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The New Age of Bullying and Violence in Health Care: Part 2

Advancing Professional Education, Practice Culture, and Advocacy

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ABSTRACT

Purpose and Objectives: This article will discuss new regulations and professional guidance addressing bullying and workplace violence including addressing recent organizational initiatives to support the health care workforce; reviewing how professional education has historically contributed to a culture of bullying across health care; and exploring how academia is shifting the culture of professional practice through innovative education programming.

Primary Practice Settings(s): Applicable to all health care sectors where case management is practiced.

Findings/Conclusion: This article is the second of two on this topic. Part 2 focuses on how traditional professional education has been cited as a contributing factor to bullying within and across disciplines. Changes to educational programming will impact the practice culture by enhancing collaboration and meaningful interactions across the workforce. Attention is also given to the latest regulations, professional guidelines, and organizational initiatives.

Implications for Case Management Practice: Workplace bullying and violence have contributed to health care become the most dangerous workplace sector. This is a concerning issue that warrants serious attention by all industry stakeholders.

Traditional professional education models have created a practice culture that promotes more than hinders workplace bullying and violence in the industry. Changes to both academic coursework and curricula have shifted these antiquated practice paradigms across disciplines. New care delivery modes and models have fostered innovative care and treatment perspectives. Case management is poised to facilitate the implementation of these perspectives and further efforts to promote a safe health care workplace for patients and practitioners alike.

Key words: *case management, collaborative care, helping professionals, integrated care, lateral violence, medicine, nursing, social work, workplace bullying, workplace violence*

Since my prior article on workplace bullying and violence (WPV) in health care appeared in Professional Case Management Journal (Fink-Samnick, 2015), there has been robust workforce response to the content, with correspondences from case managers across practice settings. Some comments professed the familiar messaging of "save the passion since nothing will change" or "this is just how health care is." The hierarchal culture often allowed to fester in health care organizations continues to be rampant—one fueling a passive atmosphere that enables bullying, as opposed to one empowering the needed change to combat it.

However, there were strong emotional reactions to the article that found me transfixed. Many professionals shared their rage at the incidence and severity of bullying in their practice settings. There was appreciation for the article identifying terms that would allow case managers to name their disturbing experiences. Tears flowed as case management audiences openly discussed how lateral violence specifically invaded their workplace on a daily basis.

Other case managers expressed concern for the profound impact that the bullying and violence epidemic has on both the quality of patient care and

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workforce retention and attrition. Of particular note was a presentation given to an audience with a large concentration of case managers employed at a nationally recognized hospital, one that experienced the murder of a beloved physician earlier in the year. Raw emotion and residual trauma filled the room, impacting all in attendance.

The media has been flushed with reports of new incidents, each event more violent and concerning than the one prior (Despart, 2015; Tedeschi, 2015; Rice, 2014; Trossman, 2015). The deafening outcry from health care consumers, professionals, and other stakeholders has been fast and furious, with a bevy of legislation and initiatives on the horizon.

Part 2 focuses on how traditional professional education has fostered the justification of bullying behaviors within and across disciplines and the implications for case management. Emerging changes to educational programming strive to advance greater collaboration and meaningful interactions across health care teams. In addition, a review of the latest regulations, professional standards, and organizational initiatives addressing workplace bullying and WPV across the health care sector will be provided. 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 the workforce itself are safe (Fink-Samnick, 2015)?

Professional Education's Role

The literature speaks to bullying as endemic to the culture of health care education overall (Bentley & Walsh, 2013; Chen, 2012; Shem, 1980; Stokowski, 2010; Wible, 2015). Experts note traditional and often-outdated models of professional education as a contributing factor to bullying's presence across the industry (Lambert, 2012; Robert Wood Johnson Foundation, 2012; Rovner, 2015).

As discussed in Part 1 (Fink-Samnick, 2015), bullying is also seen as a direct reflection of the hierarchical stratification that has existed in health care settings (Neckar, as cited in Nesbitt, 2012). This power dynamic is one most students across health care professions have been exposed to while in their internships and/or practicums. It also directly reflects traditional education paradigms. By virtue of this model, shown in Figure 1, physicians and administrators in the C-suite bully clinical professionals (e.g., nurses, social workers, pharmacists, rehabilitation staff), clinical professionals bully paraprofessionals (e.g., Certified Nursing Assistants), and paraprofessionals bully nonclinical support staff (e.g., housekeepers). Discussed in this section are the ways in which the distinct disciplines of medicine, nursing, and social work education have contributed to bullying and their unique transitions to more timely, empowering practice paradigms.

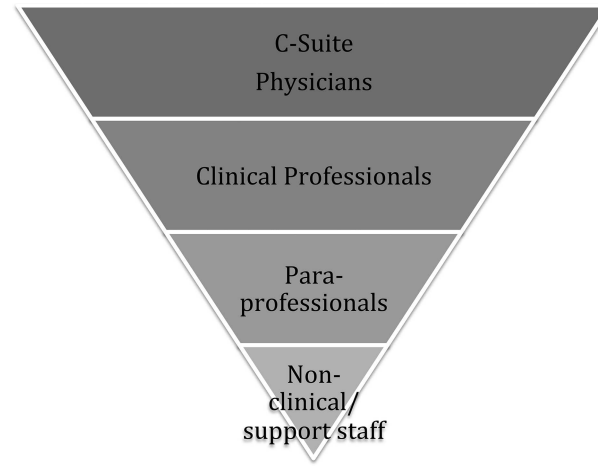

FIGURE 1
Hierarchical stratification in health care. Adapted from Neckar, as cited in "Workplace Bullying in the Healthcare Setting," by W. Nesbitt, 2012, December 12, *SMSI Online Newsletter: The Hospital Reporter, Security Management Services International and The Hospital Reporter*.

Medical Education and Practice Culture

Medical educators have long known that becoming a doctor requires more than standardized examinations, extended hours on hospital wards, and mandatory training. For many medical students, verbal and physical harassment and intimidation are also part of the exhausting process (Chen, 2012). Early studies on this topic note that bullying most frequently occurs in the third year of medical school, with as high as 85% of students acknowledging abuse, which ranged from verbal to physical harassment. Some experienced threats in the form of being told that their career would be ruined if they failed to comply with requests by those senior to them, as well as having medical objects thrown at them (Chen, 2012; Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990). As a result of the pervasive mistreatment they received, 75% of students reported becoming more cynical about academic life and the medical profession overall (Chen, 2012).

A small culture shift appeared by the mid-1990s when the David Geffen School of Medicine at the University of California, Los Angeles, began to institute reforms. Included were.

- policies to reduce abuse and promote prevention,
- the creation of a gender and power abuse committee,
- mandated lectures, workshops, and training for students, residents, and faculty, and
- the development of an office to accept confidential reports, investigate, and address allegations of mistreatment. (Chen, 2012)

University of California, Los Angeles, programming identified a slight improvement in the outcomes obtained from recent abuse and mistreatment surveys. Yet, still more than 50% of all medical students at the school continue to admit to some form of intimidation, physical or verbal harassment—a number consistent with the national average (Chen, 2012).

A glaring and rather disturbing example of the abusive climates of both medical education and health care is portrayed in book, *The House of God* (Shem, 1980). Written by a psychiatrist (under a pseudonym) who felt the need to tell the rather disturbing truth about medical education, the book graphically details the experiences of interns and their residency training at a large, fictitious hospital. Staff and patients are degraded as a matter of common course. For example, social workers are offensively referred to as *the social cervix* for their willingness to have random sex with residents in exchange for expediting nursing home placement for patients known as *gomers*. The equally offensive acronym, gomer, stands for "Get out of my emergency room." These particular patients are frequently admitted with complicated but uninspiring and incurable conditions, and thus not challenging for or appealing to budding physicians.

Multiple adjectives were used to describe *The House of God*, from raunchy and troubling to hilarious (Markel, 2009). I recall being given the book by my department director on the first day of work. The "13 Laws" were especially intriguing to me. They far from represent the patient-centered approach to care that marks the present decade. Instead, they spoke to devaluing patients, minimizing the importance of their treatment, and a pattern of overtreatment as the norm. In 2012, Shem recognized the need to update the laws and wrote four additional ones to more accurately reflect fundamental lessons for medical students. The full list of Laws from the *House of God* appears in Box 1.

While viewed as scandalous and vulgar at the time of publication, the *House of God* acquired a large cult following. It was ultimately seen as a touchstone in the evolving discussion of humanism, ethics, and training in medicine (Markel, 2009). Shem openly presented the harsh realities of medical education and employment in a hospital, which many in the field were unprepared to acknowledge.

Fast-forward to the present, medical school applications are currently at the highest point in decades. There were more than 52,000 applications to U.S. medical schools in 2015, up 6.2% from 49,480 submissions in 2014. Reasons for this rise include increased emphasis by universities to open new medical schools, expand existing programs, or tweak curricula to get students interested in certain medical disciplines like primary care (Japsen, 2015).

BOX 1
Laws of the House of God (Adapted From Shem, 1980, 2012)

1. Gomers[a] Don't Die.
2. Gomers Go to Ground
3. At a Cardiac Arrest, the first procedure is to take your own pulse.
4. The patient is the one with the disease.
5. Placement comes first.
6. There is no body cavity that cannot be reached with a #14-G needle and a good strong arm.
7. Age + BUN = Lasix dose.
8. They can always hurt you more.
9. The only good admission is a dead admission.
10. If you don't take a temperature, you can't find a fever.
11. Show me a BMS (Best medical student, a student at the best medical school) who only triples my work and I will kiss his feet.
12. If the radiology resident and the medical student both see a lesion on the chest X-ray, there can be no lesion there.
13. The delivery of good medical care is to do as much nothing as possible.

Additional Laws of the House of God (Shem, 2012)

14. *Connection comes first:* This applies not only in medicine, but in any of your significant relationships. If you are connected, you can talk about anything, and deal with anything; if you're not connected, you can't talk about anything, or deal with anything.
15. *Learn empathy:* Put yourself in the other person's shoes, feelingly. When you find someone who shows empathy, follow, watch, and learn.
16. *Speak up:* If you see a wrong in the medical system, speak out and up.
17. *Learn your trade, in the world:* Your patient is never only the patient, but the family, friends, community, history, the climate, where the water comes from and where the garbage goes. Your patient is the world.

[a]Gomer-get out of my emergency room. Refers to a patient who is frequently admitted with complicated but uninspiring and incurable conditions.

To this end, medical schools are changing both the way in which students are educated (Rovner, 2015) and the culture surrounding the medical profession overall. Medical education relied for decades on the *two-plus-two model* designed by American educator, Abraham Flexner in the early 1900s. The Flexner model comprised 2 years in the classroom memorizing facts, then 2 years shadowing doctors in hospitals and clinics. Dr. Erin McKean, a surgeon and teacher at the University of Michigan Medical School, states about the shortcomings of traditional medical education:

> We haven't taught people how to be specific about working in teams, how to communicate with peers and colleagues and how to communicate to the general public about what's going on in health care and medicine. (Rovner, 2015)

The newer models of medical education being implemented, empower a knowledge base that focuses on learning tools to be adaptable and resilient, and problem solve as team players, as opposed to unquestioned

leaders (Rovner, 2015). Working together in teams is far more reflective of the real world in which medical students will practice (Schumann, 2015).

Medical education is equally extending the scope of its lens beyond the scientific etiology and pathophysiology of illness. The social determinants to impact the disease process are becoming of equal interest to the next generation of practitioners (Schumann, 2015). Excessively high health care spending in the United States is undermined by the nation's low investments in social services, including support services for older adults, survivor benefits, disability and sickness benefits, family supports, housing and employment programs, plus unemployment benefits (Health Affairs, 2014). Health literacy and obesity are commonly added to this listing. Nonclinical factors such as education and income have been found to have a major impact on health, wellness, and prevention (Health Affairs, 2014; Schumann, 2015).

Health care's emphasis on the quality and fiscal benefits of new evidence-based models combining behavioral and physical health is another important driver of the shifting professional education landscape. Behavioral health conditions are extremely common, affecting nearly one of five Americans and leading to health care costs of $57 billion a year, on par with cancer (Klein & Hostetter, 2014). Outcomes demonstrate how independent systems of behavioral health and primary care lead to worse health outcomes and higher total spending. This is especially true for patients with comorbid physical and behavioral health conditions ranging from depression and anxiety, which often accompany physical health conditions, to substance abuse and more serious and persistent mental illnesses (Klein and Hostetter, 2014; Unützer et. al., 2013). Health care costs for Medicaid beneficiaries with major depression and a chronic medical condition are twice as high as those for beneficiaries without depression (Unützer, Harbin, Schoenbaum, & Druss, 2013).

Programs addressing the multifocal factors contributing to the illness course have been shown to be clinically and cost-effective for a variety of medical and mental health conditions, across practice settings, and using different payment mechanisms (Klein & Hostetter, 2014; Unützer et al., 2013). Integrated care programs provide both medical and mental health in primary care and other clinical settings, involving professionals across disciplines. By rendering treatment within primary care, stigma associated with the treatment of mental disorders can be reduced, existing provider relationships are maximized, and care is more focused on the interplay of medical and mental disorders (AIMS Center, 2015).

The Collaborative Care Model is the next generation of integrated care model. It actively engages professional disciplines and their treatment perspectives toward addressing common behavioral health conditions (e.g., depression and anxiety) that require systematic follow-up due to their persistent nature (AIMS Center, 2015). The model represents not only a new way to practice medicine but one to address the global care needs of patient populations, with the underlying concepts shown in Box 2.

Nursing Education and Practice Culture

The mantra of "nurses eat their young" has been a constant cliché for ions. This type of hazing or initiation experienced by new nurses at the hands of more experienced coworkers is not unique to nursing or the health care field (Katz, 2014). Teaching and law

BOX 2
The Collaborative Care Model (Data From AIMS Center, 2015)

Collaborative Care:
- defined patient populations tracked in a registry, measurement-based practice, and treatment to target;
- included trained primary care providers and embedded behavioral health professionals who provide evidence-based medication or psychosocial treatment; and
- is supported by regular psychiatric case consultation and treatment adjustment for patients who are not showing improvements as expected.

Principles of Collaborative Care (Adapted From AIMS Center, 2015)	
1. Patient-centered team care	Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals.
2. Population-based care	Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving, and mental health specialists provide caseload-focused consultation, not just ad hoc advice.
3. Measurement-based treatment to target	Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools.
4. Evidence-based care	Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition (e.g., problem-solving therapy, cognitive behavioral therapy).
5. Accountable care	Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.

…mentors can believe that being tougher on new nurses will thicken their proverbial skin. However, this approach becomes paradoxical, for it sidesteps the training tactic that competence builds confidence.

enforcement also report their share of episodes. Some view this framing as explained by nursing education (Dellasega, as cited in Stokowski, 2010; Katz, 2014), while others see it as explained by the profession itself (Katz, 2014; Thompson, 2013; Townsend, 2012).

Dellasega (as cited in Stokowski, 2010) specifically identifies the education system as a major contributor to the bullying culture in nursing. Nurses are trained to be subservient and uncertain, rather than independent and confident. Their training is counter to the messaging that medical students receive: never break down, always have the answer, and to project confidence even if they do not feel it (Stockowski, 2010). The ineffective communication and coping skills in a high-stakes environment, such as nursing school, leads to bullying. Learning to manage the stress, which accompanies all professional education, is a must (Palarski, as cited in Katz, 2014).

Within the workplace, bullying can easily be accepted as the norm. Beating down the confidence of younger colleagues provides a perverse sense of pleasure to those more senior (Thompson, 2013). In addition, mentors can believe that being tougher on new nurses will thicken their proverbial skin. However, this approach becomes paradoxical for it sidesteps the training tactic that competence builds confidence (Thompson, as cited in Katz, 2014). Nurses who survive bullying early in their careers tend to carry their learned behaviors with them. They accept the bully culture as part of the job and eventually may choose to bully other nurses (Townsend, 2012).

Dellasega (2009) identified five triggers, or situations, that can precipitate or make a nurse vulnerable to bullying.

- Being a new graduate or new hire
- Receiving a promotion or honor that others feel is undeserved
- Having difficulty working well with others
- Receiving special attention from physicians, or
- Working under conditions of severe understaffing

She also noted six types of nurses, in the context of bullying behavior, shown in Table 1. Most case managers have met at least one of these nurse types in their career. However, of paramount attention is the current push back occurring as this age-old adage of nurses eating their young is being seen as neither specific nor helpful in describing the problem of bullying in nursing (Stokowski, 2010). Although bullying behavior exists in many professions, it is far from okay. It feels worse in an industry dedicated to caring and compassion (Thompson, as cited in Katz, 2014).

A variety of societal constructs are compelling the need to transform nursing school education. Health care reform, the aging nurse faculty workforce, and the increasing complexity of health care mandate a different approach to educating new nurses (Robert Wood Johnson Foundation, 2012). Akin to medical schools altering use of the traditional Flexner model of education, nursing schools are recognizing the need to do the same. Ralph Tyler's model of curriculum development embraced by nursing for the last 50 years emphasized content, structure, and measurable, behavioral outcomes (Darrin, 2014; Robert Wood Johnson Foundation, 2012). In contrast to Tyler's strictly scientific approach to learning, newer approaches strive to integrate theory, practice, and reality. Nursing schools are merging knowledge acquisition and situated knowledge use in the classroom and clinical practice (Robert Wood Johnson Foundation, 2012).

Educational reform has manifested across academic nursing accreditation, particularly over the last decade. The American Association of Colleges of Nursing (AACN) and Robert Wood Johnson Foundation co-led a national effort to enhance the ability of nursing faculty to effectively develop quality and safety competencies among graduates of their programs. Through its significant work, the Quality and Safety Education in Nursing (QSEN) project has ensured that nursing professionals are provided the knowledge and tools needed to deliver high quality, safe, effective, and patient-centered care (AACN, 2015a).

The project had three phases:

- Phase 1 (2005–2007): Identified the knowledge, skills, and attitudes (KSAs) that nurses must possess to deliver safe, effective care.

TABLE 1
Nurse Bully Types

The super nurse	More experienced, educated, or specialized; conveys an elitist or superior attitude
The resentful nurse	Develops and holds grudges; pits nurse against nurse
The put-down, gossip, and rumors nurse	Shares negativity; quick to take offense
The backstabbing nurse	Cultivates friendships, then betrays them; "2-faced"
The green with envy nurse	Tends toward envy and bitterness
The cliquish nurse	Uses exclusion for aggression; shows favoritism and ignores others

Note. Adapted from "Bullying Among Nurses," by C. A. Dellasega, 2009, *American Journal of Nursing*, 109, pp. 52–58.

… (in Stokowski, 2010) specifically identifies the education system as a major contributor to the bullying culture in nursing. Nurses are trained to be subservient and uncertain, rather than independent and confident. Their training is counter to the messaging that medical students receive: never break down, always have the answer, and to project confidence even if they do not feel it. The ineffective communication and coping skills in a high-stakes environment, such as nursing school, leads to bullying.

- Phase II (2007–2009): QSEN faculty, a national advisory board, and 17 leaders from 11 professional organizations representing advanced nursing practice defined graduate-level quality and safety competencies for nursing education and proposed targets for the KSAs for each competency.
- Phase III (2009–2012): AACN hosted eight faculty development institutes to better prepare nurse faculty in undergraduate programs to teach quality and safety content, with regional trainings held in San Antonio, Washington, DC, Minneapolis, Phoenix, Chicago, Boston, Seattle, and Charleston, SC.

Six core competencies were defined:

1. Patient-centered care
2. Teamwork and collaboration
3. Evidence-based practice
4. Quality improvement
5. Safety
6. Informatics

Additional funding was awarded in 2012 to AACN to build on the work completed at the undergraduate level and to extend the national QSEN initiative to graduate programs (AACN, 2015a).

In 2008, AACN posed that the needs and characteristics of patients and families influence and drive the characteristics and competencies of nurses. This perspective leveraged nursing's professional image by acknowledging the critical value served by connecting specific competencies to patient care. Synergy results when the needs and characteristics of a patient, clinical unit, or system are matched with a nurse's competencies (AACN, 2015b).

Other enhancements to nursing education are coming as the result of technology. Innovations are enhancing the creativity used in teaching across nursing, as well as all the health care disciplines. Online platforms (e.g., blackboard) and programs plus mobile devices (e.g., tablets) provide new ways to engage students in interactive learning (Robert Wood Johnson Foundation, 2012). Interactive learning has been measured to triple students' gains in knowledge (Lambert, 2012). Looking at the speed by which health care continues to evolve, why would professional schools want to rely solely on the more traditional approaches to education?

Social Work Education and Practice Culture

Social work is viewed as one of the helping professions, if not the one devoted entirely to helping people function the best they can in their environment (CAREERS.socialworkers.org, 2015). The professional descriptor of "helping profession" appears across a majority of social work program websites, as well as those for social work associations (e.g., the National Association of Social Workers [NASW]). Yet, this cultural framing for social work practice equally serves as a contradiction, especially for a profession that prides itself on empowering and advocating for others (e.g., patients, clients, communities). Historically, social workers have had to engage in high levels of professional advocacy to demonstrate both their value and competence to the health and behavioral health fields. There has been considerable effort by social work to define what is unique about their professional perspective, what is shared with other disciplines, and what falls outside of their purview (Bentley & Walsh, 2013).

Flexner had an influence on the education of social workers. As the nation's leading authority on professional education, he devalued social work practice in 1915. Flexner contended that social work practice, or *social casework* as it was known in certain circles, was not a profession. He felt that social work lacked specific application of theoretical knowledge to solving human issues (Social Work Degree Guide, 2015). Earlier discussion in this article cited how medical training relied on hard science, and put little importance on the processing of feelings, whether those of the patient, family, or physician for that matter. In direct opposition to medical education, social work training emphasized values and the relationship-building process, plus the role and rights of clients and families (Bentley & Walsh, 2013). Mastering the art of engaging with individuals, couples, families, groups, organizations, and communities remains a hallmark competency of social work practice today

(Council on Social Work Education [CSWE], 2015b). Social work's professional identity was not one Flexner could relate to.

Other factors to devalue social work's importance in the professional realm included use of terms that described the historic roles of social workers as "friendly visitors" (Richmond, 1903). This verbiage did little to invoke a need for specialized training or professional distinction and contributed to the degrading, if not bullying of social workers. In fact, it equates social work practice more as a volunteer effort than a valuable health or behavioral health discipline.

In addition, social work's heritage is well known for intervening with society's most fragile, needy, and vulnerable populations. Students of baccalaureate level social work practice are educated about the origins of social welfare in America, as based on the Elizabethan Poor Laws of 1594. The laws separated the poor into two classes: the worthy (e.g., orphans, widows, handicapped, frail elderly) and the unworthy (e.g., drunkards, shiftless, lazy; Hansan, 2011). On one hand, the alignment of social workers with these less fortunate members of society empowered the professional vision to avoid stereotypes and openly addresses differences in socialization and status (Bentley & Walsh, 2013). On the other hand, it did little to engender a view of social work as deserving of professional designation.

The development of the American Association of Hospital Social Workers in 1918 boosted formal education opportunities in the field. By 1929, 10 university programs in social work added a more scientific basis to dealing with patients and changing behaviors from mental dysfunction (Social Work Degree Guide, 2015). While almost 800 accredited baccalaureate and master's-level degree programs now appear across the United States (CSWE, 2015a), social work has endured a tough road on its journey to be viewed as a competent and worthy profession. With the field primarily female oriented, social work's continued misunderstanding over the twentieth century was seen as a direct result of the devaluing of women's work (Bentley & Walsh, 2013).

Strengthening social work's foundational core took a big leap forward in 2008 with the development of competency-based standards for education. The CSWE's Educational Policy and Accreditation Standards (EPAS) (2015b) recognized the importance of competency-based education for health and human service professionals. They moved social work education from a model of curriculum design focused on content (what students should be taught) and structure (the format and organization of educational components) to one focused on student learning outcomes (CSWE, 2015b). This action translated to students and stakeholders having an easier time connecting the dots between theory and practice.

Identifying competencies and reflective practice behaviors provides a vehicle for new professionals to articulate the distinct functions of social work practice. The establishment of core competencies for social work students serves to bolster social work's unique contributions and perspective to the industry. Social work's EPAS competencies were consistent with the emerging competency-based approaches of other education accreditation programs (e.g., American Association of Colleges of Nursing, American College of Physicians; Treiger & Fink-Samnick, 2016). The 2015 EPAS version appears in Box 3.

Competency-based approaches promote a needed and heightened vision of professional identity in the workplace for social workers, as well as other disciplines. However, social work continues to struggle with justifying its value to the health care industry, often prompting workplace frustration. Clinical social workers are the largest group of professionally trained mental health providers in the United States and render the majority of counseling and psychotherapy services in the country (McCLain, 2015). There are more than 200,000 clinically trained social workers, more than psychiatrists, psychologists, and psychiatric nurses combined (McClain, 2014). Yet, while social workers have seen themselves as highly trained and knowledgeable clinicians, they constantly face having to explain and demonstrate who they are, if not make the case for their indispensability, especially in host settings (Bentley & Walsh, 2013). The manifesting frustration sets social workers up to feel powerless with respect to patient and organizational decision-making activities. It can equally lead to bullying behaviors among the workforce itself.

BOX 3
The 2015 Educational Policy and Accreditation Standards (Council on Social Work Education, 2015b)

Competency 1: Demonstrate ethical and professional behavior

Competency 2: Engage diversity and difference in practice

Competency 3: Advance human rights and social, economic, and environmental justice

Competency 4: Engage in practice-informed research and research-informed practice

Competency 5: Engage in policy practice

Competency 6: Engage with individuals, families, groups, organizations and communities

Competency 7: Assess individuals, families, groups, organizations, and communities

Competency 8: Intervene with individuals, families, groups, organizations, and communities

Competency 9: Evaluate practice with individuals, families, groups, organizations, and communities

Bullying dynamics can present in a workplace where staff feel like they do not have a voice. A negative and stressful tone is more likely to develop in organizations with pressure on the bottom line (Hoffman, as cited in Getz, 2013). The current health and behavioral health environment is synonymous for these situations. A quantitative sample of 111 social workers from the metropolitan, Washington, DC, area found 58% being the targets of demeaning, rude, and hostile workplace interactions more than once in the previous year (Whitaker, 2012).

Despite social work's mission being aligned with nurturing and helping, as human beings, professionals can have problems with communication or even problems that ultimately become bullying (Reamer, Hoffman in Getz, 2013). Long hours, large caseloads, and the overall emotional toll of the job put all health professionals, especially social workers, under tremendous stress (Getz, 2013). The lashing out of colleagues manifests across helping professions, as staff members consciously and unconsciously release their frustrations on each other—an all too common occurrence.

Implications for Case Management Practice

Traditional models of professional education and practice culture have enabled bullying across all of health care's helping professions. This theme is especially relevant to case management due to the large concentration of helping professionals, especially nurses and social workers, who transition into case manager roles. The revised educational focus across academia has built an atmosphere of greater interprofessional respect. However, there is another factor worth exploring. It involves the connection between the predominance of women in case management and the high incidence of bullying among women in the workplace.

It has long been recognized how case management includes a high concentration of women (Tahan & Campagna, 2010; Tahan, Huber, & Downey, 2006). Current data reflect the same trend. The Commission for Case Manager Certification's recent *Role and Function Study* identified more than 95.2% of the respondents as female (Tahan, Watson, & Sminkey, 2015). This is consistent with the statistics from the last study completed in 2009 (Tahan & Campagna, 2010), which listed 96.4% of the sample as female. These professional demographics for the workforce have changed little since the initial study well over 20 years ago.

The workplace is fraught with bullying, especially among women. Woman-on-woman harassment continues to be on the rise (Tulshayan, 2012). As high as 95% of women believed that they were undermined by another woman in the workplace at some point in their career. Some reports speak to as many as 40% of the reported bullies being women (Drexler, 2013). It stands to reason that women who reach positions of power should be mentors to those who followed. Yet, this is not the norm.

Woman may be conventionally viewed as natural helpers, yet they are potentially more vulnerable to, if not less secure in managing the power dynamic. Those women who work under female supervisors have reported more symptoms of physical and psychological stress than did those working under male supervisors. In fact, women employed in industries, which remain male-dominated, are reported to feel more vulnerable to threats from colleagues (Drexler, 2013).

> Though it is getting easier to be a professional woman, it is by no means easy. Some women assume that their perches may be pulled from beneath them at any given moment (and many times, they are indeed encouraged to feel this way). Made to second-guess themselves, they try to ensure their own dominance by keeping others, especially women, down. (Drexler, 2013)

This information should provide a moment of pause for every case manager, whether male or female. Otherwise, case management will surely recreate the famed cliché' of its nursing forbearers, and future generations of case managers will be referred to as "eating their young."

Advocacy and Action on the Move

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 (Fink-Samnick, 2015). Since the publication of Part 1 (Fink-Samnick, 2015), new organizational initiatives and guidelines focused on bullying and WPV have appeared. The following section discusses those of particular interest and relevance for case management.

Federal Guidelines

Occupational Safety & Health Administration (OSHA)—In April of 2015, OSHA released the updated, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (OSHA, 2015). The publication applies to those members of the health care workforce practicing across five different settings, including hospitals, residential treatment, nonresidential treatment/service, community care, and field work.

The Guidelines detail:

- Risk factors
  - Patient, clients, and setting
  - Organizational
- Violence prevention program elements
  - Management commitment and worker participation

  - Worksite analysis and hazard identification
  - Hazard prevention and control
  - Safety and health training
  - Record keeping and program evaluation
- Workplace violence program checklist

The U.S. Department of Veterans Affairs—Effective, April 20, 2015, the U.S. Department of Veterans Affairs rolled out the *Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement* (U.S. Department of Veterans Affairs, 2015). The policy

- includes commitment and obligation to proactively prevent unlawful discrimination, harassment, and reprisal;
- reaffirms the VA commitment to their Mission and core values-integrity, commitment, advocacy, respect, and excellence;
- prohibits workplace violence and bullying and harassment, as well as prohibited personnel practices of discrimination, coercion, intimidation, preferential treatment, and so forth; and
- reaffirms whistleblower rights and protection.

Professional Association Action

American Nurses Association (ANA)—The summer saw robust activity from the ANA. The *Professional Issues Panel on Incivility, Bullying and Workplace Violence* developed a new position statement. Released in July of 2015, it affirmed the ANA's commitment to protect the workforce. The key points include the following:

- The nursing profession will not tolerate violence of any kind from any source.
- RNs and employers must collaborate to create a culture of respect.
- Evidence-based strategies that prevent and mitigate incivility, bullying, and workplace violence promote RN health, safety, and wellness and optimal outcomes in health care.
- The strategies are listed and categorized by primary, secondary, and tertiary prevention.
- The statement is relevant for all health care professionals and stakeholders.
- All nursing personnel have the right to work in healthy work environments free of abusive behavior such as bullying, hostility, lateral abuse and violence, sexual harassment, intimidation, abuse of authority, and position and reprisal for speaking out against abuses. (ANA, 2015)

The American Organization of Nurse Executives (AONE) and the Emergency Nurses Association (ENA)—The ENA and the AONE recognized the negative impact of workplace violence on workforce safety, with retention and attrition of nurses also at issue (Trossman, 2015). To that end, these two powerful organizations united to publish *Guiding Principles for Mitigating Workplace Violence* (AONE and ENA, 2015).

1. Violence can and does happen anywhere.
2. Healthy work environments promote positive patient outcomes.
3. All aspects of violence, including those involving patients, families, and colleagues, must be addressed.
4. A multidisciplinary team is needed to address workplace violence.
5. Everyone in the organization is accountable for upholding behavior standards.
6. When members of a health care team identify an issue that contributes to workplace violence, they have an obligation to address it.
7. A culture shift requires intention, commitment, and collaboration of nurses with other health care professionals at all levels.
8. Addressing workplace violence may increase the effectiveness of nursing practice and patient care.

National Association of Social Workers—In August of 2015, social worker Lara Sobel was shot and killed as she left a Vermont state office building. The perpetrator was a mother who was upset that she lost custody of her 9-year-old daughter (Despart, 2015). Sobel had been intervening with the family. This crime was not the first such brazen and vicious attack on a social worker and will not be the last. More than 10 social workers have been killed in the line of duty over the past decade including Ms. Sobel, with an expanding list of names on the NASW Foundation Memorial Page (NASW, 2015a).

The U.S. Bureau of Labor Statistics reported that in 2013 nearly 1,100 social workers, including private and governmental, were injured as a result of violence. Among the 490 state government social workers injured by violence that year, nearly a third worked with children and families (Mercer, 2015). The NASW, like ANA, has assumed a strong stance to advocate for the safety of its workforce. A designated page of resources and initiatives is accessible through the NASW website (NASW, 2015b). The document, *Guidelines for Social Work Safety in the Workplace* (NASW, 2013), was discussed in Part 1 and serves as a valuable document to individual professionals and their employers.

Organizations and Initiatives

Workplace Bullying Institute (WBI)—The WBI is the first and only U.S. organization dedicated to the eradication of workplace bullying. The WBI provides help for individuals, research, books, public education, training for professionals and employers, legislative advocacy, and consulting solutions for organizations (WBI, 2015). Founded by Drs. Gary and Ruth Namie, the website (www.workplacebullying.org) includes an extensive amount of resource information.

Minding the Workplace: Blog of the New Workplace Institute—Hosted by David Yamada, Minding the Workplace is dedicated to news and community about work and employment relations. Dr. Yamada is an internationally recognized authority on the legal aspects of workplace bullying and author of model antibullying legislation titled the Healthy Workplace Bill (HWB), a template for law reform efforts across the country. The blog and further information about the New Workplace Institute can be accessed at https://newworkplace.wordpress.com/about/.

Alberta Bullying Research, Resources & Recovery Center, Inc.—Based in Alberta, Canada, Alberta Bullying Research, Resources & Recovery Center, Inc. (ABRC) offers a variety of supportive and educational services to those interested and/or affected by workplace bullying. More information can be obtained from the ABRC website at http://www.abrc.ca/index.asp.

Legislation

There continues to be no federal law directly addressing bullying, as noted in Part 1.

The United States is the last of the western democracies to not have a law forbidding bullying-like conduct in the workplace. Scandinavian nations have had explicit antibullying laws since 1994. Many European nations have substantially more legal employee protections, which compel employers to prevent or correct bullying (Healthy Workplace Bill, 2015a).

With bullying a global issue of paramount concern, strong advocacy efforts are working to obtain support for the HWB, especially in the United States and Canada. At the time of this writing, 31 legislatures across 29 states and two territories have introduced HWB or a modification (Healthy Workplace Bill, 2015b).

With respect to nursing, 21 states have enacted and/or adopted laws addressing workplace violence (ANA, 2015). The current map on the ANA website shows those states which have passed legislation. With well more than 150 shootings in health care facilities over the past decade, some states have adopted legislation banning guns in hospital settings (Keen, Catlett, Kubut, & Hsieh, 2012). The American Medical Association has amped up its advocacy efforts, including those for both physician and gun violence prevention (American Medical Association, 2015).

A number of states have worked to pass laws to protect social workers from violence, including Kentucky, Kansas, Massachusetts, and West Virginia. The NASW continues to push for a National Social Worker Safety Act. The law would be modeled after the 2013 Massachusetts Law that ensures that workplace violence prevention programs and crisis response plans are in place at agencies providing direct services to clients that are operated, licensed, certified, or funded by a department or division of the Massachusetts Executive Office of Health and Human Services (Pace, 2013).

Conclusion

This article identified multiple reasons for the presence of bullying and WPV in health care, among them traditional academic curricula, professional practice culture, gender bias, and power dynamics. Independent of cause, the mantra moving forward must be the same. Bullying and WPV are unwelcome visitors to all health and behavioral health practice settings. They represent dangerous forms of power and control to patients and practitioners that puts all in their wake at gross risk. *This buck stops here and stops now!*

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