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The New Age of Bullying and Violence in Health Care

The Interprofessional Impact

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ABSTRACT

Purpose/Objectives: This article:

1. Explores the incidence, scope, and organizational impact of workplace bullying and violence.
2. Discusses implications for the industry's emerging interprofessional practice culture and case management are addressed, including the emergence of a new dimension of trauma for health care sector victims.
3. Reviews current initiatives and recommendations to empower professionals on their own journey to overturn this dangerous reality for the workforce.

Primary Practice Settings(s): Applicable to all health care sectors where case management is practiced.
Findings/Conclusion: Despite glaring improvements in how care is rendered and an enhanced focus on quality delivery of care, a glaring issue has emerged for immediate resolution: the elimination of workplace bullying and violence. The emerging regulatory and organizational initiatives to reframe the delivery of care will become meaningless if the continued level of violence among and against the health care workforce is allowed to continue.
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 that impacts patient 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, which puts patients and professionals at risk.

Key words: *case management, health care, hospital, interprofessional, lateral violence, workplace bullying, workplace violence*

I began my professional career in the summer of 1983. As a hospital social worker, my assignment was robust, for it included the emergency department, intensive care unit and one medical surgical unit, as well as pediatrics. Amid the elation of being gainfully employed in my chosen profession, I recall feeling:

- motivated by the unique energy surging through each unit,
- respectful of the diverse professionals whom I worked with,
- proud to serve in a vital role on the front lines of the care process, and
- too busy to ponder any concerns for my personal safety.

There was no way to anticipate the lethal and often fatal influencers that would infect the health care workplace with the current rate of contagion. Managing posturing and intimidating colleagues were a daily occurrence for me. Yet that effort was minimal compared with the now virulent epidemic of workplace bullying and lateral violence enacted by those individuals responsible for rendering quality and safe care. This behavior obstructs the care process, puts patients at grave risk, and grossly hinders ethical practice by professionals (Fink-Samnick, 2014).

I felt safe within the walls of the hospital. Every once in a while a disgruntled family member would verbally threaten staff, with swift intervention by hospital security or local law enforcement as necessary. The abundance of referrals I made to child and adult protective services found me ever vigilant and

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prepared to safeguard myself. However, I was never preoccupied with the high level of concern for personal safety that exists at present. I could never have foreseen a level of violence against health care practitioners so pervasive that hospitals are ranked among the most hazardous places to work (Occupation Safety and Health Administration [OSHA], 2013).

This article explores the incidence, scope, and organizational impact of two topics that have health care professionals on heightened alert: workplace bullying and violence (WPV). Implications for the industry's emerging interprofessional practice culture are addressed, including the emergence of a new dimension of trauma for health care sector victims. A review of initiatives and recommendations are also provided to empower professionals on their own journey to overturn this dangerous reality for the workforce.

Workplace Bullying and Lateral Violence: Incidence and Implications

There is considerable variation in how workplace bullying and lateral violence are understood across the industry. The terms are often used interchangeably, though some distinctions present. Box 1 provides the definitions used for each of the terms discussed in this article. *Workplace bullying* refers to 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.

(Workplace Bullying Institute, 2015a)

More than 65 million U.S. workers are affected by bullying in the workplace, equivalent to the combined population of 15 states (Namie, 2014). More than 72% of the employers deny, discount, encourage, rationalize, or defend it (2014). Some explain the bullying dynamic as a reflection of the hierarchical stratification that exists in health care settings whereby clinicians bully nurses, nurses bully certified nursing assistants (CNAs), and CNAs bully housekeepers (Neckar in Nesbitt, 2012).

Consider the following example. A physician screams at the case manager who approaches him to clarify the code status for a patient. While this may present as an important, yet benign, request, the physician becomes enraged and threatens to have the case manager fired if she ever questions his orders again. When the case manager discusses the situation with colleagues, she is told, "Oh his bark is worse than his bite. Just ignore him like everyone else does." The behavior is dismissed and the physician is enabled to engage in further antagonistic interactions with other staff. The case manager feels devalued and hesitant to approach this physician again. Team communication is fractured and the quality of care potentially damaged through the inability of care team members to effectively dialogue with each other.

The health care profession has one of the highest levels of bullying in the workplace (Farouque & Burgio, 2013). A study completed by the Workplace Bullying Institute found that 35% of workers have

BOX 1
Definitions

Term	Definition
	Two Types of Bullying
1. Workplace bullying (Workplace Bullying Institute, 2015a)	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
2. Lateral Violence (US Legal, 2014)	Happens when 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 violence (WPV) (United States Department of Labor, 2015).	Refers to any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.

Other pivotal outcomes note that bullying is four times more common than either sexual harassment or racial discrimination on the job, though not yet illegal.

been bullied at the place of employment. The actions described included verbal abuse, job sabotage, misuse of authority, intimidation and humiliation, and deliberate destroying of relationships (Namie, 2014). Other pivotal outcomes note that bullying is four times more common than either sexual harassment or racial discrimination on the job, though not yet illegal (Drexler, 2013).

Lateral violence occurs when people who are both victims of a situation of dominance turn on each other rather than confront the system, which may have 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 (US Legal, 2014). These situations occur with increasing tenacity across health care's transitions of care, with the current figures staggering.

In a survey of more than 4,500 health care workers, 77% reported disruptive behavior by doctors and 65% reported the same presentation among nurses. Ninety-nine percent indicated that these behaviors led to impaired nurse–physician relationships (Rosenstein & O'Daniel, 2008). With the extreme daily pressures faced by case managers to intervene and transition patients more rapidly than ever, frustrations quickly ensue and colleagues become easy targets to project emotion at. Consider the case manager who throws a tantrum during the unit care conference, cursing out team members. As she abruptly leaves the area, the case manager yells, "You are all incompetent. These meetings are a waste of my time; time that I have none of to waste! A patient and her family are in attendance and shocked by the interaction. Trust and respect among team members are now hampered, with fragmentation replacing cohesion. Situations such as these are occurring with greater frequency across the continuum.

Workforce retention is another casualty of bullying and lateral violence. The Robert Wood Johnson Foundation's RN Work Project found that nurses who experience verbal abuse by both physicians and nurse colleagues report a greater intent to leave their jobs. They are also more likely to develop negative perceptions of their work environments (Robert Wood Johnson Foundation, 2013).

The Joint Commission (TJC) identified that intimidating and disruptive behaviors fuel medical errors and lead to preventable adverse outcomes (TJC, 2008). Another study yielded that more than 75% of those surveyed identified how disruptive behaviors led to medical errors with nearly 30% contributing to patient deaths (Painter, 2013). Other reports cite the number at potentially as high as 200,000 deaths a year (Brown, 2011). Bullying and lateral violence interfere with all that health care strives to be: quality-driven, patient-centered, and an interprofessional team effort marked by respectful communication (Fink-Samnick, 2014).

Case Management's Ethical Impact

How can the practice of case managers of any discipline be viewed as ethical, when circumstances impede them from intervening appropriately on behalf of their patients? There is no question of the clear connection between how the obstructive and disparaging behaviors of bullying and lateral violence directly impact patient safety, especially with the basic objective of ethical standards and codes of professional conduct to protect the public interest (The Commission for Case Manager Certification, 2014). Case managers understand the ethical tenets of practice to be:

1. Beneficence: To do good.
2. Nonmalfeasance: To do no harm.
3. Autonomy: To respect individuals' rights to make their own decisions.
4. Justice: To treat others fairly.
5. Fidelity: To follow through and to keep promises.

These tenets do not supersede the scope of an individual's primary license, yet they are viewed in the context of those professional standards and/or functions, which are endemic to this specialty practice: those to assess, plan, collaborate, implement, monitor, and evaluate (Case Management Society of America, 2010). Case managers are required to act with integrity in dealing with other professionals to facilitate their clients' achieving maximum benefits (The Commission for Case Manager Certification, 2014). Both bullying and lateral violence are paradoxical to established case management ethical standards and codes, as demonstrated by "Case Scenario 1."

Interprofessional Ethical Considerations

Bullying and lateral violence pose considerable implications for the health care sector's emerging interprofessional practice culture. To clarify, interprofessional practice speaks to the newer paradigms of teamwork appearing across the industry. These models are marked by high levels of cooperation,

CASE SCENARIO 1
Case Management Ethical Tenets & Bullying Operationalized

Stephanie is the case manager for a spinal cord injury program in an acute rehabilitation hospital.

The rehabilitation team is working with Michael, a 23-year-old involved in a motor vehicle accident. He has suffered a C-2 injury with Tetraplegia and is now wheelchair dependent. The treatment team recommend Michael be discharged with a specialized wheelchair. Having the wheelchair will translate to less energy consumption and increased independence. Michael would like to live on his own after discharge, and the specialized wheelchair would promote his self-sufficiency. The physical therapist (PT) mentioned Michael and his situation to a visiting durable medical equipment vendor, who agreed to bring a demo of the wheelchair to the unit so that Michael could try it.

Stephanie is enraged when she hears that the team arranged the demo and throws her mobile phone across the nursing station, with team members ducking for safety. Stephanie begins to yell, "Seriously? You want me to request a motorized wheelchair for this guy? If he wasn't texting his friends the accident never would have happened. He needs to understand there are consequences to his actions. Michael will see the chair as a reward, so it won't happen on my watch," The team is horrified by what they hear.

Ethical Tenets	Applicable to Bullying
Beneficence	Stephanie is not acting in Michael's best interests
Nonmalfeasance	Stephanie is potentially harming Michael's recovery
Autonomy	What do Michael and/or his family want in this situation?
Justice	Michael is not being treated fairly by Stephanie
Fidelity	Do you see Stephanie's actions as a violation or not?

Note. Adapted from CMSA (2010).

Ethical Principle	Operationalized to Bullying
4. Certificants will to act with integrity in dealing with other professionals to facilitate their clients' achieving maximum benefits Board-Certified Case Managers (CCMs) will act with integrity and fidelity with clients and others.	• Stephanie is not acting in a way to reflect the level of integrity expected for a case manager toward other professionals. • Stephanie is not communicating in a manner which marks professionalism. • Stephanie presents as biased and unable to support the team recommendations for Michael to achieve his maximum potential function.

Note. Adapted from CCMC (2014).

coordination, and collaboration characterizing the relationships between professions in delivering patient-centered care (Interprofessional Education Collaborative [IPEC], 2011).

In the interprofessional context, a new tone for the care team is set: one where practitioner cohesion, rather than continued fragmentation and competition between disciplines, is allowed to flourish (Fink-Samnick, 2014). Despite the expanded scope on interprofessional team responsibility, individual team members remain beholden to their distinct professional ethical codes. The Values/Ethics Competency defined by the IPEC is clear to that level of professional responsibility, which should transcend across the entire team, amid its distinct members and to stakeholders. Shown in Table 1, the competency frames a sense of shared purpose in supporting the common good in health care and reflects a shared commitment to creating safer, more efficient, and more effective systems of care (IPEC, 2011). The case scenario presented in "Case Scenario 2" demonstrates how bullying and lateral violence can impede the efforts of the interprofessional team.

Industry experts would agree that the emerging models of care coordination (e.g., Accountable Care Organizations and integrated behavioral health) mandate maximum team collaboration and communication. They also require a mindset that embraces an interprofessional perspective of practice, one which recognizes the value of the unique expertise contributed by each involved discipline. The manifestation of bullying within the treatment team has gross potential to hamper the quality of patient care processes. In these times when outcomes-specific patient safety and quality are paramount, a question emerges for consideration: How effective and efficient can the outcomes of any process be when the process itself is laden with impediments to quality care? (Fink-Samnick, 2014).

Workplace violence: Incidence and Implications

Workplace violence (WPV) refers to any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide (U.S. Department of Labor, 2015). It is far from a new issue to be viewed as an organizational priority in the health care industry.

Workplace violence directly impacts staff satisfaction, employee turnover, staff mental and physical health, patient satisfaction, and quality of care (Blando, 2014). In 1992, Lipscomb and Love identified violence as an "emerging hazard" in health care. Among the key points, Lipscomb and Love (1992)

TABLE 1
Values/Ethics (VE) For Interprofessional Practice

General Competency Statement-Values/Ethics: Work with individuals of other professions to maintain a climate of mutual respect and shared values

Competency Designation	Competency
VE1	Place the interests of patients and populations at the center of interprofessional health care delivery.
VE2	Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.
VE3	Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.
VE4	Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.
VE5	Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.
VE6	Develop a trusting relationship with patients, families, and other team members.
VE7	Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.
VE8	Manage ethical dilemmas specific to interprofessional patient-/population-centered care situations.
VE9	Act with honesty and integrity in relationships with patients, families, and other team members.
VE10	Maintain competence in one's own profession appropriate to scope of practice.

Note. Adapted from IPEC (2011).

framed the need for health care institutions to be educated in the efforts to identify and reduce the current epidemic of violence in these settings. The intricacies of WPV were subsequently noted to arise from a combination of factors. These involved the absence of strong violence prevention programs and protective

CASE SCENARIO 2
Interprofessional Values/Ethics Competencies & Bullying Operationalized

Gail is the case manager for the cardiac care unit (CCU) in a Magnet hospital. It is a fast-paced environment where the *care is patient-centered and the highest quality*; or so says the mission printed on every staff member's identification card.

The interprofessional team is comprised of staff across disciplines. Each member has been assigned for their expertise with the high level of acuity that accompanies the majority of unit admissions. Team members are provided the latest generation of mobile devices to support both the interprofessional mindset at the facility, plus the mandate for in the moment communication by all involved. It is expected this technology access will maximize the team's efforts and contribute to successful program outcomes.

Dr. Spock is the medical director. He brings a strong reputation for his mastery of health information technology. Team members never see Dr. Spock without a mobile device in hand. As a result, team members give him the nickname "Manic Mobile." It is not uncommon for Dr. Spoke to text sarcastic comments and discriminatory jokes to other team members about the patients and their family members in attendance. Dr. Spock's rationale for this behavior is that it contributes to laughter and a lighter mood amid the constant work stress. He also feels it enhances team camaraderie. Dr. Spock has provided clear messaging to the team that he has no intention of changing his style. At the first team meeting, Dr. Spoke stated: "My texting style works. Should anyone have an issue with it, they can leave. I'll provide you a solid recommendation."

Team members initially resist engaging in the texting interchanges, recognizing how disrespectful the actions present to patients and their families. However, fear of retribution for whistleblowing and potential unemployment trump ethical practice. The majority also prevail with texting now occurring fast and furiously.

Gail is horrified at what she observes during an especially emotional family meeting convened to discuss a patient's code status. Team members are viewing their mobile devices instead of looking at the family. Several are posting comments about the family across social media.

Competency	Applicable to Bullying
VE 1	The team places engagement on social media above patient-centered care
VE 2	The team disrespects the dignity of patients/families with confidentiality at risk
VE 3	The team allows bias to invade the care process
VE 4	The team disrespects the culture, values, and roles of other professionals
VE 5	The level of cooperation between those receiving and rendering care is at issue
VE 6	The level of trust between the team and family, and among other professionals is grossly compromised
VE 7	The team does not demonstrate adherence to high standards of ethical conduct and quality of care in their contributions to care, either by the team overall or by individual members
VE 8	The team is focused on negative and disruptive behaviors vs. patient care
VE 9	The team acts dishonestly in their communications and relationships with stakeholders
VE 10	What do you think? Violation or not?

Note. Adapted from IPEC (2011).

regulations, plus the presence of a health care culture resistant to the notion that health care providers are at risk for patient-related violence, combined with complacency that violence (if it exists) "is part of the job" (McPhaul & Lipscomb, 2004). However, with patient populations becoming even more complex and psychosocial stressors heavier to bear, there are escalating concerns regarding the true safety of the health care workforce.

About 10% of victims of WPV are in medical settings (Rice, 2014). 76% of nurses with at least 10 years of experience reported that they had experienced some form of workplace assault in 2013 alone (Crosby, 2015). OSHA found one hospital to have 40 instances of violence from patients and visitors against hospital employees between February and April 2014 (Herman, 2014).

According to Bureau of Labor Statistics data, the rate of WPV has risen considerably in the past several years alone. In 2010, health care and social assistance workers were victims of approximately 11,370 assaults, rising 13% from 2009 (U.S. Department of Labor, 2015). By 2012, nonfatal occupational injuries and illnesses involving days away from work for health care and social assistance workers were 15.1 per 10,000 full-time workers in 2012. OSHA (2013) reports 6.8 work-related injuries and illnesses for every 100 full-time hospital employees. Other reports cite that more than 50% of nurses had been threatened or verbally abused at work (LaGrossa, 2013). The American Nurses Association (ANA, 2015a) Health and Safety Survey noted concerns about "on the job assault" increases from 25% to 34%.

Social work has seen comparable rises in incidents of physical assault and abuse by clients, with fatalities occurring across those employed at facilities, as well as those who engage with clients in the community. Similar to other research (McPhaul & Lipscomb, 2004), the manifestation of violence against the professional workforce is viewed as just part of the job and is not being treated seriously (Schraer, 2014). One survey indicated 70% of attacks and threats toward social workers and other agency staff members were never investigated (2014). Although this survey was specific to incidents that occurred against individuals who practice solely in the community as opposed to hospitals, the results still demonstrate the gross lack of attention to the issue by employers and the public at large. At the least, employers must look urgently at what leaving this issue unchecked is costing them through absences, loss of skilled experienced staff, and recruitment costs (2014). The list of identified recommendations is equally applicable to most practice settings:

- Mandatory training
- Better internal recording of incidents
- Provision of equipment (e.g., attack alarms)
- Closer work with police
- A policy of visiting in pairs
- Better risk assessments

(Schraer, 2014).

The Federal Bureau of Investigations (FBI) delineates four broad categories for WPV, all of which have been witnessed in the health care workplace (Blando, 2014). These categories or types include:

- Type 1: Aggression where the offender has no relationship with the victim
- Type II: Aggression where the offender is receiving services from the victim
- Type III: Aggression where the offender is either a current or former employee acting out against other coworkers

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The manifestation of violence against the professional workforce is viewed as just part of the job and is not being treated seriously. One survey indicated 70% of attacks and threats toward social workers and other agency staff members were never investigated. While this survey was specific to incidents that occurred against individuals who practice solely in the community as opposed to hospitals, the results still demonstrate the gross lack of attention to the issue by employers and the public at large.

BOX 2
Posttraumatic Stress Disorder

Diagnostic criteria include history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Criterion A: stressor
The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: **(one required)**
1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect nonprofessional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms
The traumatic event is persistently reexperienced in the following way(s): **(one required)**
1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance
Persistent effortful avoidance of distressing trauma-related stimuli after the event: **(one required)**
1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood
Negative alterations in cognitions and mood that began or worsened after the traumatic event: **(two required)**
1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pretraumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity
Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: **(two required)**
1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: duration
Persistence of symptoms (in Criteria B, C, D, and E) for more than 1 month.

Criterion G: functional significance
Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion
Disturbance is not due to medication, substance use, or other illness.

Note. Data from APA (2013) and National Center for PTSD (2015).

- Type IV: Aggression where the offender has a personal relationship with an employee and acts out at the employee's workplace.

(FBI, 2002)

Type II WPV presents as the most prevalent source of OSHA-reportable injuries among those employed in hospitals (New Jersey Department of Health and Senior Services, 2007). News stories have appeared with increasing regularity to detail assaults and, in some instances, shootings. The death of Dr. Michael Davidson in January 2015 at Boston's Brigham and Women's reverberated across the health care community. The headline was more reflective of

a movie plot than real life, although it was painfully true; "Man Who Killed Brigham Doctor Had Blamed Him for Mother's Death (Associated Press, 2015). It was not the first of these incidents and will, most likely, not be the last. In 2010, a gunman upset over the news of his mother's medical condition opened fire inside Johns Hopkins Hospital, wounding a physician before fatally shooting his mother and then turning the gun on himself (Friedman, 2010).

The Common Thread: The Impact of Trauma on the Workforce

The harsh realities of both workplace bullying and violence are visible across today's news sources as incidents are reported consistently and with increasing fervor, including fatalities. The traumatic impact of these situations is felt by anyone who has interfaced with the health care industry. The negative consequences of this behavior on the mental health and well-being of employees are a growing focus in the literature, as it directly impacts organizational performance (Ariza-Montes, Muniz, Montero-Simo, & Araque-Padilla, 2013).

The emotional toll on the mental health of the workforce is particularly concerning, especially given the way in which the manifesting trauma can influence factors such as workforce retention, quality of care, and overall patient safety. When professionals feel disempowered to address the dynamics of bullying, whether manifesting as insults and/or threats toward them and/or patients and families, the outcomes can and will be deadly (Fink-Samnick, 2014).

The psychological emotional impact of bullying takes a profound toll on those who endure it. The Workplace Bullying Institute reports the following symptom prevalence:

- Debilitating Anxiety—80%
- Panic Attacks— 52%
- Clinical Depression—either new to the person or exacerbated condition, 49%
- Post Traumatic Stress—30%

(Workplace Bullying Institute, 2015b)

Studies across the industry are consistent in demonstrating how with the physical injury resulting from bullying and WPV, employees experience extensive psychological manifestations. These behaviors include but are not limited to loss of sleep, nightmares, and flashbacks (Gates, Gillespie, & Succop, 2011). Short- and long-term emotional reactions experienced by victims can also include anger, sadness, frustration, anxiety, irritability, apathy, self-blame, and helplessness (Gates, Fitzwater, & Succop, 2003; Gillespie, Gates, Miller, & Howard, 2010). As stated by the FBI (2002), "Workplace violence creates ripples that go beyond what is done to a particular victim. It damages trust, community, and the sense of security every worker has a right to feel while on the job. In that sense, everyone loses when a violent act takes place, and everyone has a stake in efforts to stop violence from happening."

As many as 20% of those individuals affected by bullying and WPV have met the symptom criteria for posttraumatic stress disorder (PTSD; Laposa, & Alden, 2003; Laposa, Alden, & Fullerton, 2003). The severity and increased incidence of PTSD among society is reflected by how the diagnosis appears in the latest version of the *Diagnostic and Statistical Manual of Psychiatric Disorders*, 5th edition. Posttraumatic stress disorder is no longer categorized as an anxiety disorder. Instead, it is listed as a distinct diagnosis within the new chapter of trauma and related stressor-related disorders (American Psychiatric Association, 2013). The eligibility criteria is shown in Box 2.

Interprofessional Action

While professional standards are appearing specific to WPV, more can and must be done. The health care industry has a primary responsibility to protect all stakeholders from the ripple effect of these often violent and usually traumatic occurrences for employees and patients alike. Standards of professional behavior must be developed and implemented with uniform application across all departments. In addition, it is imperative that there be consistent monitoring to ensure adherence to the industry's professional standards. All employees need to be aware that they can report incidents confidentially (Brown, 2011). An atmosphere of support is essential to minimizing the stigma and retraumatization often associated with those who are victims of bullying (Fink-Samnick, 2014).

Effective January 1, 2009, TJC created a new standard in the Leadership chapter, LD.03.01.01. This standard calls for organizational leaders to create and maintain a culture of safety and quality throughout the (organization):

- A4: Leaders develop a code of conduct that defines acceptable and disruptive and inappropriate behaviors and
- A 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors that undermine a culture of safety.

(TJC in ANA, 2015b)

As many as 19 states have increased the penalties for individuals convicted of assaulting nurses and/or other health care personnel.

TABLE 2
Guidelines for Social Work Safety in the Workplace

Standard	Focus
1	Organization culture of safety and security
2	Prevention
3	Office safety
4	Use of safety technology
5	Use of mobile phones
6	Risk assessment for field visits
7	Transporting clients
8	Comprehensive reporting practices
9	Postincident reporting and responsibility
10	Safety training
11	Student safety

Note. Data from *Guidelines for Social Work Safety in the Workplace* by National Association of Social Workers, 2013, Washington, DC: Author.

The National Association of Social Worker's (2013) *Guidelines for Social Work Safety in the Workplace* defines 11 standards, which are shown in Table 2. At the time of this writing, there is no federal standard that requires WPV protections although a number of other efforts are in place to support minimizing bullying. Several states are enacting or considering laws amid growing concerns about the safety of hospital staff caused by recent widely reported attacks (Rice, 2014). As many as 19 states have increased the penalties for individuals convicted of assaulting nurses and/or other health care personnel (2014). A number of states have in place, or are amid passage of legislation to address WPV, with a current map appearing on the ANA website (ANA, 2015b).

Conclusion

The health care industry is a far cry from the one I entered over 30 years ago. Despite glaring improvements in how care is rendered and an enhanced focus on quality delivery of care, a glaring issue has emerged for immediate resolution: the elimination of WPV. The emerging regulatory and organizational initiatives to reframe the delivery of care will become meaningless if the continued level of violence among and against the health care workforce is allowed to continue. How can that holy grail of quality and safe patient-centered care be achieved in the absence of an atmosphere where neither the patients nor workforce itself are safe?

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