouraging ruthless competition or by neglecting to take bullying and harassment complaints seriously (Koenig, 2017; Vize, 2018).

Energies must be dedicated to advance formal guidelines and procedures that address the various dimensions of bullying in the workplace. More than 60% of organizations have no policies in place to manage these situations (Morgan, 2014). One glaring example in health care was the toxic culture that was allowed to permeate at the National Health Service (NHS) in Liverpool, England. Inexperienced and inadequate management teams took the helm of the NHS, with disastrous results. Although their strong leadership efforts reduced operating costs, the clinical quality was not up to par. As a result, there was an increased incidence of illness and other occurrences (e.g., falls, bedsores, extractions of the wrong teeth). The staff felt powerless to comment and were unable to address any of their concerns about the care rendered. Reports identify that the only thing worse than the quality of care was the mistreatment of the staff, many who were subject to bullying and harassment. Ultimately, reorganization and restructuring of operations at the NHS took place, with the full tally of the expense ongoing (Vize, 2018).

Workplace cultures are framed by clear values, beliefs, customs, and norms. Table 4 categorizes four types of workplace organizational cultures that impact bullying within health care (An & Kang, 2016; Fink-Samnick, 2016; Han, 2002; Nesbitt, 2012). The research on this topic yielded considerable food for thought and interesting implications on the role played by each of the cultures presented.

Faas (2017) frames an alternate perspective of three unique organizational cultures across sectors:

- *Dictatorial culture*: It relies on power and control, with high levels of secrecy and jealousy. There is

TABLE 4
Organizational Cultures and Impact on Bullying

Organizational Culture	Definition
Hierarchy-oriented	*Focus*: Characterized by high degrees of control, formalization, and rivalry *Key values*: Authority, obedience, order, stability, and strictness Mixed evidence across the literature about contribution to bullying, with the hierarchical nature of health care cited as a major influencer of bullying.
Innovation-oriented	*Focus*: Marked by flexibility and change of organization *Key values*: Change and creativity, educational support, a mind-set of trial and error, and dynamicity Mixed views on the impact toward bullying. A constant state of flux can empower bullying whereas the dynamic and creative nature of the work environment can limit it.
Task-oriented	*Focus*: High priority on the productivity and goals of the organization *Key values*: Competition, goal directness, outcomes Organizational and employee structure may precipitate bullying in some health care environments while minimizing occurrence in others due to clear role delineation.
Relation-oriented	*Focus*: High levels of interpersonal relationships *Key values*: Mutual trust and respect, strong collaborative relationships Most effective culture to mitigate bullying.

Note. From An and Kang (2016); Han (2002); Nesbitt (2012).

little room for positive relationships to be built among and by employees.
- *Disjointed culture*: It lacks core values and checks and balances on power. It can appear hierarchical and bureaucratic, with little consistent enforcement and emotional reactions common to handle conflicts.
- *Stable culture*: It provides clear goals, rules, and values for employees, along with clear communication patterns.

The type of organizational culture can influence how readily an entity is able to prevent and respond to bullying, if not also eliminate it (Faas, 2017). The ways that accountability for organizational culture and workplace behaviors are managed will continue to warrant attention by the industry to ensure more positive operations. However, one thing is certain; organizations must first acknowledge these disruptive dynamics exist in their space. Only then can there be the necessary level of shared commitment to create and enforce anti-bullying and harassment policies, instill trust in the workplace, plus offer prevention programs to employees that minimize future occurrences.

Workforce Considerations

Since I wrote Part 1 article of this series (Fink-Samnick, 2015), countless colleagues have approached me to share their perspectives and experiences on bullying. Some continue to challenge that leaving the organization is the only way to successfully cope with the negative occupational experience. In other instances, although leaving may be necessary it is a more difficult choice. Not everyone is in a position to exit his or her employer. Survival is always a matter of individual choice, amid a weighing of critical factors. Many professionals have valued years invested in organizations, where leaving before retirement age can negatively impact their pension. A number of persons loudly profess nothing will change and feel they are left little choice but to stay the course and deal with the unfortunate reality of the bullying behaviors. Others have reached out to share painful stories of how they took demotions when making the tough decision to leave a role, at times for the sake of their mental health. Although anti-bullying, sexual harassment legislation, and professional initiatives have continued to advance, the journey for a majority still involves being forced to make untenable choices.

Another intriguing theme presented to me; how often staff members rationalize their poor performance by blaming it on mislabeled bullying behaviors of colleagues and bosses. For example, a new manager updates job functions and expectations for the case managers. Among the performance expectations are clear deadlines for deliverables on monthly and quarterly outcomes. Because the expectation is new, one staff member views the action as an incidental task. As a result, the work is not completed, the case manager is counseled and then written up. Rather than accept accountability for not fulfilling the performance expectation, the case manager diverts the blame for his own shortcoming back onto the manager. The manager is mislabeled a bully,

*** Editorial note: this is an original figure, content used is as cited.

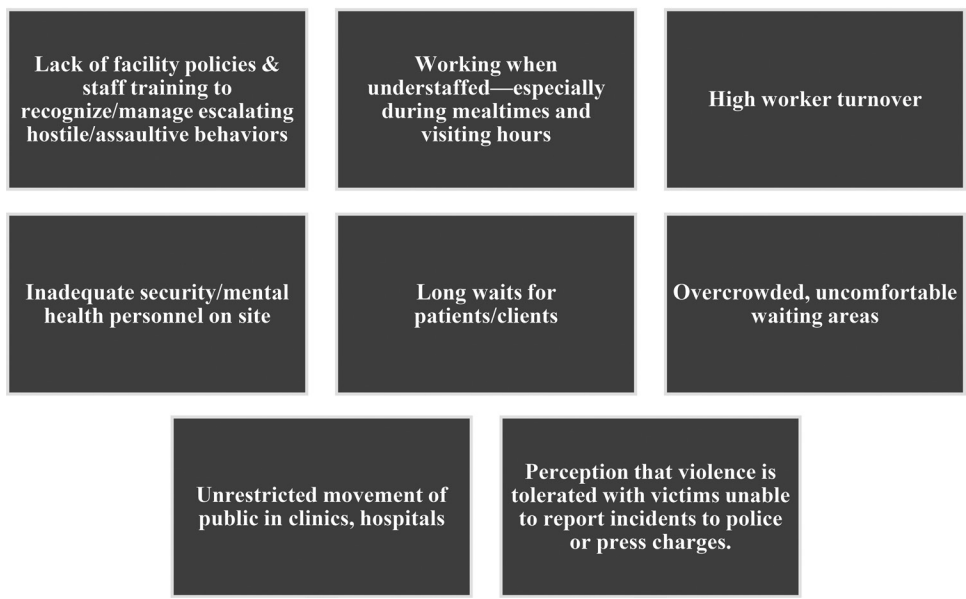


FIGURE 1
Organizational risk factors. From Occupational Safety and Health Administration (2015).

BOX 2
The Joint Commission Sentinel Event Alert 59: Physical and Verbal Violence Against Health Care Workers Recommendations

1. Clearly define workplace violence and put systems into place across the organization that enable the staff to report workplace violence instances, including verbal abuse.
2. Recognizing that data come from several sources. Capture, track, and trend all reports of workplace violence—including verbal abuse and attempted assaults when no harm occurred.
3. Provide appropriate follow-up and support to victims, witnesses, and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.
4. Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence, and worksite conditions, to determine priority situations for intervention.
5. Develop quality improvement initiatives to reduce incidents of workplace violence.
6. Train all staff members, including security, in de-escalation, self-defense, and response to emergency codes.
7. Evaluate workplace violence reduction initiatives.

Note. From The Joint Commission (2018).

with the rumor spreading like wildfire through the organization. The rumor unfortunately diverts attention from the performance issue at hand, the failure of the case manager to complete assigned job functions. This event demonstrates how easily the dynamics discussed in this section (e.g., bullying, toxic workplace culture, harassment) can be misused and misunderstood.

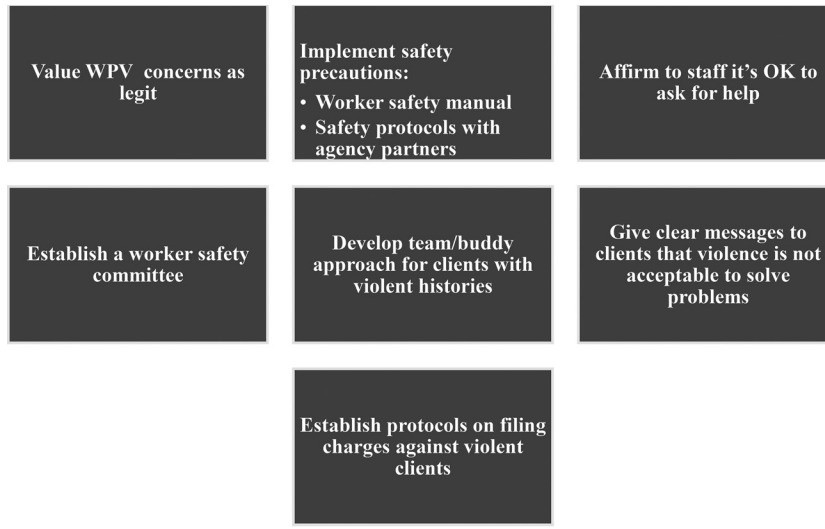
Organizational Focus on Workplace Violence

Although a broad swipe of the topic of WPV was presented in Part 1 (Fink-Samnick, 2015), the times have yielded critical information to impart. Some 2 million workers in the United States are victims of WPV per year. Seventy-five percent of the incidents annually occur in a health care or social services setting (Occupational Safety and Health Administration [OSHA], 2015). Studies show that violence in emergency departments often goes unreported, especially if no staff members are hurt. As high as 64% of staff members view violence as a part of the job (Copeland & Henry, 2017). It is especially concerning to see workplace homicides up 600% from 2015 to 2016, now to more than 500 distinct occurrences (Bureau of Labor Statistics, 2017).

The OSHA (2015) details risk factors endemic to health care organizations, which are presented in Figure 1. In the effort to further assist those organizations to better prevent and address violence in their work spaces, The Joint Commission released a new Sentinel Event Alert in April 2018 to inform about physical and verbal violence against health care workers. As the entity responsible for accrediting and certifying health care organizations and programs in the United States, The Joint Commission took an especially strong stance. From its vantage, every episode of violence or credible threat to health care workers warrants notification to leadership, internal security, and as needed law enforcement. Incident reports should be completed to analyze the events and inform actions to be undertaken. The numbers continue to be alarming, with 75% of aggravated assaults and 93% of all assaults against health care workers attributed to clients or customers of the organization. The sentinel alert affirms that no health professional is immune from either physical or

**Editorial note: content in boxes from citation; figure is original.

FIGURE 2
Promote workplace safety: Home and community visits. From Blank (2006).



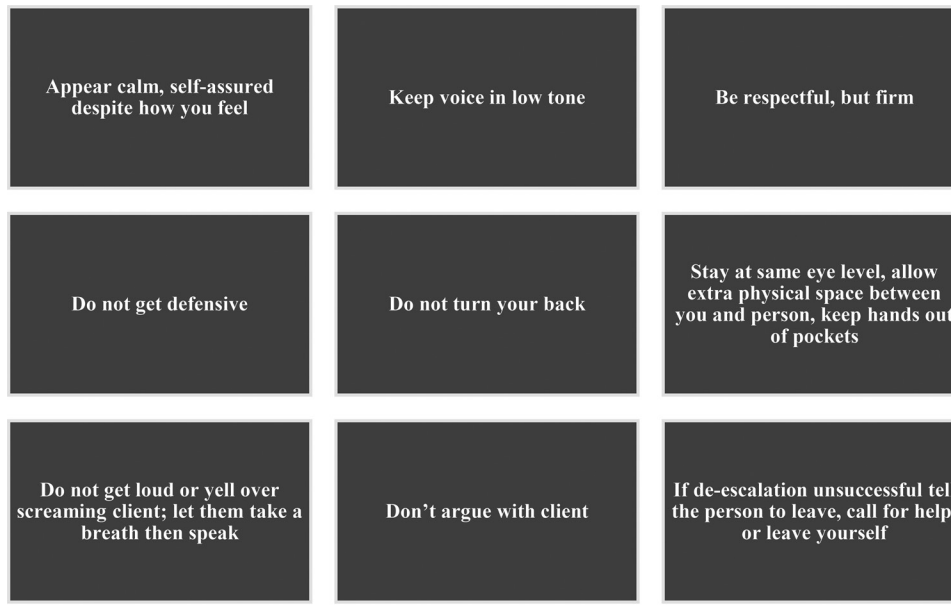
** Editorial note: content in boxes from citation; figure is original

FIGURE 3
Promote workplace safety: Organization and agency accountability. WPV = workplace violence. From Blank (2006).

verbal assault. The actions recommended in the alert are presented in Box 2.

With case managers present across every practice setting, diligence to prevention tactics that promote safety is essential. The workforce can be overly trusting, with threats easily minimized. When the clinical gut of any health or behavioral health professional screams, it should be heeded. Occupational hazards do exist and should never be ignored. These are not the times to play martyr or think that being hypervigilant conveys weakness. A number of health and behavioral health professionals have lost their lives in 2018 alone, with the vital reminders to self-protect and be mindful in all areas of practice. Figures 2 and 3 provide strategic guidance on how to promote workplace safety across the domains of:

- home and community visits, and
- organizations and agencies.



** Editorial note: content in boxes from citation; figure is original

FIGURE 4
Promote workplace safety: De-escalation strategies. From Blank (2006).

BOX 3
Where Can Clients Legally Carry a Gun?

State with "open carry" laws, do not allow weapons everywhere

- Colleges and universities decide if firearms are allowed on campus.
- No weapons are allowed in places of worship without "good and sufficient reason."
- No guns allowed in:
  - courthouses;
  - post offices or their parking lots;
  - federal properties,
  - any building or office space owned, leased, or rented by the federal government;
  - federal prisons;
  - national cemeteries; and
  - military bases.

Private property rights traditionally override second amendment rights:

- When on private property, gun owners are required to put the weapon away if asked.
- Businesses can hang signs that state "guns not allowed" on the property.

Note. From Guns to Carry (2018); Kavanaugh (2016).

There are a number of de-escalation strategies that can be used when working with clients, or others who present as a danger to the staff or the public, independent of the work site. These strategies are presented in Figure 4.

Managing Weapons

New levels of scrutiny and concern exist across society regarding weapons management and security, particularly in the health care workplace. Emergency departments, community agencies, and urgent care clinics have witnessed their share of violent events. These acts may be by clients who bring weapons into the care facility or family members disgruntled with care who attack providers. There have been several recent situations where former professional staff who were fired from a site return for retribution. The new era of laws allowing persons to carry weapons has broached concern by those on the front lines of care, especially whether or not they can ask persons to leave weapons (e.g., guns, knives) outside of the facility. Clear laws and regulations guide actions so that professionals, their organizations, and all stakeholders are assured a safe work environment. Box 3 provides a summary of these regulations. Professionals are encouraged to review their individual state gun laws (Guns to Carry, 2018; Kavanaugh, 2016).

…long-lasting change will only be achieved if the issues are addressed by the workforce as a whole. Otherwise, the efforts to propel change become siloed, which perpetuates the hierarchical system that helped create the negative behaviors in the first place.

On to Action

Workplace bullying, harassment, and violence are interprofessional sports; everyone plays and nobody gets to sit out. None of the disrupters discussed in this article discriminate. Specific to workplace bullying and harassment, the individual focus and attention given the topic by each discipline are valued. However, long-lasting change will only be achieved if the issues are addressed by the workforce as a whole. Otherwise, the efforts to propel change become siloed, which perpetuates the hierarchical system that helped create the negative behaviors in the first place.

The #MeToo movement has reinforced the importance to speak up against harassment of all types, especially the oppressive behaviors that leverage all forms of bullying. Power is a primary factor in health care organizations. It embeds itself within the fabric of the organizational culture and manifests as misused power, which has less than optimal side effects. For those members of the workforce who have been reluctant to stem the tide and advocate for necessary change, the time is now. Time is clearly up in every sector: Every gender and professional must take a stand.

As for WPV, there must be consensus of the severity of this disrupter by the industry as a whole. Every organization must be committed to prioritize the workforce and their safety, plus actively guarantee that standards of practice are consistently enforced and complied with. Although unpredictable occurrences will take place, there must always be attention to developing a culture of awareness that fosters active education on workplace safety for each department and practice setting and across the transitions of care. Continuing education must acknowledge that WPV happens, with proactive means to endorse a culture that prioritizes the security and risk of the workforce. A professional workforce not prioritized will cease to be able to prioritize the needs of its clients and consumers.

Continuing education must acknowledge that WPV happens, with proactive means to endorse a culture that prioritizes the security and risk of the workforce.

References

American Medical Association. (2017). *Sexual harassment in the practice of medicine, Code of Medical Ethics Opinion 9.1.3*. Retrieved July 6, 2018, from https://www.ama-assn.org/delivering-care/sexual-harassment-practice-medicine

American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.

American Nurses Association. (2015b). *Incivility, bullying and work place violence, nursing world*. Retrieved October 28, 2015, from http://www.nursingworld.org/Bullying-Workplace-Violence

An, Y., & Kang, J. (2016, September). Relationship between organizational culture and workplace bullying among Korean nurses. *Asian Nursing Research*, *10*(3), 234–239.

Blank, B. T. (2006). Safety first: Paying heed to and preventing professional risks. *The New Social Worker*. Retrieved, April 2, 2018, http://www.socialworker.com/feature-articles/careerjobs/Safety_First%3A_Paying_Heed_to_and_Preventing_Professional_Risks

Bureau of Labor Statistics. (2017). *Census of fatal occupational injuries, 2016*. Retrieved January 8, 2018, from https://www.bls.gov/news.release/cfoi.toc.htm

Case Management Society of America. (2016). *CMSA standards of practice for management*. Little Rock, AR: Author.

Commission for Case Manager Certification. (2015). *The code of ethics and professional conduct for case managers*. Mount Laurel, NJ: Author.

Copeland, D., & Henry, M. (2017, March–April). Workplace violence and perceptions of safety among emergency department staff members: Experiences, expectations, tolerance, reporting, and recommendations. *Journal of Trauma Nursing*, *24*(2), 65–77.

Erdogan, V., & Yildirim, A., (2017). Healthcare professionals' exposure to mobbing behaviors and relation of mobbing with job satisfaction and organizational commitment, *Procedia Computer Science*, *120*, 931–938.

Evans, G. (2018, March 1). #MeToo in medicine? Sexual harassment in HEALTHCARE. *Relias/AHC Media*. Retrieved July 6, 2018, from https://www.ahcmedia.com/articles/142185-metoo-in-medicine-sexual-harassment-in-healthcare

Faas, A. (2017). *From bully to bull's eye: Move your organization out of the line of fire*. Toronto, Ontario, Canada: RCJ Press.

Falzoi, D. (2016). New study shows that prolonged exposure to workplace bullying can lead to suicide—and it can happen to anyone. *MA Healthy Workplace Bill*. Retrieved February 9, 2018, from https://mahealthyworkplace.wordpress.com/2016/04/24/new-study-shows-that-prolonged-exposure-to-workplace-bullying-can-lead-to-suicide-and-it-can-happen-to-anyone

Fink-Samnick, E. (2015). The new age of bullying and violence in health care: Interprofessional impact. *Professional Case Management*, *20*(4), 165–174.

Fink-Samnick, E. (2016). The new age of bullying and violence in health care, Part 2: Advancing professional education, practice culture, and advocacy. *Professional Case Management*, *21*(3), 114–126.

Gresham, T. (n.d.). What is mobbing at the workplace, small business. *Chron*. Retrieved July 5, 2018, from http://smallbusiness.chron.com/mobbing-workplace-43426.html

Guns to Carry. (2018). *Federal and state gun laws*. Retrieved, July 8, 2018, from https://www.gunstocarry.com

Han, S. J. (2002). A study on the relationship between nursing organizational culture and organizational performance. *Journal of Korean Academy of Nursing Administration*, *8*(3), 441.e56.

Henshaw, S. (n.d.). Bullying at Work: Workplace mobbing is on the rise. *PsychCentral*. Retrieved July 5, 2018, from https://psychcentral.com/blog/bullying-at-work-workplace-mobbing-is-on-the-rise

Houseman, M., & Minor, D. (2015, November). *Toxic workers*. Evanston, IL: Kellogg School of Management, Northwestern University.

IPSOS. (2017, December 15). American attitudes on sexual harassment. *IPSOS Poll and NPR*. Retrieved July 5, 2018, from https://www.ipsos.com/en-us/news-polls/npr-sexual-harassment-2017-12-14

Jewett, C. (2018, March 18). Women in medicine shout #MeToo about sexual harassment at work. *Washington Post*. Retrieved from https://www.washingtonpost.com/national/health-science/women-in-medicine-shout-metoo-about-sexual-harassment-at-work/2018/03/16/81673f82-0c37-11e8-8b0d-891602206fb7_story.html?utm_term=.74841de96e73

Kavanaugh, M. (2016). Know where you can legally carry your gun? *WTKR News 3*. Retrieved March 31, 2018, from https://wtkr.com/2016/02/09/a-newschannel-3-investigation-looks-into-your-gun-and-your-rights-2

Koenig, R., (2017, December 13). Battling bullying in the workplace. Company culture. *US News and World Report*. Retrieved July 6, 2017, from https://money.usnews.com/money/careers/company-culture/articles/battling-bullying-in-the-workplace

Kurtzleben, D. (2018, February 24). Poll: Where Americans draw the lines on workplace behavior. *NPR*. Retrieved July 5, 2018, from https://www.npr.org/2018/02/24/588567650/poll-where-americans-draw-lines-on-workplace-behavior#

LegalMatch. (2018). *What is mobbing in the workplace*. Retrieved July 5, 2018, from https://www.legalmatch.com/law-library/article/mobbing-in-the-workplace.html

Levin, M. (2018, April 10). Harvard research proves toxic employees destroy your culture and your bottom line. *Inc*. Retrieved July 5, 2018, from https://www.inc.com/marissa-levin/harvard-research-proves-toxic-employees-destroy-your-culture-your-bottom-line.html

Morgan, T. (2014, March 26). The organizational challenge of workplace bullying. *Workplace Answers*. Retrieved June 6, 2017, from http://www.workplaceanswers.com/resources/blog/the-organizational-challenge-of-workplace-bullying-/

Murphy, B. (2018, May 16). #MeToo in med ed: 1 in 7 students subjected to sexist remarks. Education. *AMA Wire*. Retrieved July 6, 2018, from https://wire.ama-assn.org/education/metoo-med-ed-1-7-students-subjected-sexist-remarks

Nesbitt, W. (2012, December 12). Workplace bullying in the healthcare setting. *SMSI Online Newsletter*. Retrieved September 18, 2018, from http://www.smsi-inc.com/education-center/newsletters/

Occupational Safety and Health Administration (OSHA). (2015). *Guidelines for preventing workplace violence for healthcare and social service workers*. Washington, DC: U.S. Department of Labor. Retrieved from www.osha.gov

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2011). *Crucial conversations: Tools for talking when stakes are high* (2nd ed.). New York, NY: McGraw Hill.

Porath, C. (2016, November 14). Isolate toxic employees to reduce their negative effects. *Harvard Business Review*. Retrieved July 6, 2018, from https://hbr.org/2016/11/isolate-toxic-employees-to-reduce-their-negative-effects

Rogers, K. (2018, July–August). Do your employees feel respected. *Harvard Business Review*, pp. 62–71.

Smith, J. (2013, September 20). How to deal with a bullying boss. *Forbes*. Retrieved July 8, 2017, from https://www.forbes.com/sites/jacquelynsmith/2013/09/20/how-to-deal-with-a-bullying-boss/2/#56c0786c28d1

The Joint Commission. (2018, April 17). *Physical and verbal violence against health care workers* (Sentinel Event Alert Issue No. 59). Oakbrook Terrace, IL: Author.

U.S. Equal Employment Opportunity Commission. (2016). *Select task force on the study of harassment in the workplace*. Report by C. R. Feldblum & V. A. Lipnic. Retrieved July 5, 2018, from https://www.eeoc.gov/eeoc/task_force/harassment/report.cfm

U.S. Equal Employment Opportunity Commission. (2018a). *Harassment. Types of discrimination*. Retrieved June 12, 2018, from https://www.eeoc.gov/laws/types/harassment.cfm

U.S. Equal Employment Opportunity Commission. (2018b). *Sexual harassment*. Retrieved July 5, 2018, from https://www.eeoc.gov/laws/types/sexual_harassment.cfm

US Legal. (2018). *Lateral violence. Definition*. Retrieved July 5, 2018, from https://definitions.uslegal.com/l/lateral-violence

United States Department of Labor. (2018). *What do I need to know about workplace harassment*. Retrieved July 5, 2018, from https://www.dol.gov/oasam/programs/crc/2011-workplace-harassment.htm

Vize, R. (2018, February 10). Liverpool NHS scandal shows how culture of denial harms patients. *The Guardian*. Retrieved July 5, 2018, from https://www.theguardian.com/healthcare-network/2018/feb/10/liverpool-nhs-scandal-shows-how-culture-of-denial-harms-patients

Wiseman, P. (2017, August 14). One-fifth of Americans find workplace hostile or threatening. *Bloomberg News*. Retrieved July 5, 2018, from https://www.bloomberg.com/news/articles/2017-08-14/one-fifth-of-americans-find-workplace-hostile-or-threatening

Workplace Bullying Institute (2017). *U.S. Workplace Bullying Survey*. Retrieved July 5, 2018, from https://www.workplacebullying.org/wbiresearch/wbi-2017-survey

Workplace Bullying Institute. (2018). *Definition of workplace bullying*. Retrieved July 5, 2018, from https://www.workplacebullying.org/individuals/problem/definition

Yamada, D. C., Duffy, M., & Berry, P., (2018). Workplace bullying and mobbing. In M. Duffy. & D. C. Yamada (Eds.), *Workplace bullying and mobbing in the United States* (Vol. 1, pp. 1–23). Santa Barbara, CA: Praeger.

Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP, is an award-winning industry thought leader who empowers health care's transdisciplinary workforce through professional speaking, writing, mentoring, and consultation. A subject matter expert on ethics, Ellen is an esteemed author with more than 100 publications to her credit. She has authored content for many of the industry's knowledge projects for case managers, including chapters on the Ethical Use of Case Management Technology, Workplace Bullying, Collaborative Care, and the Social Determinants of Health. Her contributions to professional case management, ethics, and clinical social work transverse professional associations and credentialing organizations, including roles as subject matter expert, examination item writer, and leadership positions. She is a vibrant professional voice.

Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM. Tests can no longer be mailed or faxed.
- You will need to create (its free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.

Continuing Education Information for Certified Case Managers:

This Continuing Education (CE) activity is provided by Lippincott Professional Development and has been preapproved by the Commission for Case Manager Certification (CCMC) for 1.5 clock hours. This CE is approved for meeting the requirements for certification renewal.

Registration Deadline: November 1, 2019

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):

This continuing education (CE) activity is provided by Lippincott Professional Development and has been approved by the National Association for Healthcare Quality (NAHQ) for 1.5 CE Hours. CPHQ CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

This CPHQ CE activity expires on November 1, 2019.

Continuing Education Information for Nurses:

Lippincott Professional Development will award 1.5 contact hours for this continuing nursing education activity.

LPD is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749. LPD is also an approved provider by the District of Columbia, Georgia, and Florida CE Broker #50-1223.

The ANCC's accreditation status of Lippincott Professional Development refers only to its continuing nursing educational activities and does not imply Commission on Accreditation approval or endorsement of any commercial product.

Registration Deadline for Nurses: November 1, 2019

Disclosure Statement:

The authors and planners have disclosed that they have no financial relationship related to this article.

Payment and Discounts:

- The registration fee for this test is $17.95
- CMSA members can save 25% on all CE activities from *Professional Case Management*! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

DOI: 10.1097/NCM.0000000000000333