

BULLY-BUSTING Basics

Workplace aggression destroys morale, leads to staff turnover, threatens patient care, and wreaks financial havoc. Learning to recognize intimidating behaviors and how to stop them makes sense legally and financially.

FOR 10 YEARS, JANE HAD DONE EVERYTHING FOR the ever-absent Clinical Director, Peter Clark, MD, from creatively balancing his budget to picking up his children and his dry cleaning. She opened his mail, screened his calls, and checked his e-mails. When he announced his plan to hire a development professional to generate support for the Charity AIDS Clinic, Jane had hoped she could take on these responsibilities too.

Instead, Clark hired Sarah, a nurse turned fund-raiser. Sarah was quiet, independent, had a strong fund-raising record, and was passionate about the cause. When writing grants, she kept her office door closed, especially to Jane, who routinely pumped people for gossip. Most days, Sarah ate at her desk and used lunch breaks to train for charity runs. Jane called her “the worm.” One day Sarah overheard Jane tell colleagues Sarah had an eating disorder and serious family problems. The next week, Jane accused her of spreading a computer virus. Jane confiscated Sarah’s computer and assigned her the spare in the break room. Jane demanded Sarah’s documents be submitted to her for final clearance and distribution, declaring it office policy. When Sarah requested the budget for the Charity fund-raiser six months away, Jane said she’d get the numbers if Sarah thought she’d



survive that long. Five months and numerous requests later, Sarah still had no budget and no computer. Every time Sarah booked a meeting with Dr. Clark, Jane canceled it. The staff had stopped speaking to Sarah and no one made eye contact. On the rare occasions when Dr. Clark breezed into the office,

Jane dominated his time. After one such occasion, Jane told Sarah that Dr. Clark canceled the fund-raiser.

Six months after she was hired, Sarah succeeded in getting one message through to Dr. Clark—her resignation.

Bullying in the workplace—a.k.a., psycho terror, mobbing, psychological violence, neuropsychological compromise, can cause irreparable harm to individuals and pose significant financial burdens for health-care facilities and institutions. The Workplace Bullying Institute (WBI) (www.bullyinginstitute.org) calls it the silent epidemic and defines bullying as “the repeated mistreatment of one employee targeted by one or more employees with a malicious mix of humiliation, intimidation, verbal abuse, and work interference.”

Despite its healing orientation, the health-care field offers no immunity to bullying. Gary Namie, PhD, the director of the Workplace Bullying Institute in Bellingham, Washington, and the co-author of *The Bully at Work* (Sourcebooks, 2003) believes bullying is endemic in the health-care arena.

Physicians may encounter such abusers of power in any health-care setting. A bully might be the office manager who is always good for a dose of gossip, or the head nurse

who just lost the best half of the staff, or the new center director smiling across the hospital billboard who has turned staff meetings into a stage for his relentless raging criticism.

As with other forms of abuse, victims frequently suffer in silent shame. Human nature moves coworkers to avoid the troubled target, remain on guard, and even befriend the bully out of fear of becoming the next victim. The disorder spreads and the symptoms appear—a decline in work performance, a rise in ab-

senteism, rapid staff turnover, and the departure of the best and brightest, a prevailing aura of distrust, resentment, and hostility. Pity the patients who seek care within a facility staffed by distracted and bullied professionals. Toxicity in the health-care workplace has the potential to affect patient care and safety. Recognizing and effectively dealing with workplace bullying and backing it up with a code of conduct and zero tolerance for less-than-civil behavior are critical to preventing human and financial harm that can reach devastating levels.

A malignancy of power

“It’s all about power,” says Judith Glaser, the CEO of Benchmark Communications, Inc., and author of *The DNA of Leadership*, (Platinum Press, 2006). Leaders who abuse their role and cross the line from boss to bully turn workers into victims, thereby creating a toxic environment for everyone.

A lot of classic social psychology experiments like the Lombardo experiment at Stanford and the Milgram Studies at Yale show that putting people in positions of power over others can lead them to be surprisingly cruel, says Ben Dattner, PhD, a professor at New York University and a principal of Dattner

Consulting, LLC, a New York-based organizational consulting and research firm.

Of course, not everyone who is entrusted with power is destined to abuse it. “I wouldn’t say that all narcissists are bullies or that all bullies are narcissists, but there is certainly some overlap conceptually between narcissists [and those] who are exploitative,” says Dattner. “With such personalities, there is an attitude of entitlement that could definitely correlate with

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A Long-Range Plan to Beat Bullying

- * Establish a policy against all forms of harassment that includes bullying
- * Develop a policy-enforcement strategy
- * Involve Human Resources to be advocates of complainants
- * Teach all employees how to recognize bullying
- * Teach managers that bullying is unacceptable and to report peers who abuse power
—WBI
- * Set an example for the behavior you wish others to model
- * Pay close attention to staff morale
- * Reward those who display the consideration and tact you hope to propagate
—B. Dattner
- * Create a patient-centered environment
- * Avoid “boss-centric” operations that encourage staff to become boss-pleasing rivals
—J. Glaser

✓ Bullies often target people who are talented, popular with clients or patients, and independent thinkers.

being a bully.”

While bullying is often thought of as the bad behavior of bosses, a phenomenon known as “horizontal violence” is a form of bullying that occurs among workers on the same level. Despite a dearth of U.S. statistics, this form of bullying is considered a significant problem in the nursing profession. (*Journal of Advanced Nursing*, 2003).

A bully’s strategies can range from

bold public displays to insidious destructive acts. “[Bullying behavior] could be screaming, cursing, spreading vicious rumors, sabotaging people by destroying their property or their work product. A lot of times, with bosses, it’s excessive criticism,” says Robin Bond, Esq., the managing partner of Transition Strategies, LLC, a workplace law firm in Wayne, Pennsylvania, who served as a hospital counsel for 10 years. Bullying

behavior can also lead to hitting, slapping, and shoving.

Bullying that escalates to physical violence among health-care workers only sounds like fiction, but in 1993, the U.S. Bureau of Labor Statistics reported health-care and social service workers as having the highest incidence of occupational assault injuries.

According to WBI, three main workplace factors set the stage for bullying: opportunity—often created by a highly competitive environment; the presence of people willing to exploit others; and an employer who refuses to punish or one who promotes and rewards individuals who bully.

The health-care environment is particularly bully-prone, says Namie. “We get the most complaints from health care.” A 2002 national survey of workplace aggression reported 41 percent of workers experience psychological workplace aggression in a given year. (*Handbook of Workplace Violence*, Sage 2006). By comparison, a study of 2,884 medical students representing 16 U.S. medical



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When Paul Rodenhauer, MD, now an emeritus professor of psychiatry at Tulane School of Medicine, was at another institution, he was continually ridiculed by the department chairman and vice-chairman. Over several years, the chair continued to criticize Rodenhauer’s work. One day, the chair admitted being jealous of him, but the admission didn’t stop the behavior. Fortunately, Rodenhauer had supportive peers and positive feedback from his work, including teaching awards, and there was a growing unpopularity of the two department leaders that helped balance the skewed reality of the encounters with his supervisors.

schools from the class of 2003, found that 42 percent reported having experienced harassment and 84 percent experienced belittlement during med school. (*BMJ*, September 30, 2006).

Health-care work settings tend to be fast-paced and attract a distinct mix of people—a large population of individuals with strong egos and a willingness to exploit others working alongside a large population of people who have a pro-social orientation and want to heal, teach, and help others, says Namie. In addition, bullying behavior often passes as ambition. Ironically, these are the very people who get rewarded and promoted and who have made themselves invaluable to key people. Dattner agrees. “There’s definitely a dynamic where people kiss up and kick down,” he says.

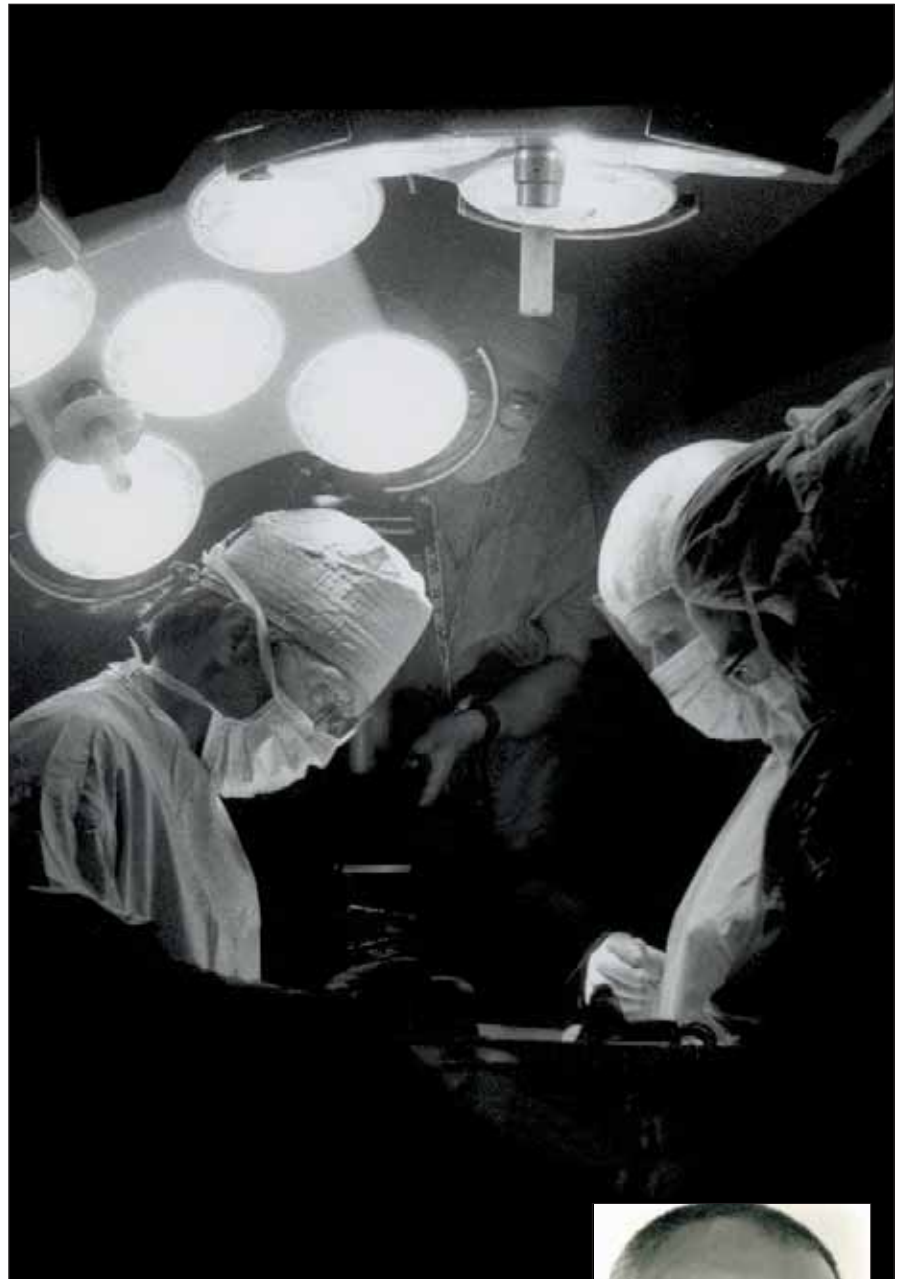
In addition, Namie says, few institutions have an established code of conduct or a policy against bullying. It’s so prevalent in health care that employees often think of bullying as an acceptable occupational hazard. This makes it even more dangerous as people become immune to the consequences, do not challenge the manner of conducting business, and become increasingly suppressed and oppressed.

The WBI describes four common bullying behavior patterns: the screaming, fist-pounding individual who cultivates fear; the friend-to-your-face who stabs in the back; the constant critic; and the gatekeeper who bars access to materials and information. Though their styles may differ, “what all bullies share is that they are Machiavellian,” says Namie. “They are willing to manipulate other people to accomplish their own goals. Everything is driven by their personal agenda.”

The plight of the target

Bullies often target people who are talented, popular with clients or patients,

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PHOTOS COURTESY MAX AGUILERA-HELLWEG, MD



Prior to entering medical school, Max Aguilera-Hellweg, MD (above, top) spent eight years in the operating room photographing more than 100 procedures for his book, *The Sacred Heart: An Atlas of the Body Seen Through Invasive Surgery*. Ironically, during his surgical rotation, he was continually belittled and physically pushed and shoved. When he reported these incidents to administration, he was told to say nothing for fear he would fail the rotation.

and independent thinkers. They tend to victimize individuals of integrity who possess a strong sense of values and who have an exploitable vulnerability. "They don't match aggression directed at them with aggression coming back from them," says Namie.

Victims may suffer a gamut of stress-related physical and psychological symptoms, and most end up paying with their jobs. In a 2003 WBI survey of 1,000 volunteer respondents who were victims of bullying, 37 percent were terminated involuntarily and 33 percent quit their jobs.

Bullies affect more than just their targets. They intimidate and manipulate situations so others observe and start to fear, says Glaser. They collect people around them who revere them and want to be a part of their inner circle. Bond says people pick up on bullying dynamics very quickly. They notice how one person is being singled out, and this can lead them to shun or snub the individual, compounding the isolation.

When Max Aguilera-Hellweg, MD, photojournalist, filmmaker, and the author of *The Sacred Heart: an Atlas of the Body Seen Through Invasive Surgery*, (Bulfinch Press, 1997) was an intern, he tried to ignore the name-calling and insults of residents. Though it was not his nature to tolerate abuse, medical school had taught him speaking out gets you nowhere.

Prior to attending medical school, Aguilera-Hellweg spent eight years in the operating room photographing more than 100 surgical procedures for his book. So he greatly anticipated his third-year surgical rotation. However, the rotation became a lesson in intimidation.

Aguilera-Hellweg knew something wasn't right on the second day of his rotation when he expressed to his supervising resident his concern over a patient who had no family and was about to receive a diagnosis of AIDS. The resident

harshly informed him, "we're f***ing surgeons, and if we can't fix it, we don't want to know about it." After that, Aguilera-Hellweg recalls, "it proceeded to get worse on a daily basis."

For inexplicable reasons, Aguilera-Hellweg was singled out. He was told he could ask questions as long as they weren't stupid ones. One resident shouted and demanded that Aguilera-Hellweg address her by her first name while other students were permitted to use her surname without reproach.

A medical condition, essential tremor, further contributed to Aguilera-Hellweg's vulnerability. He elected to take medication as prophylaxis throughout his surgical rotation. However, during a procedure requiring him to apply retraction at an odd angle for an extended period, his arm began to tremble. He informed the resident of his condition. However, instead of requesting relief, the resident yelled at him. A repeat scenario occurred the next day. When Aguilera-Hellweg reminded the resident of his condition twice, she shouted both times, "That's not an essential tremor."

The harsh treatment Aguilera-Hellweg received extended to patients. When he broached the subject of a psychiatric referral for a clinically depressed patient, the resident dismissed the observation and labeled the patient a "mental retard." After reporting these and other incidents to administration, he was advised not to say anything for fear he might fail the rotation.

Unfortunately, the chief resident from surgery rotated into his subspecialty as well. The new intern informed Aguilera-Hellweg that the resident had characterized him as slow and incompetent. The intern advised him to keep his head down and not to ask questions, as the resident would only make fun of him later behind his back. The intern hounded

him on all his duties for the first two days and pushed Aguilera-Hellweg physically. "If I couldn't answer a question correctly, he would shove himself into me. Because I had been told by the administration not to say anything, I held back." With the support of a few upper-level medical residents, he found the courage to tell the intern to stop pushing him around. When he reported the new level of abuse to one of deans who had advised against reporting the behavior, Aguilera-Hellweg was removed from the service.

Despite the new assignment, he was treated as an outcast. He was so traumatized by his surgical rotation his confidence plummeted. In a letter he eventually sent to two administrators, Aguilera-Hellweg described the learning atmosphere: "Daily there is an air of intimidation, ridicule, and spite." In closing, he added, "I hope that drafting this letter will somehow begin to heal me and serve to address these individuals, for no other student or patient should suffer their brutality and unprincipled behavior." In the end, however, Aguilera-Hellweg says his letter didn't change anything. The resident matriculated. And his best friend in medical school, who had born witness to his plight, ultimately shunned Aguilera-Hellweg prior to rotating into surgery with the same abusive resident, hoping to gain favor in anticipation of a future surgical residency application.

Bullying behavior may be more prevalent in acute-care settings and life-or-death situations—a work culture commonly portrayed by prime-time television programs, such as "ER" and "Grey's Anatomy." However, even a gentler-paced field such as psychiatry can suffer the wrath of the bully.

When Paul Rodenhauer, MD, now an emeritus professor of psychiatry at Tulane School of Medicine in New

Orleans, accepted his first academic position as the director of residency education at another institution, he soon began to wonder why the chairman and the vice-chairman had hired him. The chairman visited his office regularly to ask one question: "What have you done now?" He routinely accused Rodenhauser of upsetting the vice-chair. "No matter what I did," says Rodenhauser, "I'd upset him. Of course, I never quite knew what I had done." Over time, he observed an unusual dynamic between the two administrators that appeared to need a third person to serve as the "bad one," a role unwittingly filled by Rodenhauser. "They were pleasant socially, but in the office, they were incredibly oppressive."

Over several years, the chair continued to criticize Rodenhauser's work. One day, the chair admitted being jealous of him, but the admission didn't stop the behavior. Fortunately, Rodenhauser had supportive peers and positive feedback from his work, including teaching awards, and there was a growing unpopularity of the two department leaders that helped balance the skewed reality of the encounters with his supervisors.

Five years after Rodenhauser was hired, he was named department chair while the chairman retired but remained on the faculty as an emeritus professor. With the dramatic power shift and the positioning of Rodenhauser as the vice chair's new supervisor, the former chair and the vice chair quieted down considerably.

Throughout the long career in academic medicine, Rodenhauser has experienced and observed other incidents of bullying in medicine. While he served as an assistant dean for academic and counseling services, numerous medical students sought his guidance in dealing with abusive individuals. One year, reports of bullying were so prevalent that students

met as a group with Rodenhauser. The process of sharing and discussing their experiences seemed to offer some therapeutic benefits.

Legal considerations

Despite the cruelty of workplace bullies, there are no laws in the United States barring such behavior. Eleven states have introduced anti-bullying legislation since 2003; however, not one law has resulted. Anti-bullying laws do exist in some countries in Europe and in Canada. Quebec law states that "Every employee has a right to a work environment free from psychological harassment." And "Employers must take reasonable action to prevent psychological harassment and, whenever they become aware of such behavior, to put a stop to it."

However, even without specific anti-bullying laws in the U.S., there is potential for legal recourse. When you put someone in fear of imminent harm, you could be at fault, says Bond. "Some state criminal codes define 'assault' to include the act of putting someone in imminent fear of serious bodily injury even without an actual touching," she says. Actual physical contact could constitute battery.

Infliction of emotional distress, whether negligent or intentional, and disparagement—the ruining of someone's reputation—are among the more likely legal claims that could stem from workplace bullying. In addition, "harassment, such as bullying, can be illegal if it is directed at someone who is protected by Title VII," says Bond. Discriminatory practices under Title VII of the Civil Rights Act include harassment on the basis of race, color, religion, sex, national origin, disability, or age.

Bullying is trouble for hospitals and medical practices and bad for business. According to Bond, in a 2005 case, an Indiana cardiac surgeon was ordered by

a jury to pay \$325,000 to a perfusionist who sued him for assault and reckless or intentional infliction of emotional distress. Namie says the verdict broke ground as the first workplace bullying case heard in the United States.

How to Stop a Bully

With institutions largely ignoring the problem, "stopping bullying falls to the individual who is targeted," says Namie. While some organizational experts encourage victims to implement traditional conflict resolution strategies, Namie believes such approaches only make a victim more vulnerable. "You'll never reason with a bully."

Instead, he advises victims to do the following: First, name it. Labeling bullying behavior is the first step to restoring personal power. Next, take time off to check physical and mental health. Obtain counseling with a personal clinician rather than one offered through the institution's employee assistance program. EAP clinicians work for the institution, creating the potential for a breach in confidentiality, however inadvertent. Determine if the bully violated any laws. In one-fourth of bullying cases, discrimination plays a role. Undertake the research to determine the institutional cost of keeping the bully—investigate staff turnover rates and the impact on patient care and safety. Focusing on building the business case helps victims move beyond the emotional snare. Finally, expose the bully by presenting the business case rather than the emotional case to the board or someone who has no alliance with the bully and is positioned to take action.

A physician supervising an offender should talk to the individual about the destructiveness of bullying behavior and the consequences on others, Namie says. Don't wait for the offender to make such

discoveries. Implement a contract making continued employment contingent upon refraining from the problematic behaviors. It is important to reinforce intervention at the individual level with an anti-bullying policy or code of conduct at the institutional level. Bullies who aren't psychopathological are usually able to constrain their behavior, however, "Most of the bullies leave," Namie says. "They don't want to play by the changed rules. They refuse to be constrained because all bullying is about control."

Physicians who witness their colleagues bullying should call them on it. Ask them what such behavior has to do with patient care. Muster the courage to stand by victims and refuse to side with a bullying colleague. If an offender is not apparent and an office suffers the classic symptoms of bullying, the physician/leader should pose the tough question: "Could it be me?"

An ounce of prevention

While there is no foolproof approach to avoid hiring a bully disguised as a highly qualified applicant, specific interview strategies can help pinpoint individuals who are more likely to turn tyrannical when entrusted with a degree of power. In addition to thoroughly checking references of all prospective employees, Dattner suggests undertaking consistent behavioral interviews, asking applicants to: "describe a time when you had a difficult time motivating an employee" or "describe ways you adapt your style based on the unique expectations and needs of diverse employees." Other useful questions might include, "Describe a time when you lost a valued employee," or "How would others characterize the good aspects of your management style and the more challenging aspects of your management style?" Such questions will help determine whether a person is able

to articulate sensitivity and consideration for other people. Personality testing, such as the Hogan Personality Inventory, may also be useful.

Along with carefully screening prospective employees, "what doctors can do in their practices is make sure there is a disincentive," says Dattner. The leader can make it clear to individuals in supervisory positions—"what the people below you think of you is as important if not more important than what I think of you." Implementing 360-degree feedback, in which an individual's compensation is a function of how well the person is regarded by other staff, is one such strategy. If someone begins to abuse their position of power over others, it's possible to reposition that individual so that they do not have direct or indirect power over other staff.

Glaser says the U.S. must do something about bullying in the workplace and in the world. "It has to be elevated to the level of global consciousness."

It takes only one bully to turn an entire workplace toxic. It takes only one courageous person to stop the cruelty. A stand against bullying is a stand against abuse.



Susan Sarver lives in Chicago and writes regularly for *Unique Opportunities*.