Ann & Robert H. Lurie
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Children's Community Physicians Association

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ccpa news

SUMMER/FALL 2024

Letter from CCPA/CCPAPP's Executive Director Kena Norris, D.Sc., MJ, FACHE

Workplace violence is becoming a more common reality than we care to imagine with about two million employees impacted annually. The U.S. Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site."

Moreover, OHSA reported that 'incidents of serious workplace violence were four times more common in healthcare settings than in the private industry,' thus posing a real threat to healthcare employees. Therefore, OSHA strongly recommends that "the best protection healthcare employers can offer workers is to establish a zero-tolerance policy toward workplace violence." Once the policies and procedures are completed, the next step is properly training staff to handle workplace violence situations, which could mean the safety and survival for patients, their families, and staff.

Hence, this CCPA newsletter issue will address serious matters such as preparing for a violent patient encounter and dealing with on the job bullying and harassment. We found healthcare experts in these subject areas to provide critical information needed to either create or enhance workplace violence policies and procedures for your practice. And while we cannot stop all workplace violence, having a plan in place is the best protection that an employer can offer.

Reference:

Workplace Violence. (n.d.). U.S. Department of Labor OSHA Safety and Health Topics Healthcare Workers' Rights Workplace Violence. https://www.osha.gov/healthcare/workplace-violence.

Association Updates

2024 CCPA Annual Meeting: Time for a Check-Up – Videos Available

CCPA's Annual Meeting: Time for a Check-Up was held on Wednesday, May 15, 2024 at Fountain Blue Banquets & Conference Center. Session topics covered were revenue cycle strategic planning, human resource information about hiring the right people and cyber security: protecting your practice. To view the recordings for this event, please visit the Member's Portal section at www.ccpaipa.org in the membership section.

CCPA Member Benefit Reminders

Please be sure to check out the online American Academy of Pediatrics' (AAP) Communicating Visually in Pediatrics. This new online visual communication aid is designed to assist pediatric practices to communicate with children who are nonverbal or who do not speak English. There is also the Pediatric Coding Newsletter that has been updated to include the new 2024 Red Book, which contains a new diagnosis detective feature, outbreaks information, system-based treatment, and vaccine status tables. Other benefits include new coding webinars, access to past issues, and other pediatric coding resources that are free to CCPA members. The monthly newsletter and the visual communication aid can be accessed via the CCPA website at www.ccpaipa.org in the Members' Portal section.

Also, as a reminder, cardiopulmonary resuscitation (CPR) reimbursement is available up to $60 for all CCPA members. Please submit your paid invoice and a copy of your CPR card to ccpa@luriechildrens.org or by fax to 312.227.9526.

CCPA Credentialing Corner

One of the most frequent questions that CCPA staff receive is about CCPA's initial and recredentialing processes. Therefore, we created the Credentialing Corner located on the CCPA's website. Practice staff and members can find written instructions on completing the initial and recredentialing Illinois applications, practice checklists for both processes, and much more. You can access Credentialing Corner on CCPA's website at www.ccpaipa.org in the membership section.

Lurie Children's Physician Services Webpage

The Physician Services' department webpage, can be accessed at luriechildrens.org/physicianservices. This site may be a useful resource to "favorite" or bookmark for future use because it includes:

- Satellite clinic schedules
- Quick reference guides
- Referral and consultation to/from Lurie Children's
- Contact resources at Lurie Children's
- Video library of virtual round table discussions on a variety of topics
- Community Provider Symposium Video Library
- LurieMD Provider Call Line (1.855.LurieMD or 1.855.587.4363)

CCPA News

CCPA News has expanded its content to cover pertinent healthcare law, practice management and other related issues using experts in these areas. If there is a legal, regulatory or practice management matter that you would like us to address in the newsletter, please contact LaVonna Swilley, CCPA Director of Operations at 312.227.7425 or lswilley@luriechildrens.org.

In the Spotlight

Did you know that CCPA has several members who are pediatric specialists? This section will provide a rotating spotlight on CCPA's subspecialists.

Deborah R. Fishman, MD & Lisa C. Verderber, MD

Pediatric Eye Associates, PC
3612 Lake Avenue, Suite 2C
Wilmette, IL 60091
847.256.2020
https://pediatriceyeassociates.weebly.com

Deborah R. Fishman, MD has been practicing pediatric ophthalmology and adult strabismus on Chicago's Suburban North Shore for over 30 years. She graduated Phi Beta Kappa with a Bachelor of Science degree in Chemistry from Cornell University in 1983, completed her medical degree at The Albert Einstein University College of Medicine in 1987 and fulfilled an internship year in pediatrics at Montefiore Medical Center in the Bronx in 1988. In 1991, Dr. Fishman finished her ophthalmology residency at Ohio State University and in 1992, she completed her training with a one-year fellowship in pediatric ophthalmology and adult strabismus at Indiana University.

Dr. Fishman is a member of the American Association of Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology and is board certified in ophthalmology. For many years she participated in clinical research as part of the Pediatric Eye Disease Investigator Group through the National Eye Institute. She is currently an investigator for a clinical trial to determine if nightly low dose Atropine eye drops effectively slow myopic progression. When not working with patients, she enjoys traveling, playing the oboe, being outdoors, and working with her scout troop.

Dr. Deborah R. Fishman

Dr. Lisa C. Verderber

Lisa C. Verderber, MD has enjoyed practicing pediatric ophthalmology and adult strabismus for over 25 years. She graduated summa cum laude from Duke University in 1986 with a Bachelor of Arts degree in Chemistry and Psychology. After a one-year internship at Evanston Hospital, she completed a year of molecular biology research and in 1995, she completed her residency. Both academic achievements were completed in the department of ophthalmology at Northwestern University. Dr. Verderber finished her fellowship in pediatric ophthalmology in 1996 at Children's National Medical Center in Washington, DC.

After practicing in Louisville, KY, she joined Pediatric Eye Associates in 2000. She is board certified in ophthalmology and is a member of the American Academy of Ophthalmology and the American Association of Pediatric Ophthalmology and Strabismus. She is an investigator and member of the Pediatric Eye Disease Investigator Group. In her free time, Dr. Verderber loves to exercise, read and cook.

How to Prepare for and Survive a Violent Patient Encounter

When the unthinkable happens, having a plan that you have practiced regularly can make all the difference.

By Kenneth S. Cheng, DO, FAAFP

On January 28, 2013, Stanwood Elkus arrived for a doctor's appointment at the Newport Beach, California office of urologist Ronald Gilbert, MD. This was the second time in a week that Elkus had attempted to see Dr. Gilbert. Previously, after staff members had prevented Elkus from entering the back-office area as a "walk-in" patient, he had agreed to make an appointment, which he did using a false name and telephone number.

Elkus blamed Dr. Gilbert for a surgical procedure he had undergone 25 years earlier that had damaged his prostate and led to complications. Two other physicians actually performed the procedure, but Dr. Gilbert, then a young resident at a local veterans' administration hospital, had recommended the procedure to Elkus.

On that January day, after Elkus filled out his new patient paperwork in the waiting room, office staff took his vitals and escorted him to an exam room. Shortly after, Dr. Gilbert entered the room and introduced himself to Elkus. The patient then shot the physician ten times in the chest and neck, killing him.[1]

For several hours following the shooting, my nearby office was on lockdown and ordered to "shelter in place," during which we kept our staff members and patients safe inside. Other offices, however, did not seem to understand the shelter in place order or follow other safety training, and we saw physicians, staff members, and patients moving in the direction of the shooting. The shooter in this case surrendered immediately, but the outcome could have been very different had the assault continued.

KEY POINTS

- Workplace violence is most common in the medical setting, and it frequently involves a patient or family members threatening physicians or practice staff.
- Physicians and staff should receive training on spotting potential violent behavior and defusing these situations before they escalate.
- Practices should develop detailed plans for dealing with violent incidents, including how and when to escape, how to protect patients, and how to cooperate with law enforcement.
- If a violent incident is inescapable, physicians and staff must be ready to fight back with whatever resources they have available.

PREVALENCE

One of the most difficult situations a physician will face in his or her career is being threatened with physical harm, most commonly by a patient or family members of a patient.[2] Violence in the medical setting is sadly not unheard of; according to the U.S. Bureau of Labor Statistics, more than 70 percent of all workplace assaults occur in the health care and social services industry.[3] Reasons for this include feelings that health care services have become more impersonal, longer wait times, unmet patient expectations, increased patient agitation, lack of mental health support services, prescription drug abuse, and poor or non-existent security at health care facilities.[4]

Psychiatrists and emergency medicine physicians typically see the highest rates of violence,[4] but pediatricians are not immune. Primary care physicians often treat patients who are seriously ill or have challenging psychiatric conditions, which can result in heightened patient discontent.

> According to the U.S. Bureau of Labor Statistics, more than 70 percent of all workplace assaults occur in the health care and social services industry.[3]

This article discusses how to prevent, train for, and react to violent patient encounters. Mitigating workplace violence requires that physicians and their practices take preventive steps and craft and follow specific plans of action. Physicians must take the lead; their actions can be influential with other colleagues and staff members and their interactions with, and knowledge of patients can provide vital information about potentially violent encounters.

Note that many of the recommendations are not evidence-based from a medical standpoint. However, they reflect best practices from law enforcement agencies.

WORKPLACE SAFETY TIPS

Before an incident

- Notify others of suspicious individuals or actions.
- Identify available exits and places to hide.
- Develop and practice an emergency response plan.
- Seek the help of security experts and active-shooter training.

During an incident

- Run from the incident.
- Hide behind a locked door.
- Fight if there are no other options.

After the incident

- Be aware of law enforcement's response.
- If safe, assist others and provide first aid.
- Be available to provide information to law enforcement.

PREVENTION

The first and most important tool in preventing a violent encounter is heightened awareness, which can help you spot behavior that may potentially develop into future violence, such as the following:

- Depressed moods
- Changes in personality or performance
- Unusual, odd, or bizarre behavior, including clenched fists, excess sweating or altered breathing
- Disciplinary problems
- Paranoid ideation
- Delusional statements
- False or fictitious information
- Actual threats of violence

All physicians and staff should receive situational awareness training as part of their initial job orientation and receive annual mandatory refresher courses. Larger organizations may already have formalized training programs, but individual offices or smaller medical groups could ask their local hospital to share these resources. They could also obtain training through online sources, expert consultants, or local law enforcement agencies.

In addition to learning how to identify potentially violent behavior, you will also need to learn how to defuse the situation, because failing to address it can allow the violence to escalate. One method is to maintain a firm but calm and reassuring demeanor as you speak with the individual. Allow the person to verbally vent his or her concerns. Acknowledge his or her statements and show understanding by repeating what you have heard and empathize with the person's frustrations. All the while, remain vigilant for cues that the situation is deteriorating. You should be always prepared to alert others, identify an escape route, or plan for self-defense. Law enforcement officers are taught to never turn their back to a potentially violent person, and the same holds true in health care.

Putting appropriate security measures in place can also help prevent workplace violence. For example, practices should establish and enforce policies that limit public access to restricted areas, ensure locked doors always remain secured, and regularly change door keypad codes, if the practice has them. Front-desk staff should check in or question all visitors as to the purpose of their visits. All employees should wear uniforms or display name badges so they can be easily identified. And employees should be empowered to report what they believe are suspicious persons or activities without fear of reprisal. The instruction "If you see something, say something" is critically important in the workplace, because employees are often the first to observe potential problems. Also, remember that sometimes attacks occur outside of the office, such as in the parking lot, so practices should ensure proper lighting and look for and address potential hiding places for perpetrators.

Lastly, employers and managers should regularly review security at their facilities for potential improvements, even consulting with experts if necessary to advise on new information or preventive methods.

PREPARATION

Even the best observation, de-escalation, and security procedures will not prevent every violent encounter, and physicians and staff members should be prepared for an actual incident. Although obtaining active shooter training is ideal, you should at the very least develop a written emergency operation plan (EOP) with policies and procedures for dealing with violent encounters.

For example, health care facilities provide unique challenges during violent encounters because we have a responsibility

to not only ensure the safety of ourselves and our staff members but also the safety of our patients, who may be of varying ages and abilities. You need to identify multiple evacuation routes, especially from patient-accessible locations. Your procedures must also specify how and when to evacuate patients or, if necessary, how best to shelter in place. The type of practice you have will dictate this planning; a practice with many older patients will make different decisions than a practice with many younger patients.

Remember that even if the violent incident does not occur in your office but elsewhere in your building or a nearby building, your office may still be affected. It is common in active shooter incidents for law enforcement officers to lock down an entire building or campus to prevent a perpetrator from escaping or to minimize casualties. The incident involving Dr. Gilbert led to the lockdown of three medical buildings, dozens of medical offices, and hundreds of staff members and patients.

At minimum, an Emergency Operation Plan should answer the following questions:

- How do we report an active violent incident to the proper authorities, which may include calling 9-1-1 as well as notifying our facility's security personnel and office manager?
- When and how do we evacuate both staff and patients?
- What are the primary and secondary escape routes?
- What are the designated safe areas or "casualty collection points," locations where the wounded can be triaged and provided first aid?
- How do we lock down the office?
- How do we contact emergency responders once they are on the scene?

Besides creating the plan, you also need to regularly practice and rehearse it using a variety of violent encounter scenarios. That way, if a violent incident does occur, staff members can immediately fall back on their training.

RESPONSE

The likelihood of being involved in a violent encounter at work is rare. Still, knowing how to appropriately respond will greatly improve your chances of survival. The U.S. Department of Homeland Security and the City of Houston jointly developed the "run, hide, fight" response to a violent act.

Run. If possible, escape from the violence. Escaping effectively, however, means taking a route that has been pre-planned and practiced. Keep in mind that escape routes will vary based on your location within your office and the location of the violent action. Quickly gather others and be direct in your escape, but don't delay your escape by waiting for others. As you are escaping, keep others from entering the violent area. If you do not know the exact location of the perpetrator, avoid using a "main" or common entrance as your escape route unless that is your only option. When you are in a safe area, call 9-1-1 to alert the authorities to where you are and to provide any specific details you can about the perpetrator. The authorities may want to ask you additional information, so do not hang up.

Hide. If escape is not possible, you must do your best to conceal your presence. If you are hiding in a room, lock and, if possible, barricade the door to prevent entry. If time permits and you aren't compromising your safety, lock all the doors, even for empty rooms. This will stall the perpetrator because he or she will not know which locked rooms are empty and which are occupied. Turn off all lights, and silence all mobile devices, even switching off "vibration mode" as it could make enough noise to be located. Remain extremely quiet, and if there are windows on or near the door, stay out of view. If possible, take cover behind large objects such as exam tables, file cabinets, or bookcases. Interior walls made of drywall or sheetrock will not provide sufficient protection if the perpetrator is using a firearm, and although most interior doors in commercial buildings are solid enough to protect against most handguns, they likely won't stop a rifle. Regardless of where you are hiding, you should still plan an escape, such as going out a back door or an exterior window if close enough to the ground. If considering an exterior window, keep in mind that many

commercial buildings have safety glass windows that require special glass breakers. These breakers should be placed in every room as part of proper planning.

Fight. If an assailant is entering the room in which you and others are hiding, or if the violence begins in your immediate presence and you have neither the time nor opportunity to run, then you must be prepared to fight. This is probably the most difficult scenario to prepare for or even think about as it is likely outside your normal character, but fighting back when no other option exists is critical to survival. As FBI statistics show, almost half of active shooter situations end before law enforcement officers arrive, and the potential victims stop the shooter themselves in a third of those cases.[5] When fighting back, your goal is to incapacitate the individual. The survival mentality must become all-encompassing, and you should consider and use all resources available. This could include techniques learned in self-defense classes or items found in the typical medical office, such as fire extinguishers, chairs, bookends, scalpels, scissors, or liquid nitrogen. Use whatever options you have available and be prepared to use them forcefully.

Once law enforcement officers arrive on the scene, keep in mind that Special Weapons and Tactics (SWAT) and Multi-Assault Counter-Terrorism Action Capabilities (MACTAC) officers are trained to immediately enter a location, find, and engage a violent individual. These first responders' sole responsibility is to stop the threat, and they will not stop to provide medical aid or assistance to victims.

Physicians or staff encountering officers should expect them to be firm and direct in their commands, and they should do nothing to draw suspicion. Keep your hands high in the air and empty and avoid making any sudden movements. Officers will direct you to evacuate the area, generally in the direction from which the officers came. You and other staff should leave all personal belongings behind; exiting with your purse or bag could heighten officers' focus on you as a potential assailant. Avoid pointing, yelling, or attempting to stop the entering officers as they may misinterpret such actions as hostile. When you exit the building, other officers will likely direct you to a safe location. Do not leave this location, as you may be an important witness who can help identify or aid in the apprehension of the assailant.

If you are barricaded in a room, officers may command you to open the door. Assailants have been known to

impersonate law enforcement officers to trick occupants, so you should take reasonable steps to identify the person giving you a command. For example, you can listen for a police radio or have the officer slide his or her identification card under the door.

Once you determine that you are safe from the violent incident, you can provide aid to others, such as medical attention.

SURVIVAL

Every violent encounter is unique and unpredictable so there is no single approach that will cover every situation or every practice. However, the information in this article should give you a general starting point for addressing your individual situation. The steps you take now to prevent and prepare for violent encounters are not time wasted. They will improve your odds of survival should you ever have to face such horror.

Reprinted with permission from American Academy of Family Physicians www.aafp.org, accessed August 31, 2023.

References:

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Kenneth S. Cheng, DO, is a board-certified family physician practicing in California. Dr. Cheng's qualifications to write and speak on this topic include being a 12+ year member of the Orange County Sheriff's Department, where he is a volunteer reserve deputy sheriff. Having attended the Sheriff's Training Academy for Law Enforcement, SWAT School, and Tactical Medicine School, he is currently a SWAT officer and Tactical Physician. He has been involved in hundreds of high-risk encounters and training scenarios, including active shooter, barricaded suspects, felony high-risk arrest, and search warrants situations. He is also currently a SWAT School instructor and Critical Incident Response Training instructor, having taught over 100 California law enforcement officers on tactical medicine.

CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION AND
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Do I Work with the Wrong People and How Does Culture Matter?
Identify those who should work for you versus those who should work for someone else. Pinpoint characteristics in employees that will predict their long-term job dissatisfaction regardless of the workplace culture. Obtain strategies for recruiting and retaining the right staff.

Cyber Security: Protecting Your Practice
Recognize the spectrum of cyber threats. Implement effective cybersecurity measures to develop a cyber resilient culture. Prepare a repose plan for cyber incidents. Understand and evaluate ransomware insurance. Secure patient data and practice revenue.

Session videos can be found at ccpaipa.org/members-portal/2024-annual-meeting.

Harassment & Bullying: A Sepsis in Healthcare

By Susan Strauss Ed.D., RN

Introduction

You passed your boards and are feeling the satisfaction of being a pediatrician, especially an African American male pediatrician. On this particular morning, you entered a patient exam room to assess a 16-year-old white female who was admitted to the emergency department the night before with severe cellulitis on her leg from a cat scratch. As you stood by her on the exam table, you could have sworn she intentionally touched you inappropriately. It was a quick gesture but nonetheless it felt intentional. Well, you are not sure and ignored it believing a 16-year-old would not even think of doing such a thing. You continue with your assessment of your teenage patient when she inappropriately touches you again makes a rude and stereotypical comment about your physical body.

Is this scenario difficult to read, let alone believe it would happen? Well, in my work in the harassment arena, a pediatrician shared this sexual assault experience with me.

1) What should this physician do about the incident?

2) What should the practice's human resources (HR) or practice manager do about the assault? Is the patient's behavior an actual sexual assault – after all, it is by a 16-year-old female, and not only that but a patient?

3) Are healthcare professionals protected by such misconduct by a patient?

To answer the above questions: 1) The physician should report the incident to the practice manager or human resources professional or other employee identified in the practice's harassment policy. The physician should also firmly inform the teen patient and her parents that her actions were not okay, that he was offended by the behavior, and she is not allowed to behave that way. She and her parents may need to be told immediately to leave the clinic, depending on the practice's policy. 2) HR or the practice manager should professionally confront the 16-year-old patient and her parents about her behavior as a violation of policy and it is not allowed. Her parents need to be aware of the seriousness of their daughter's behavior and ensure it will not occur again. 3) The practice's harassment policy should state that healthcare professionals are protected from harassment and sexual assault by a third party, such as a patient, visitor, vendor or another health professional. When the patient deliberately touched the doctor, it would constitute sexual assault by the practice's policy.

Definition of Harassment

Workplace harassment is based on several federal laws including The Civil Rights Act Title VII (Title VII), Age Discrimination in Employment Act (ADEA), Genetic Information Nondiscrimination Act (GINA), American Disabilities Act Amendment Act (ADAAA), and state's laws.

Title VII uses the term *protected class* to describe any individual or group who falls within a specific class, which is protected from harassment in the workplace. Almost everyone fits within several protected classes including age, race, religion, national origin, gender, pregnancy, veteran status, marital status, socioeconomic status, creed, or disability. Harassment is defined as an unwelcome conduct based on race, color, religion, sex (including sexual orientation, gender identity, or pregnancy), national origin, age (beginning at age 40), disability, or genetic information (including family medical history). Harassment is unlawful where it is a condition of continued employment, or it is so severe or pervasive that it creates a hostile or abusive work environment that a reasonable person would consider intimidating, hostile, or abusive.

Anti-discrimination laws prohibit harassment against employees in retaliation for filing a discrimination charge, testifying, or participating in an investigation, or lawsuit under these laws; or opposing employment practices that they reasonably believe discriminate against individuals, in violation of the Equal Employment Opportunity Commission (EEOC) laws.

The EEOC, a federal agency, defines sexual harassment as: unwanted sexual behavior such as jokes, name calling, gestures, touching self or others, asking personal questions, persistently asking someone for a date after being told, "no," infringing on one's body space, innuendo, e-mails and voicemails, sexist comments, comments about body parts or

sexual behavior, are examples of sexual harassment. Sexual harassment, a form of sex discrimination, is against the Civil Rights Act, Title VII, of 1964, and applies only to the workplace.

> Harassment is unlawful where it is a condition of continued employment, or it is so severe or pervasive that it creates a hostile or abusive work environment that a reasonable person would consider intimidating, hostile, or abusive.

Behavior that is considered gender harassment does not have to be sexual in nature (even though it is a form of sexual harassment) for it to be a violation of Title VII. For example, gender harassment can be abusive behavior directed at a woman or group of women just because she is a woman. This is true even if it does not include sexual comments, language, behavior, or activity, yet where the behavior is severe and/or pervasive enough to create a hostile work environment.

Quid pro quo and hostile work environment are two forms of harassment. Quid pro quo harassment is when a manager, or anyone else in a position of power over an employee, offers to give employment benefits in exchange for sex or a romantic relationship. It is considered quid pro quo – trading this for that. For example, "sleep with me and the promotion is yours," "have late night meetings/dinners/dates with me, and I won't fire you," "go to the conference with me and I will make sure you get the raise." There is absolute liability for this harassment, and it is illegal.

In contrast, the hostile work environment aspect of the law is more common and requires unwelcome sexual or gender-based harassment to be so severe and or pervasive that it interferes with an employee's ability to do her or his job; creates a hostile work environment, both subjectively and objectively, based on a *reasonable person*. Research has found that men and women view sexual attention differently, so a reasonable person often defaults to applying more to men. However, judges will sometimes use a reasonable woman standard when presiding on these cases.

If discussing other protected classes, then the misconduct must be racial, age, LGBTQI+, disability etc. In other words, a colleague may not be displaying overt sexual or racial or age comments but rather "bullies" someone because they are part of that protected class. It might be race-based or age-based harassment. When someone from a protected class complains of being "bullied," it is at the practice's own peril if they do not complete an investigation to determine if the misconduct has taken place. If a single incident of misconduct is not severe, nor pervasive, it is therefore not harassment based on the law. It will, however, (hopefully) be a violation of your harassment policy which requires follow through.

A new area in the EEOC's recent 2023 proposed guidance indicates that harassment outside the workplace may also constitute illegal harassment, if it negatively affects the work environment thereby creating a hostile work environment. This can include text messages, e-mails, phone calls, social media, and stalking, to name a few.

Employees may also be harassed by a third party such as a patient, as depicted in the scenario in the beginning of the article, a visitor, a vendor, or another health professional. Your practice is responsible for ensuring that your employees are not harassed by external customers. Therefore, the practice must respond to an employee's report of harassment by a third party.

> Systemic harassment includes incidents involving multiple employees within the same protected class that are subjected to the same or similar forms of harassment. It is often referred to as a *pattern or practice* of harassment within that protected class.

Another EEOC's new proposed guidance discusses *systemic harassment*. Systemic harassment includes incidents involving multiple employees within the same protected class that are subjected to the same or similar forms of harassment. It is often referred to as a *pattern or practice* of harassment within that protected class. If this is a problem

in your practice, then you must implement a systemic remedy and not merely address harassment to specific employees.

> When someone from a protected class complains of being "bullied," it is at the practice's own peril if they do not complete an investigation to determine if the misconduct has taken place.

The federal courts and the EEOC are each responsible for the enforcement of Title VII but through different roles and compliance standards. The EEOC's role is to provide guidance and technical assistance to oversee and correct discrimination/ harassment issues, whereas the courts' role is to offer compensation and other forms of redress to victims.

Prevention

The EEOC states employers must demonstrate that they exercised *reasonable care* to prevent harassment *and* to promptly correct harassment when informed of the misconduct. According to the courts, exercising reasonable care is examining the effectiveness of the harassment policy including the definition of harassment and examples of harassing behavior. The policy needs to be actively communicated to employees and widely disseminated. Merely posting the policy on a bulletin board or disseminating it only via e-mail will be insufficient.

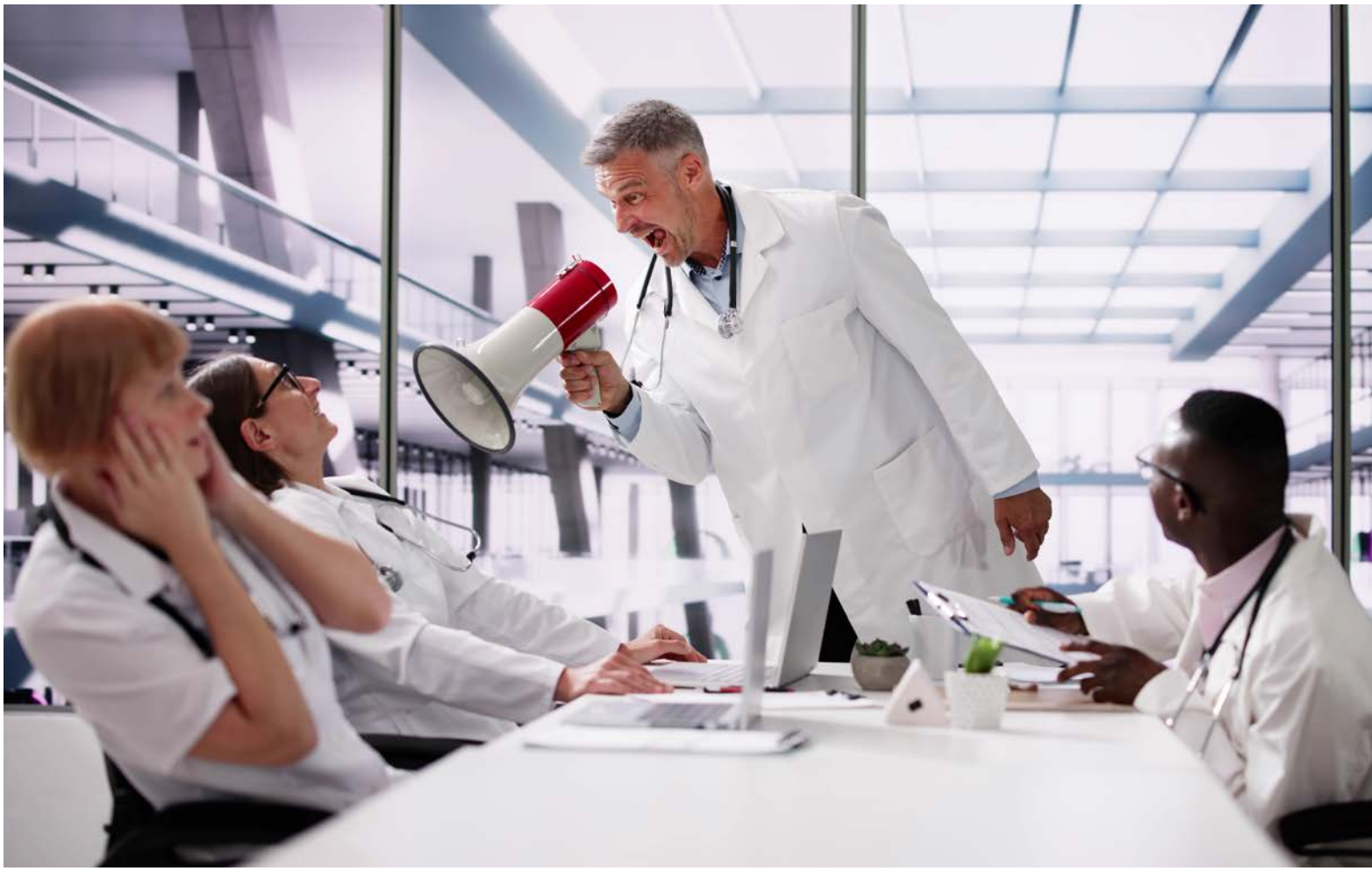
A policy needs to meet the needs of those employees who may struggle with comprehension, such as employees with English as a second language or those with a cognitive disability. Management must be informed of their responsibility to report harassment as soon as they become aware of overt or covert harassment. The EEOC requires the policy to discuss criteria in determining prevention and intervention of harassment including identify those employees who are tasked with receiving complaints. The complaint process must include a discussion about confidentiality and retaliation.

The policy is only one task in preventing harassment. Your practice needs to develop a valid and reliable climate survey specifically focusing on harassment, bullying, and the practice's culture. Conduct focus groups (depending on the size of your practice) and/or interviews with leads and managers (including physicians who are owners and/or have responsibility for harassment and bullying prevention and the health of the practice). All employees need to be informed of the results of the survey before your comprehensive anti-harassment and bullying strategy is implemented. Once the survey has been developed, using information gathered from focus groups and one-on-one interview, begin your anti-harassment and bullying strategy.

The practice's strategy should include a mission statement, three to five goals, SMART objectives (specific, measurable, attainable, relevant, and timely), and a monitoring and evaluation tool. Without the preliminary audit prior to implementing your strategy, you will have no data to determine the effectiveness of your strategy to compare the results of a subsequent survey following the implementation of your strategy. It is best if you wait one to two years after your strategy has been up and running before you disseminate the next survey to get meaningful metrics and determine next steps.

On November 1, 2018, Harvard Business Review suggested a survey from National Academies of Sciences, Engineering and Medicine (NASEM) or Association of American Universities (AAU), or Equity Quotient, which are all standardized and valid instruments. The aggregate data from the survey will provide your practice with areas that need improvement. Providing a transparent environment in which quality measures are shared with staff, addressing intimidating behaviors that might undermine a safe culture with quality indicators present that are essential elements in prevention.

Providing comprehensive training a minimum of every other year is another important prevention tactic. It should also be implemented as a teachable moment if systemic harassment is evident. The training needs to consist of three to four hours to adequately cover the vast amount of information required to minimize harassment and provide employees with reporting mechanisms if they are targeted. It should include the definition of harassment, what employees should do if targeted by the misconduct, to whom to report, discussion about bystanders' role, same-sexed harassment (same-raced, etc. harassment), LGBTQI+ harassment, (such as using correct pronouns and not misgendering) and documentation.



In addition, managers and practice leaders require an additional 90 minutes of training, to review their legal and ethical roles. Their extended course will explain their responsibilities in the prevention and intervention of harassment (and bullying), including how to prevent harassment; how to recognize, identify, intervene, correct, report and document harassment. For example, the use of experiential training methodology is recommended using case studies, small group discussion, and Q&A sessions. Managers should be held to a higher standard than employees and upper management to a higher standard than managers. The training should outline the framework for that higher standard.

Bullying

Mistreatment of employees in the workplace is labeled by various terms in the literature depending upon what perspective the construct is studied, for example, a psychological, sociological, or business approach. Terminology defining the phenomenon varies; there is no consistent definition of the construct across the literature. There were common threads interwoven within the definitions for example, repeated and/or severe, unwelcome, hostile, oppressive, controlling, and abusive behavior directed from one or more individuals to others. Examples of specific behaviors identified in the literature included: rude, demeaning language/offensive remarks, disregard of others, disrespectful berated exclusion/isolation/ silence threats, belittle/ridicule/insult, public humiliation shouting/angry outbursts, offensive language, aggressive eye contact, name-calling, scapegoating, physical violence, micromanagement, and gossip. Unlike harrassment, the difficulty of defining bullying is that it is not illegal because there is no federal law. It is best, therefore, if your practice has a code of conduct policy rather than a bullying policy that lists behaviors that are a violation of your practice's code of conduct.

Impact

The impact of workplace abuse and harassment on its victims (including bystanders) can be devastating. Examples include loss of self-esteem, helplessness, increased illness such as hypertension, insomnia, and gastro-intestinal problems, accidents, depression, anger/rage/hostility, and

Post Traumatic Stress Disorder (PTSD). Feelings of alienation increase feelings of confusion, isolation, paranoia, panic attacks/anxiety, increased stress, attempted suicide, and heart attacks. Studies suggest that when an employee is bullied, the strongest effect is on the target's psychological health.

> Healthcare has a history of tolerance and indifference to intimidating and abusive behaviors.

The impact of workplace aggression including harassment, is not only towards the victim but the healthcare organization is scathed as well. The costs to the organization are increased financial costs such as medical, disability and legal costs, and malpractice, the cost of declining quality and patient satisfaction, increased absenteeism, turnover, loss of trust and morale and revenge or sabotage.

Healthcare Environment

Unfortunately, the healthcare environment is a potentially abusive environment as a myriad of studies demonstrates. The Joint Commission acknowledges in their Sentinel Alert Event Issue 40 on July 9, 2008, that healthcare has a history of tolerance and indifference to intimidating and abusive behaviors. They identify systemic issues such as pressure due to productivity, cost containment, embedded hierarchies, and fear of retaliation. The disruptive and abusive healthcare behaviors often go unreported which exacerbates the toxic healthcare environment including harassment of protected classes. The Joint Commission along with other legal and regulatory agencies list the behaviors of harassment and bullying as forms of workplace violence in healthcare. OSHA touts that healthcare is the number one industry with the most violence. So, when thinking of your training agenda, keep in mind the need to address workplace violence.

Research indicates that the abuse takes a toll on nurses and other staff resulting in feelings of anger, frustration, disgust, absenteeism, turnover, and a negative relationship with the physician, who may often be the offender due to more power. Additionally, the abuse negatively impacts the quality of patient care by interfering with efficiency, accuracy, and safety, as well as quality patient outcomes. The abuse is compounded when the practice and medical staff administration fail to take the necessary steps to ensure that all practice employees are not victimized by this behavior.

The Practice Manager's Responsibilities

Depending on your practice, its infrastructure, ownership, board of directors, size, and policies, it is often the practice manager that carries the brunt responsibility in the prevention and intervention on incidences of harassment and bullying. The prevention strategies have been outlined in this article. But what about dealing with a complaint once it has been brought to the practice manager's attention?

It is critical that the practice manager (or whomever is tasked with conducting investigations) has been trained on how to receive a complaint and how to investigate. Conducting a fair and impartial investigation may be enough to minimize liability.

The steps in investigating include the following:

- Receiving the complaint from target.
- Interviewing accused.
- Determining and interviewing the witnesses of both the target and accused.
  - Creating and asking questions for the target, accused and witnesses.
  - Documenting their answers.
  - Reviewing pertinent practice policies that align with the complaint.
  - Determining if policies were violated.
  - Determining credibility of each interviewee (this is routinely absent from any documentation and the final report).
  - Drawing conclusions (this is also almost always lacking from documentation and final report).
  - Determining, with management, the consequences, if pertinent, for the accused.
  - Reading between the lines to see the holes in their story.
  - Following through to ensure the harassment has stopped and there is no retaliation.
  - Writing final report.

Any investigation should determine a violation of the practice's policies and potentially a violation of civil rights law – not criminal law. The investigator cannot determine liability (only a jury can). As the investigator, the practice manager should not strive to prove beyond reasonable doubt; that standard is for criminal law in the courts. Rather, a preponderance of evidence standard is used indicating "more likely than not" the incident either did or did not occur; 51% of the evidence supports the preponderance of evidence.

Any report of retaliation requires a separate investigation because it is against your policies and is illegal. Retaliation has been the most frequent reported harassment to the EEOC since 2013. It is also the most challenging for employers to disregard. Examples of retaliation may include the following behaviors:

- Sabotage
- Threats
- Ridicule
- Poor work assignments
- Demotion
- Failure to promote
- Continuing harassment

The practice manager is tasked with conducting investigations in a fair, impartial, and comprehensive manner to promote a healthy climate, high morale, and trust that the practice is responsive to complaints and following the policy and procedure to support a safe environment.

Conclusion

Healthcare organizations, including pediatric practices, are at an increased risk of harassment and bullying. The risk is due to the hierarchical nature of healthcare, the toxic healthcare environment, and lack of attention to harassment and bullying allowing it to fester and become a normal aspect of the culture.

Recognizing the risk of this misconduct is essential in establishing the prevention strategies needed to minimize the misconduct thereby decreasing the potential of liability. But perhaps more important is knowing how to intervene to stop the behavior to make sure patient care is not compromised and employees are treated with respect and dignity.

Dr. Susan Strauss is a nationally recognized expert, author and international speaker on discrimination, harassment and bullying in the workplace and education. She works with private and public sector organizations to provide professional services for business, legal, healthcare, education and government settings. Dr. Strauss investigates workplace and school complaints of bullying, discrimination, and harassment. She is also an expert witness for harassment, discrimination, and bullying lawsuits in the workplace and schools, and conducts training on those topics in workplaces and schools. Dr. Strauss has been selected to speak on sexual harassment at international conferences in Botswana, Thailand, Egypt, Israel, and the United States.