Is Your Hospital Safe? Disruptive Behavior and Workplace Bullying

WILLIAM F. MARTIN

Abstract. The author defines disruptive behavior; distinguishes among disruptive, impaired, and incompetent behavior; describes the prevalence of disruptive behavior; and identifies some recommendations to prevent and resolve disruptive behavior in hospitals. The proactive prevention and management of workplace bullying have implications on managing costs, quality, and satisfaction in hospitals among patients, families, staff, and physicians. The author describes an evidence-based framework and recommends that hospital administrators use it to design an organizational approach to promoting a work environment that is psychologically and physiologically safe and that enables staff to focus on delivering high-quality, cost-effective, and satisfying care.

Keywords: bullying, disruptive, impairment, performance, quality

One of the most significant challenges in organizations today is dealing with disruptive behavior in the workplace. Hospitals face such challenges. The Center for American Nurses (2007) published a booklet entitled *Bullying in the Workplace: Reversing a Culture*. Even the landmark Institute of Medicine report, *To Err is Human,* stated that for years "the health system has not had effective ways of dealing with dangerous, reckless, or incompetent individuals and ensuring that they do not harm patients" (1999, 146). In hospitals, the challenge of workplace bullying extends beyond high performance and civility. Recent evidence suggests a link between performance failures, particularly among physicians, and declines in patient safety and welfare (Leape and Fromson 2006). Researchers in this field have also suggested an association between "intimidation (bullying) of and by nurses" (Leape and Fromson 2006, 189) and retention of nurses (Longo and Sherman 2007; Stevens 2002).

Physicians throwing charts, nurses berating less experienced nurses, and supervisors publicly belittling staff are all common examples of disruptive behavior. Such behavior represents one of those managerial challenges that affect not only the target but also the organization itself. This phenomenon is not new; neither are the organizational approaches to preventing and addressing it. Still, bullying remains problematic in most workplaces (see Appendix). Per a survey of 7,740 U.S. adults conducted by Zogby International and the Workplace Bullying Institute (2007), nearly two-thirds (62%) of the respondents reported that employers ignored the situation. The stakes are too high, and the risk is too great for healthcare leaders and managers to ignore them.

Although researchers have documented disruptive behavior for some time and have even devised theoretical models to address such behavior (Piper 2006), the challenge persists. Recent efforts to tackle the problem include the following: (*a*) On

William "Marty" Martin, PhD, is director of the Master's of Science program in Human Resource Management at DePaul University and an associate professor in the College of Commerce. His current research interests are disruptive behavior and socially responsible investing. He has held senior human resources positions at organizations including The Johns Hopkins Hospital.
Copyright © 2008 Heldref Publications

April 9, 2008, in *Daniel H. Raess v. Joseph E. Doescher*, the Indiana Supreme Court affirmed a jury award of $325,000 to a former St. Francis Hospital employee who had accused a prominent heart surgeon of bullying him. (*b*) In March 2008, New York state legislators passed a bill establishing a cause of action for employees who are subjected to an abusive work environment (New York State Assembly 2008). (*c*) In adopting the 2009 Leadership Chapter Standards, the Joint Commission on Accreditation of Hospitals (2008) included requirements that leaders create protocols for managing disruptive behaviors and that they maintain a hospital culture of safety and quality. (*d*) In February 2008, the Center for American Nurses adopted its statement on Lateral Violence and Workplace Bullying. And (*e*) at the 75th Annual Congress of the American College of Health Care Executives, the speaker for the 2008 Bachmeyer Address delivered a call for coordinated, organizational action by healthcare leaders and managers entitled "The Human Aspects of Quality Improvement" (Martin 2008).

Today, healthcare leaders and managers must view workplace bullying not only from a legal point of view but also from the perspectives of organized labor and ethics. More unions are notifying members about workplace bullying. For example, the 2007 Service Employees' International Union (SEIU) contract bulletin at a California hospital warned, "A word on allegations of bullying and threats . . . we have zero tolerance for bullying and threats by anyone inside or outside the organization" (El Camino Hospital 2007).

Lavan and Martin (2007) proposed a model to address workplace bullying as an ethical issue. The popular media have called for a more organized response to workplace bullying, with articles such as "Is Your Boss a Bully: 5 Ways to Fight Back" in the March issue of *Essence* magazine (Hamilton-Wright 2008) and "Don't Tolerate Disruptive Physician Behavior" in the March online issue of *American Nurse Today* (Lazoriz and Carlson 2008).

Hospital leaders and managers must take action when faced with such behavior. They must (*a*) ensure that the environment is a safe place to work, (*b*) make certain that individuals focus on performance rather than protection or vengeance, and (*c*) instill respect and civility as pillars of the organizational culture.

Some researchers assert, "effective antibullying practices must include a statement of exactly what constitutes bullying, because often perpetrators do not define their behavior as problematic" (Stevens 2002, 191–92, citing Gorman 1997). The ability to distinguish among disruptive, impaired, and incompetent behavior is critical because the strategies used to prevent and resolve these issues are specific to each type. The distinctions are especially important when dealing with physicians because the Joint Commission on Accreditation of Hospitals (2008) in its 2009 leadership chapter, in the prepublication standards, requires that healthcare organizations have a specific process to address impaired physician behavior. Furthermore, The Joint Commission on Accreditation of Hospitals' 2009 leadership standards (2008) require that each hospital has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors. This distinction among disruptive, impaired, and incompetent behaviors is not purely academic; it is critical for two reasons. First, to meet the leadership standards, hospital administrators must formulate definitions. Second, a treatment plan is limited by the accuracy of the diagnosis, and a managerial and organizational intervention is limited by the accuracy of the assessment and the root cause of the problem.

Disruptive behavior, sometimes called "dysfunctional behavior" (Griffin and Lopez 2005), is a vague and emotionally laden term. Disruptive behavior ". . . can have a significant impact on care delivery, which can adversely affect patient safety and quality outcomes of care" (Rosenstein and O'Daniel 2008, 1,564).

Similar to the definition of disruptive behavior, the definition of impaired behavior addresses personal issues. Leape and Fromson (2006) defined *impairment* as a "disability resulting from psychiatric illness, alcoholism, or drug dependence" (107). But it focuses on personal health, suggesting that there may be an underlying physiological or psychological illness related to the manifestation of such behavior. Baldisseri (2007) estimated that about 10–15% of healthcare professionals misused drugs at some time during their careers.

The interventions also differ. In the case of disruptive behavior, the initial response is often risk management preceding discipline. For impaired behavior, the initial response is often a referral to employee assistance or physician wellness programs, using the Maslach Burnout Inventory as a pre–post measure (Dunn et al. 2007). For example, the Pharmacy Recovery Network (PRN) covers all

50 states and uses a rehabilitative approach to pharmacists suffering from alcohol and drug abuse (Kenna, Erickson, and Tommasello 2006).

The definition of *incompetent behavior* focuses on professional behavior related to standards, guidelines, and professional norms. *Competence* can be defined as possessing the requisite abilities and qualities to effectively perform professional duties according to specific professional and ethical standards.

Disruptive, impaired, and incompetent behaviors are not mutually exclusive. Any given practitioner may display all three behaviors simultaneously. In this article, I focus on disruptive behavior.

Prevalence of Disruptive Behavior

Namie (2003) found that 71% of the targets of disruptive behavior were bullied by those who outranked them in the hierarchy. Tepper (2000) labeled this as *abusive supervision*, "subordinates' perception of the extent to which supervisors engage in the sustained display of hostile verbal and non-verbal behavior, excluding physical contact" (82).

No definitive source describes the incidence of disruptive behavior in hospital settings. But several recent studies have indicated that the problem is significant. Weber (2004) found that 54.6% of responding physician executives reported that problems with physician behavior occurred more than five times per year. In another study of 1,500 nurses and physicians in 12 states, researchers discovered that 68% of the nurses and nearly half (47%) of the physicians reported witnessing disruptive behavior in which fellow hospital workers targeted other hospital workers (Rosenstein 2002). In an additional study, 88% of the respondents reported encountering some form of disruptive behavior (Institute for Safe Medication Practices 2003).

Gender affects the prevalence of disruptive behavior. Bruder (2001) found verbally abusive behavior toward female nurses was pervasive. Namie (2003) discovered that 80% of all targets of disruptive behavior were women.

Even if the prevalence of such behavior were less frequent, hospital leaders and managers must take into account and would be prudent in heeding the impact of the behavior. As previously mentioned, the 2007 Workplace Bullying Survey found that more than one in three workers (37%) have been bullied, almost three of four bullies (72%) are bosses, and nearly six in ten of the targets (57%) are women.

Disruptive Behavior: Individual and Organizational Consequences

Disruptive behavior has a ripple effect (Keogh and Martin 2004). Negative consequences affect both the individual and the organization. Pfifferling (2003) described the consequences of disruptive behavior on one type of clinical team:

> Disruptive behavior by any member of the oncology team can sabotage professionalism and has clinical, operational, and economic consequences. The interdisciplinary team becomes less productive and creative. At best, work is not as exhilarating as it could be. In the worst-case scenario, working becomes filled with anxiety. (16)

On the level of individual employees, researchers have shown that those who are the targets of disruptive behavior report less organizational citizenship behavior, more psychological distress, greater dissatisfaction with work and life, and an increasing intention to quit work (Duffy, Ganster, and Pagon 2002; Zellars, Tepper, and Duffy 2002). With the national nursing shortage already being a critical problem (Rosenstein 2002), hospitals can not afford to have another cause for turnover.

On the organizational level, disruptive behavior has a negative effect on patient satisfaction, staff performance, and—in more recent studies—quality of care (Longo and Sherman 2007). First, Rosenstein (2005) found a link between disruptive behavior and patient satisfaction. Second, other researchers have established a relation between disruptive behavior and staff health, retention, and even patient care (Firth-Cozens 2001; Hicks 2000). Field (2002) found that bullying was associated with staff turnover, absenteeism, impaired performance, decreased productivity, and poor teamwork. As hospitals struggle with staffing because of labor shortages and escalating hospital costs, hospital leaders and managers must remove all obstacles to staff performance and then develop a culture of high performance.

The most serious potential consequence of disruptive behavior concerns medical errors and patient safety. The *2004 Institute of Safe Medication Practices Survey on Workplace Intimidation* found that "healthcare providers frequently employ intimidating behaviors when interacting with each other" (1). Of the 2,095 respondents in this survey, 7% reported that they were involved in

a medication error during the past year in which intimidation played a role. Other behavior problems may have an even greater effect on medical errors. One analysis of adverse medical events attributed 60% of the cause to "out-of-control physicians" (Atlantic Information Services 2005, 1). Rosenstein and O'Daniel (2005) reported, "between 53% and 75% of respondents said they saw a strong link between disruptive behavior and negative clinical outcomes" (57).

Not only is disruptive behavior linked to a potential increase in errors and mistakes, but also reporting of these problems may be affected. Physicians may not report mistakes and errors because they are concerned about external bodies, such as state medical boards (Kingston et al. 2004). Nurses may not report the mistakes of physicians because they fear being threatened (Kingston et al.).

As of October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will no longer reimburse hospitals for eight preventable conditions: patient falls, pressure ulcers, urinary tract infections, vascular-catheter-associated infections, mediastinitis, air emboli, removal of objects left in the body during surgery, and injury caused by use of incompatible blood products. In short, CMS ends coverage for hospital errors.

Recommendations: Prevention to Treatment

The literature of best practices indicates a variety of strategies to decrease disruptive behavior in hospital settings. These organizational approaches may seem like common sense, but it is not uncommon for healthcare organizations to have "cultural blind spots" (Smith 2003, 313) in which even common sense is difficult to execute. In addition, many organizational change initiatives fail, and healthcare organizations often are slow to learn. Adopting one of the following recommendations is not enough. Leaders need to focus on executing all such changes and must hold themselves accountable for their success.

(*a*) Adopt a policy of zero tolerance for disruptive practitioner behavior and enforce the policy consistently throughout the organization.

(*b*) Create and sustain a high-performance work culture that focuses on attaining organizational goals by enabling individuals and groups at all levels to maximize their full potential.

(*c*) Recognize and reward behaviors that demonstrate collaboration, respect, and a high regard for interpersonal ethics.

The culture of the organization must make clear that disruptive behavior of any type is not acceptable under any circumstances. No exceptions should be made, even for those who are politically connected and those who produce high revenue.

Hospital leaders should consider three themes when constructing an organizational strategy to deal with disruptive behavior: laws and regulations, culture, and systems and processes.

Laws and Regulations: Begin with Compliance, but Move toward Commitment

In the United States, no specific federal legislation forbids disruptive behavior at work. New York is the only state that forbids abusive conduct in the workplace. To date, 13 states have introduced bills. Among them is Oregon State Legislature's (2007) Senate Bill 1035, which would outlaw workplace bullying. As used in this section, "harassment, intimidation or bullying" means any persistent verbal or physical act of an employer or employee that is unrelated to the employer's legitimate business interests and that a reasonable person would find threatening, intimidating, hostile, or offensive. "Harassment, intimidation, or bullying" includes, but is not limited to, derogatory remarks; insults or epithets; physician conduct that a reasonable person would find threatening, intimidating, or humiliating; and the gratuitous sabotage or undermining of an employee's work performance (2).

However, there are two federal statutes that spell out the affirmative duty of managers to provide a safe working environment for employees (Occupational Safety and Health Act of 1970) and ensure a nonhostile work environment (Title VII, Civil Rights Act). Lapenta (2004) asserted that a managerial duty exists "to provide an environment where care can be delivered to patients in a safe and effective manner" (24). Under the General Duty Clause, Section 5(a)(1), of the Occupational Safety and Health Act of 1970, employers must provide their employees with a place of employment that "is free from recognizable hazards that are causing or likely to cause death or serious harm to employees."

Even accreditation standards (e.g., The Joint Commission on Accreditation of Hospitals 2009 leadership standards; Joint Commission on Accreditation of Hospitals, 2008) address the issue. Both the American Medical Association (AMA; 2004) and the American Bar Association (ABA; 2005)

have set forth recommendations for healthcare organizations. In 2000, the AMA adopted a disruptive behavior policy setting forth this recommendation:

> Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions or policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness or equivalent committee. (2)

Although this recommendation addresses the medical staff, healthcare organizations should implement policies and procedures for all staff who display disruptive behavior. In nursing, for example, the Florida Nurses Association (Florida Nurses Association; 2007) Board of Directors formulated *FNA Proposal for Action 2007 on the Eradication of Horizontal Violence and Bullying in Nursing*.

The American Bar Association (ABA; 2005) also recommended a five-step disciplinary process for disruptive behavior. This process starts with a verbal warning and proceeds to governance action if the behavior continues.

For any policies and procedures to be perceived as just, it is essential that reporting a complaint has no repercussions. Because nurses are concerned about intimidation and fear retaliation (Rosenstein 2002), this condition is critical. Another way of assuring perceived fairness is to attend to due process in all procedures, but particularly in peer review and any grievance procedures (Pfifferling 2003). No direct competitors of the disruptive individual should be involved in any of the proceedings.

The Workplace Bullying Institute in collaboration with Zogby (2007) found that 3% of targets of workplace bullying filed lawsuits. One such example is *Dunn v. Washington County Hospital and Thomas J. Coy*, in which the court ruled as follows:

> Employees are not puppets on strings; employers have an arsenal of incentives and sanctions (including discharge) that can be applied to affect conduct. It is the use of (or failure to use) these options that makes an employer responsible—and in this respect independent contractors are no different from employees. Indeed, it is no difference whether the actor is human. (3)

Culture: The Way We Act Around Here

Healthcare leaders and managers in hospital settings must take a proactive role in creating and sustaining a safe, high-performing hospital culture for all workers. Smetzer and Cohen (2005) strongly recommended that healthcare organizations develop a culture of openness, honesty, respect, and cooperation to address workplace intimidation.

The first step to a functional organizational culture is a psychologically and physically safe culture. To develop a safe culture, administrators should first write and publish behavioral expectations for all employees and manage adherence to those expectations with the same diligence as with a balance sheet, income statement, marketing plan, or the Joint Commission on Accreditation of Hospitals (2008) requirements. Second, administrators should address complaints of workplace bullying if they arise. One empirical investigation found that less than half of all nurses were satisfied with the response of their organization when they complained of workplace bullying (Aiken 2001). Third, administrators should approach bullying as an organizational-development intervention and should leverage existing resources, such as the Call for Action of the American Association of Critical-Care Nurses Zero Tolerance for Abuse position statement, which falls under their Healthy Work Environment initiative.

Thus, at one urban hospital on the Gulf Coast, voluntary turnover among nursing staff was higher than in comparable hospitals in that region. One of the factors identified through observations, focus groups, and data review was that the climate was "abusive." Staffers demonstrated "disruptive behaviors," ranging from verbal threats and unwarranted accusations to berating of other staff in front of patients, family members, and others. Some staffers reported that they had experienced physical and psychological harm. To change the culture, senior hospital leadership launched the American Association of Critical Care Nurses' Healthy Work Environment Initiative (2004).

Systems and Processes

Systems and processes enable hospital leaders and managers to weave policies, procedures, and behavioral expectations into the fabric of the organization. I address three systems and processes influential to disruptive behavior: selection and orientation, education and training, and performance management.

Selection and orientation. First, hospital administrators can use selection and orientation as a resource to prevent disruptive behavior. A well-designed selection and orientation system should be able to

differentiate not only between potential high and low performers but also between those who are likely to demonstrate desired behaviors and those who are not, especially under stress. Suggestions for a functional selection and orientation system are to:

(*a*) Develop an orientation process for new employees and voluntary medical staff to clearly teach the expected behaviors and norms.
(*b*) Update job descriptions on the basis of a job analysis and competency development process that focuses on collaboration and teamwork.
(*c*) Adopt a behavior-based job interview process to not only select for skills but also for behavioral competencies and a behavioral fit with the culture.

Education and training. To modify the behavior of those who demonstrate disruptive behavior, it is critical to identify the root causes and to work on the source of such behavior, without condoning or excusing it in any way. For the potential victims of disruptive behavior, Gardner and Johnson (2001) advised that employers train workers about their rights and responsibilities on an ongoing basis. For the disruptive individual, administrators should use simulations, role-playing, and case studies or other experiential learning tools to maximize "transfer of learning" to the actual work situation (10). Outside the classroom, a powerful educational influence occurs when key executives model expected behaviors. According to LeTourneau (2004),

> The lead physician executive and the lead nurse executive must forge, then become a model for, a collaborative and respectful relationship. . . . The physician and nursing executives must initiate the development of an organizational vision of how physicians and nurses should work together for the benefit of the patient. (13)

LeTourneau further advocated that at the highest levels of the organization, the "senior management team, the medical staff leadership, and the board must participate in the development of these activities" (13). Peskett, Empey, and Johnson (2006) argued that "culture and leadership are inextricably intertwined" and that "successful leadership must incorporate emotional intelligence and should encourage its development in others" (194).

Performance management. Although managers must be actively engaged throughout all of these interventions, hospital leaders and managers must take a unique role in preventing and swiftly resolving issues related to disruptive behavior in hospital settings. Keogh and Martin (2004) proposed a managerial framework that first invites the manager to determine the "ripple effects" of the disruptive behavior (19). If the consequences, or ripples, are too large to be ignored, then managerial action must be taken. Keogh and Martin outlined four different actions: coaching, mediating, referring, and disciplining. They recommended that these interventions be woven into part of a hospital management system:

> In the end, preventing and managing disruptive behavior is directly proportional to your organization's underlying performance management system and associated policies and procedures. (22)

Conclusion

Hospital leaders and managers are agents of their respective organizations, but they are also fiduciaries. As fiduciaries, they are required by sound leadership principles and increasingly by legal and accreditation standards to ensure that healthcare organizations are not only safe for patients but also safe for employees. These organizations must be safe not only physically but also psychologically. Thus, hospital leaders and managers must proactively create high-performance work cultures that enable the talented members of the organization to realize their full potential. The realization of full potential is naturally limited if disruptive behavior harms its target, if such behavior distracts and distresses witnesses, and if the perpetrator of such behavior focuses on bullying rather than accomplishing work tasks that directly or indirectly benefit the patient and the organization. Dealing with disruptive behavior must share the stage with other organization-wide initiatives by which hospital administrators attempt to build an excellent organization.

REFERENCES

Aiken, L. H., S. P. Clarke, D. M. Sloane, J. A. Sochalski, R. Busse, H. Clarke, P. Giovannetti, J. Hunt, A. M. Rafferty, & J. Shamian. 2001. Nurses' reports on hospital care in five countries. *Health Affairs* 20 (3): 43–53.

Alspach, G. 2007. Editorial: Critical care nurses as coworkers: Are our interactions nice or nasty? *Critical Care Nurse* 27 (3): 10–14.

American Association of Critical Care Nurses. 2004. *Zero tolerance for abuse position statement.* http://classic.aacn.org/AACN/pubpolcy.nsf/Files/ZeroPosStmt/$file/Zero%20Tolerance%20for%20Abuse%204.12.04.pdf (accessed March 17, 2008).

American Bar Association (ABA). 2005. Disruptive practitioners: Managing the risks. *ABA Health eSource* 6 (1). http://www.abanet.org/health/esource/vol1no6/ (accessed March 30, 2008).

American Medical Association (AMA). 2004. Staff less tolerant of rude doctors. *AMA Medical News Online*. http://www.ama-assn.org/amednews/2004/09/20/prl20920.html (accessed March 30, 2008).

Atlantic Information Services. 2005. Disruptive physicians pose compliance, risk management problems for hospitals. *Report on Medicare Compliance* 14 (17): 1–8.

Baldisseri, M. R. 2007. Impaired healthcare professional. *Critical Care Medicine* 35 (Suppl. no. 2): S106–S116.

Bruder, P. 2001.Verbal abuse of female nurses: An American medical form of gender apartheid? *Hospital Topics* 79 (4): 30–34.

Center for American Nurses. February 2008. *Position statement on lateral violence and workplace bullying.* http://www.centerforamericannurses.org/positions/lateralviolence.pdf (accessed March 30, 2008).

———. 2007. *Bullying in the workplace: Reversing a culture*. http//www.nursingworld.org/books/candescr.cfm?cnum=33& (accessed March 30, 2008).

Daniel H. Raess v. Joseph E. Doescher. No. 49S02–0710–CV–424 (April 8, 2008). www.bullyinginstitute.org/education/indianacase/INsupreme.pdf (accessed April 12, 2008).

Duffy, M. K., D. Ganster, and M. Pagon. 2002. Social undermining and social support in the workplace. *Academy of Management Journal* 45:331–51.

Dunn, P. M., B. A. Bengt, J. F. Christensen, & L. Homer. 2007. Meeting the imperative to improve physician well-being: Assessment of an innovative program. *Journal of General Internal Medicine* 22:1544–52.

Dunn v. Washington County Hospital and Thomas J. Coy. No. 65–1277_F.3d._(7th Cir. 2005).

El Camino Hospital. July 18, 2007.*2007 SEIU contract bulletin* 2 (10): 1–3. http://www.elcaminohospital.org/documents/SEIU/SEIU_Bulletin_10_071807.pdf (accessed March 30, 2008).

Field, T. 2002. Bullying in medicine. *British Medical Journal* 324:786.

Firth-Cozens, J. 2001. Interventions to improve physicians' well-being and patient care. *Social Science & Medicine* 52 (2): 215–22.

Florida Nurses Association. 2007. Eradication of horizontal violence and bullying in nursing. *Florida Nurse* 55 (4): 1–29.

Gardner, S., and P. R. Johnson. 2001. Sexual harassment in healthcare: Strategies for employers. *Hospital Topics* 79 (4): 5–11.

Griffin, R. W., and Y. P. Lopez. 2005. Bad behavior in organizations: A review and typology for future research. *Journal of Management* 31:988–1005.

Hamilton-Wright, K. J. 2008. Is your boss a bully? 5 ways to fight back. *Essence* [Magazine], March 2008. http://www.essence.com/essence/workandwealth/atwork/0,16109,1713371,00.html (accessed March 30, 2008).

Hicks, B. 2000. Time to stop bullying and intimidation. *Hospital Medicine* 61:428–31.

Institute of Medicine. 1999. To err is human. Washington, DC: National Academy Press.

Institute for Safe Medication Practices. 2003. ISMP survey on work place intimidation. *ISMP Medication Safety Alert,* March 11, 2004. http:www.ismp.org/MSArticles/intimidation.html (accessed March 30, 2008).

The Joint Commission on Accreditation of Hospitals. 2008. *2009 leadership chapter: Hospital* program pre-publication standards. Oak Brook, IL. http://www.jointcommission.org/NR/rdonlyres/0376B4EC-0F1A-42E0-AD23-7D7D1680E3C3/0/09_ld_hap_prepubstds.pdf (accessed March 30, 2008).

Kenna, G. A., C. Erickson, and A. Tommasello. 2006. Understanding substance abuse and dependence by the pharmacy profession. *United States Pharmacist* 31 (5): HS21–HS33.

Keogh, T., and W. Martin. 2004. Managing unmanageable physicians: Leadership, stewardship and disruptive behavior. *Physician Executive* September/October: 18–22.

Kingston, M. J., S. M. Evans, B. J. Smith, and J. G. Berry. 2004. Attitudes of doctors and nurses towards incident reporting: A qualitative analysis. *Medical Journal of Australia* 181 (1): 36–39.

Lapenta, S. 2004. Disruptive behavior and the law. *Physician Executive* September/October: 24–26.

Lavan, H., and W. M. Martin. 2007. Bullying in the U.S. workplace: Normative and process-oriented ethical approaches. *Journal of Business Ethics*, July 13, 2007. http://www.springerlink.com/content/xlrxu764222n4237/ (accessed March 30, 2008).

Lazoriz, S., and P. J. Carlson. 2008. Don't tolerate disruptive physician behavior. *American Nurse Today* 3 (3). http://www.americannursetoday.com/ME2/dirmod.asp?sid=&nm=&type=Publishing&mod=Publications%3A%3AArticle&mid=8F3A7027421841978F18BE895F87F791&tier=4&id=F7C9DD1DE0C846FD8DA829B312338D81 (accessed March 30, 2008).

Leape, L. L., and J. A. Fromson. 2006. Problem doctors: Is there a system-level solution? *Annals of Internal Medicine* 144:107–15.

LeTourneau, B. 2004. Physicians and nurses: Friends or foes? *Journal of Healthcare Management* 49 (1): 12–15.

Longo, O., and R. Sherman. 2007. Leveling horizontal violence. *Nursing Management* 38 (3): 34–37, 50–51.

Martin, W. F. March 10, 2008. The human aspects of quality improvement. Bachmeyer Address at the 75th Annual Congress of the American College of Health Care Executives, Chicago, IL.

Namie, G. 2003. Workplace bullying: Escalated incivility. *Ivey Business Journal* November–December: 1–6.

New York State Assembly. March 17, 2008. An act to amend the labor law, in relation to establishing a private cause of action for employees who are subject to an abusive work environment. Bill 10291. http://assembly.state.ny.us/leg/?bn=A10291&sh=t (accessed April 11, 2008).

Oregon State Legislature. 2007. Senate Bill 1035. 74th Oregon Legislative Assembly. http://workplacebullyinglaw.org.states/pdf-docs.sb1035.intro.pdf (accessed April 11, 2008).

Peskett, S., D. Empey, and N. Johnson. 2006. Safety, culture, and leadership. *British Medical Journal Career Focus* 332(7550): 194–95.

Pfifferling, J.-H. 2003. Disruptive staff members. *Oncology Issues* 16–21.

Piper, L. E. 2006. A theoretical model to address organizational human conflict and disruptive behavior in health care organizations. *Health Care Manager* 25 (4): 315–320.

Public Law 91-596. 1970. Occupational Safety and Health Act of 1970.

Public Law 88-352. Title VII. Civil Rights Act of 1964.

Rosenstein, A. H. 2002. Nurse–physician relationships: Impact on nurse satisfaction and retention. *American Journal of Nursing* 102 (6): 26–33.

Rosenstein, A. H., and M. O'Daniel. 2008. Managing disruptive physician behavior: impact on staff relationships and patient care. *Neurology* 70:1564–70.

Smetzer, J. L., and M. R. Cohen. 2005. Intimidation: Practitioners speak up about this unresolved problem. *Joint Commission Journal on Quality and Patient Safety* 31:594–99.

Smith, T. 2003. How can healthcare organizations enhance their capacity to learn? *Quality and Safety in Health Care* 12:313–16.

Stevens, S. 2002. Nursing workforce retention: Challenging a bullying culture. *Health Affairs* 21 (5): 189–193.

Tepper, B. J. 2000. Consequences of abusive supervision. *Academy of Management Journal* 43: 178–90.

Weber, D. O. 2004. Poll results: Doctors' disruptive behavior disturbs physician leaders. *Physician Executive*. September/October: 6–14.

Workplace Bullying Institute. 2007. The workplace bullying institute U.S. workplace bullying survey, September 2007. http://www.bullyinginstitute.org/wbi-zogby.2007.html (accessed March 30, 2008).

Zellars, K. L., B. J. Tepper, and M. K. Duffy. 2002. Abusive supervision and subordinates' organizational citizenship behavior. *Journal of Applied Psychology* 87:1068–76.

APPENDIX
Key Findings from 2007 Survey

- 37% of workers have been bullied.
- Most bullies are bosses (72%).
- Most targets are women (57%).
- Bullying is four times more prevalent than harassment.
- 62% of employers ignore the problem.
- 45% of targets suffer stress-related health problems.
- 40% of bullied individuals.
- Only 3% of bullies file lawsuits.

Source: Workplace Bullying Institute (2007).

SERVICES FROM
heldref PUBLICATIONS
Advertising • Archives
Back Issues • Bulk Orders
Meeting Room Rental
Reprints • Sample Copies
Subscriber List Rental

HELDREF PUBLICATIONS
Subscription Office:
PO Box 830350,
Birmingham, AL 35283-0350
T: 866.802.7059
F: 205.995.1588
heldref@subscriptionoffice.com

Editorial Office:
1319 Eighteenth St., NW
Washington, DC 20036-1802
T: 800.365.9753
F: 202.296.5149
www.heldref.org

Copyright of Hospital Topics is the property of Heldref Publications and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.