Workplace Bullying in Healthcare Professions

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Abstract

Workplace violence presents a substantial and increasing risk to employee health and wellbeing. In particular, healthcare professionals are at heightened risk of workplace bullying, also commonly known as mobbing, aggression, emotional abuse, lateral violence, horizontal violence, undermining and incivility etc. It is therefore often argued that bullying has become 'endemic' within healthcare. The physical and psychological consequences of workplace bullying include sleeping disorders, substance use, stress, chronic pain, anxiety, depression, cardiovascular disease and post-traumatic stress disorder. In addition, workplace bullying impacts on the delivery of high quality patient centred care and the wellbeing of those witnessing the bullying behavior. The current article highlights the prevalence of workplace bullying experienced by healthcare professionals and the consequences of this exposure. The organizational (e.g. job insecurity) and individual (e.g. personality) factors contributing to workplace bullying are also discussed.

Keywords: Bullying, Healthcare, Perpetration, Victim, Violence

1 Introduction

Healthcare professionals are at substantial and increasing risk of workplace violence [1-4], defined by the International Labour Organization as "Any action, incident or behaviour that departures from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work" (2004, p4). For example, Spector, Zhou and Che (2013) report nurse exposure rates of 36.4%, 66.9%, 39.7% and 25.0% for physical violence, non-physical violence, bullying and sexual harassment respectively. Prevalence rates do however display considerable variation [7], reflecting differences in the recognition or classification of workplace violence and actual incidence of this behavior. Those working in related professions and environments such as psychiatric services [8] and facilities for eldercare [9] are also at greater risk of workplace

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violence than other non-health oriented professions. The figures currently available are of course underestimates as victims are often unwilling to report workplace violence for a variety of reasons such as lack of evidence or fear of reputational damage [10].

Previous research indicates that exposure to workplace violence is associated with a range of negative consequences such as intrusive memories and hypervigilance [11], burnout [12], and reduced productivity [13]. Furthermore, workplace violence impacts on the healthcare services provided to patients or clients [14], quality of care [15] and professional standards [16]. Therefore, the subject requires considerable attention. Healthcare leaders often fail to recognize the existence of workplace violence however and the issue has not been adequately addressed [13]. Furthermore, though previous research indicates that patients and visitors are the most frequent perpetrators of workplace violence [14-16], healthcare professionals are less concerned by aggression perpetrated by patients than the bullying perpetrated by colleagues [15]. Hence, a greater understanding of workplace bullying in particular is required in order to protect the health and wellbeing of healthcare professionals.

2   Definitions of Workplace Bullying

At present, there is no single accepted definition of workplace bullying [21]. Furthermore, a range of terms have been employed by researchers and practitioners to refer to bullying behavior. These include mobbing [22, 23], harassment [24], psychological harassment [25], aggression [26], emotional abuse [27], lateral violence [28], horizontal violence [29], inappropriate behavior [30], undermining [31] and incivility [32]. In part, the specific term adopted may reflect the bullying behaviors most frequently experienced. For example, researchers in Germany often employ the term mobbing, reflecting the greater prevalence of bullying perpetrated by more than one individual [22, 23]. Though these terms are often used interchangeably, it is important to note that differences do occur, most notably between the term mobbing and other labels, with mobbing referring to behavior involving more than one perpetrator. This lack of standardization within the field hinders comparisons between studies and undermines our understanding of prevalence rates etc. Therefore, researchers and practitioners each acknowledge the value of a universal definition of workplace bullying [33]. The development of a universal definition would also have substantial practical benefit, for example encouraging agreement between employees and employers with regards to acceptable and unacceptable behavior types. Though formal definitions display substantial variation, researchers, practitioners and lay people each adopt definitions of workplace bullying that include the occurrence of harmful behavior indicating a degree of shared understanding. Lay definitions also frequently feature the concepts of fairness and respect [34].

The term workplace bullying may be used to refer to a wide range of negative behaviors targeted at an employee. Specific bullying behaviors may include social exclusion (informally or during formal meetings etc), personal insults, gossiping, vicious humor, criticism, facial expressions (e.g. smirking, glaring, rolling eyes), withholding information, providing misleading information, breaching confidentiality, denying opportunities for professional development, asking a person to complete low status work, undermining authority, allocating unfair workloads and other acts intended to create a negative working environment [35]. Bullying behaviors of particular relevance to healthcare professions include refusing to cooperate or provide support and unfair patient or shift assignment [36,

37]. The incidence and impact of each behavior type may vary and additional research investigating each form of negative behavior is required. These findings may inform the development of appropriate interventions in order to target the most disruptive and distressing behaviors. For example, future research may consider the following bullying categories. Einarsen and Hoel (2001) distinguish between work-related bullying (e.g. unmanageable deadlines) and personal bullying (e.g. spreading rumors) whereas Dick and Rayner (2004) identify four categories of harassment: personal (e.g. criticism, humiliation); task (e.g. withholding information, setting unrealistic deadlines), isolation (e.g. social exclusion); verbal (e.g. shouting). The extent to which these behavior types occur or impact on victims may of course differ in each profession or institution.

Despite considerable variation in the terms adopted and classification of bullying behavior, there is widespread agreement that (unlike harassment) behavior must occur more than once in order to be classified as bullying [40]. Hence, definitions of workplace bullying often refer to the frequency and persistence (i.e. duration) of the behavior. However, whilst some researchers specify a particular timeframe e.g. the number of acts that occur monthly [41] or weekly [42], others ask participants to consider experiences during their overall career [22]. Thus comparisons between studies are often inappropriate and misleading. Definitions of workplace bullying also frequently refer to an imbalance of power between the perpetrator and victim [43, 44]. This is consistent with research indicating that victims are most frequently bullied by supervisors and least frequently bullied by a subordinate [45]. It is important to note however that the power imbalance may reflect a range of power types such as power resulting from social relationships (e.g. popularity) or resources (e.g. the ability to allocate professional development opportunities), thus workplace bullying is not limited to supervisor-subordinate relationships [46]. In particular, recent studies have highlighted the occurrence of upward bullying which refers to the bullying of senior staff members by subordinates [47]. This often occurs when senior staff fail to meet the demands of their position and typically experience humiliation and disproportionate monitoring by other employees [48].

As outlined, workplace bullying may constitute a range of behavior types including facial expressions and social exclusion. Consequently, the varied behaviors that characterize workplace bullying are often confusing [49], even to those that are direct victims of the bullying [50]. Subtle bullying behaviors may be particularly challenging to recognize [51] and therefore are difficult for supervisors to address [52]. For example, victims often describe the bullying via examples of the behavior (e.g. not being selected for a training event, being allocated excessive work) which (unless documented in a systematic and comprehensive manner) do not convey the intensity or duration of the experience. Consequently, many victims do not label themselves as a victim of bullying [53]. For example whilst 24.1% of employees were classified as a victim using objective measures, 8.8% self-identified as a victim [41]. The reluctance to self-identify as a victim of bullying may reflect both a lack of awareness and the stigma associated with victimization and additional research is required to investigate those factors influencing the process of self-identification. Culture may also impact on lay definitions of workplace bullying and thus recognition that an employee is being victimized. For example, those in Central America primarily view workplace bullying as physical and overt, whereas employees in Southern Europe are more likely to identify subtle behaviors as bullying [54]. This cultural variation further highlights the importance of establishing a single definition and unified approach.

3   Prevalence of Workplace Bullying

Healthcare professionals experiencing substantial levels of workplace bulling include physiotherapists and physiotherapy students [55, 56], community therapists [57], junior doctors [58], medical students [59, 60], general surgery residents [61], nurses [62, 63], nursing students [64], psychiatrists [65] and midwives [19]. Thus it is often argued that bullying is 'endemic' in healthcare professions. It is important to note however that the prevalence of workplace bullying varies between disciplines and cultures. For example, though comparisons between studies are often compromised by the use of different definitions and measures, Seo (2010) reported lower bullying prevalence in Korean compared to British employees. Furthermore, bullying by supervisors is less frequent in countries with a low power distance between supervisors and subordinates than those with a high power distance in which an aggressive coercive style is able to develop [67, 68]. Therefore caution is required when extrapolating from current findings which typically recruit employees from Western Europe or North America only and additional cross-cultural studies are required.

4   Consequences of Workplace Bullying

The physical and psychological consequences of workplace bullying are clear. In particular, those experiencing workplace bullying are at increased risk of poor sleeping behavior [69, 70], sleeping disorders [67], substance use [71], stress [72], chronic pain [73], cardiovascular disease [74] and post-traumatic stress disorder [75]. The negative impact of workplace bullying has been demonstrated in a range of healthcare professions including nurses [63, 76, 77], student nurses [51], junior physicians [78] and nursing program directors [79]. Findings indicate that healthcare professionals experiencing workplace bullying experience poor quality sleep [80], depressive symptoms [78], depression and anxiety [81] and burnout [82, 83]. It is important to note however that much of the research conducted has been cross-sectional and cannot establish a cause and effect relationship. Hence, though experience of workplace bullying may impact on employee health and wellbeing, poor health may increase an employee's vulnerability to bullying. Prospective studies have demonstrated for example that whilst exposure to workplace bullying predicts nurse's symptoms of anxiety and fatigue, symptoms of anxiety and depression predict exposure to workplace bullying [84]. Therefore, additional longitudinal research is required.

Healthcare professionals experiencing workplace bullying often doubt their own competence [56], reporting reduced confidence [51] and self-esteem [80] together with feelings of humiliation, powerlessness, and oppression [85]. These effects are further exacerbated by an impaired ability to learn which impedes future development and career progression. As stated by one participant "It did make me feel like a bad physio and that I didn't want to do it anymore and having been away from that placement a little while, I feel a bit better, but I would say, the residual effects are that I am full of self-doubt...All up until that time I'd cruised along fine, had good marks, had great experience but this last one seems to have really knocked my confidence. I'm going to still try [and] get into physio but if it doesn't work out I won't be heartbroken now as I have this fear that if I go in as a rotational band 5 and I have to come across that situation again, I am really scared of it to be honest as I just feel like, you know, you're there, you're trying to learn, you don't really

know what you're doing and the person who is supposed to teach you is a bully, it makes your life a living hell basically" [56, p43).

Understandably, employees that experience workplace bullying report low levels of job satisfaction [77, 86, 87] and higher intentions to leave the organization or profession [76]. These outcomes may not of course fully reflect the experience of those subjected to workplace bullying and the trajectory of the bullying behavior. Specifically, it is argued that victimized employees first adopt a problem solving coping style (e.g. informing relevant authorities or enhancing their performance). When these attempts are unsuccessful they become avoidant and lower their commitment to the organization [85]. Consequently, it is at this later stage that healthcare professionals experiencing workplace bullying are more likely to terminate their position [62, 63]. For example, over 30% of healthcare professionals report that they have observed a nurse leaving their organization as a result of physician perpetrated disruptive behavior [89]. Workplace bullying is therefore financially costly to organization due to increased levels of absenteeism [35] and staff turnover [90]. The impact of this is exacerbated by the level of training required by healthcare professionals, staff shortages [91] and the reduced productivity often associated with workplace bullying [82]. Litigation, investigation, compensation and reputational damage to the organization further contribute to the cost of workplace bullying to both the organization and wider economy [92].

The work environment has a substantial impact on the quality of patient care delivered. In particular, hostile working environments and workplace bullying impede patient care [81, 93-95]. For example, the concentration of those experiencing workplace bullying may be compromised, increasing the likelihood of errors. Similarly, tasks requiring emotional labor (e.g. providing patients with a diagnosis) may be problematic. Research indicates that the impact of workplace bullying on job performance is recognized by the victims themselves [63] and poor performance, accidents and errors may each result from poor peer relationships and workplace bullying [96, 97]. In part, the relationship between workplace bullying and the delivery of high quality patient centered care may reflect the reluctance to seek support from colleagues. It is important to note that the impact of workplace bullying extends beyond the initial victim and patient care. Specifically, previous research has established that employees that are not directly targeted by perpetrators but observe this behavior are influenced by the presence of workplace bullying [98, 99]. For example, healthcare professionals witnessing workplace bullying report greater intentions to leave the organization and reduced participation in decision making [25], which may reflect the distress associated with observing these behaviors or the perception that workplace bullying is tolerated by the organization and fear of later victimization. Thus, workplace bullying impacts on those not considered in initial prevalence estimates and findings may underestimate the consequences of this behavior.

5   Organizational Factors

Organizational factors may contribute to the emergence and maintenance of workplace bullying [70, 100]. Overall, the more positive the environment, the less likely it is that healthcare professionals will experience workplace bullying [101]. Those working in large organizations [102] or unpleasant situations characterized by high temperatures and crowded spaces [103] are most likely to be targeted. Factors related to workplace bullying also include organizational change such as restructuring [104], job insecurity [105] and a

lack of resources [106]. An organizational culture which promotes competition [107] for example through the use of performance related compensation practices [108] can be particularly problematic though research in this area is often inconsistent. Indeed, some researchers have reported that performance related pay is associated with lower rather than higher levels of workplace bullying [109]. Within healthcare, poor group cohesion, low levels of support, increased workload and organizational constraints are each related to the level of abuse experienced [110] highlighting the challenges experienced by those working in this sector.

A considerable body of research has investigated those employees most likely to engage in bullying behavior. Senior staff and those in positions of responsibility are most often the perpetrators of workplace bullying [110] and workplace bullying is often associated with the abuse of power by leaders within the organization [112]. Leadership styles are often associated with the emergence of workplace bullying, for example, workplace bullying is related to passive [113], authoritarian [114], autocratic [107, 115], non-contingent [115] and laissez-faire [116] leadership. In contrast, workplace bullying is less likely to occur in the presence of transformational [117] and authentic leadership [118]. Authentic leadership emphasises self-awareness, honesty, integrity and consistency whilst transformational leaders serve as role models which inspire and encourage their employees [119]. Overall, employees reporting that their leaders are fair and supportive are less likely to experience workplace bullying [120]. Therefore, training programs targeted at leadership style are likely to impact on the prevalence of workplace bullying within an institution. Though researchers have identified a range of factors that are associated with the prevalence of workplace bullying within healthcare professions, the manner in which these influence bullying behavior is less clear. In particular, the working environment may (a) increase employee frustration which influences perpetrator and victim behavior, (b) increase incidence of poorly managed conflicts which result in bullying or (c) promote a culture that accepts or promotes bullying behavior [103, 121]. Further research, particularly longitudinal research that can monitor the occupational culture and bullying behavior is required.

6   Individual Factors

A range of demographic factors are associated with victimization [122, 123]. In particular, Women are more likely to experience bullying than men [41, 64, 107] and ethnic minorities are more likely to experience bullying than Caucasian employees [122, 123]. The greater proportion of women entering healthcare professions [124] may suggest that the number of employees impacted by workplace violence will also increase. The situation is however likely to be complex. For example, research indicates that men working in female dominated professions such as nursing are at greater risk [125] and different predictors of workplace bullying emerge for men and women [109]. Amongst healthcare professionals, age and experience are also related to abuse [126]. For example, workplace bullying is most frequently experienced by nurses within the first five years of their employment [127]. Exacerbating the initial experience of workplace bullying, those new to the profession may be particularly vulnerable as they do not have previous professional experience on which to judge their competency or to develop self-esteem and appropriate coping strategies. Employees experiencing low levels of autonomy [128], or team autonomy [129] and high levels of task conflict [130] or stress [131] are also at an increased risk of workplace

bullying, suggesting that those in particular roles are most susceptible.

A substantial body of research has established the relationship between personality and victimization [132-135]. For example, victims of workplace bullying display higher levels of neuroticism and lower levels of extraversion [134-135] than those that are not targeted. Victims also display high levels of negative affect e.g. anxiety and sadness [132, 134] and low self esteem [136, 137] which perpetrators may perceive as vulnerability or reluctance to retaliate. It is difficult however to establish the cause and effect of these relationships and victimization may lead to withdrawal, low self-esteem and negative affect. There may also be different categories of victim, each with different personality, occupational and demographic characteristics [134]. For example, it has been argued that victims can be classified as vulnerable and provocative [138]. Vulnerable victims are less likely to defend themselves whereas provocative victims display both anxious and aggressive reactions. It is important to acknowledge that the hypothesized relationship between personality and employee victimisation has been criticized [139] and additional research investigating the role of individual factors such as personality is recommended.

Though fewer studies have considered the factors which predispose a person to bullying perpetration, those engaging in workplace bullying are more likely to be male [41], in a senior position [127], and experience low self esteem [136]. Employees that are under particular stress [131] or have high strain jobs [128] are also more likely to participate in bullying. Whilst it is important to consider predictors of individual behavior, patterns of abuse also occur. For example, physicians are often the source of verbal abuse targeted at nurses [140, 141] and the organizational climate which encourages or maintains workplace bullying must be addressed. Culture also impacts on the extent to which workplace bullying is perceived as acceptable within the workplace [107]. For example Confucian Asia is more accepting of work related bullying than Anglo, Latin American and Sub-Saharan African countries [142] which may influence the emergence or maintenance of this behavior. Furthermore, cultures with a high performance orientation are more accepting of workplace bullying [142]. Culture also impacts on the type of bullying that is most accepted. For example, British employees are least and most tolerant of bullying from a superior and peer respectively whereas Korean employees display the opposite pattern [66]. Thus, the respect for authority figures that is prominent in Korean society may increase tolerance of bullying from supervisors.

7   Reporting and Acceptance of Workplace Bullying

Victims often find it difficult to report bullying or engage with the organizational support available [56]. Therefore the majority of incidents remain unreported [143]. Victims may fail to disclose the bullying experience for a range of reasons. For example the subtle bullying behaviors that are most prevalent [26] are difficult to recognize [51]. Therefore, victims may not understand that they are being bullied [50]. Furthermore, the subtlety of these behaviors may make it difficult for the victim to fully convey the intensity of the experience to others, leading to fears that they will be ignored or perceived as petty [143]. Victims also fear the repercussions that may follow from reporting workplace bullying [144]. Underreporting is particularly problematic in the context of student placements. Victims often rationalize that will be exposed to the bullying for a limited amount of time and may fear escalation and retaliation, particularly with respect to their grades or prospects of a permanent position [56].

Failure to challenge bullying behavior can contribute to a culture of acceptance [145-147] which perpetuates the existence of bullying [148]. This form of institutionalized bullying can be particularly difficult to address. In particular, widespread acceptance of bullying behavior communicates to employees that they are not respected or valued [149] and may increase the prevalence or intensity of bullying. The behavior of witnesses may also encourage the bully to continue [148]. This may include explicit support of the perpetrator due to fear of retaliation [150]. Hence, when bullying is not directly challenged, witnesses may adopt the aggressive behavior exhibited by perpetrators of workplace bullying [107]. Additional research investigating the acceptability of workplace bullying and the manner in which organizational acceptance impacts on employer or employee behavior is required. Present studies indicate that whilst physically intimidating bullying is overall less acceptable than work related bullying cross-culturally [142] the acceptability of workplace bullying varies. For example Confucian Asia is more accepting of work related bullying than Anglo, Latin American and Sub-Saharan African countries [142]. Furthermore research is required as workplace bullying studies are most often conducted in Western Europe or the United States.

8   Workplace Bullying Policy

The introduction of a written anti-bullying policy represents one of the most common measures adopted to counteract workplace bullying [151] and 83% of organisations (90% in the public sector) have anti-bullying policies [152]. Researchers and practitioners are consistent in their recommendations. For example, it is argued that there should be an explicit commitment to a bullying free environment together with a statement of the consequences of breaching the organizational standards. A comprehensive definition of workplace bullying is particularly important as researchers have highlighted the importance of improving awareness and the employee's ability to recognise bullying [37]. These definitions should specify the behaviors that are and are not regarded as bullying. In practice, there is often however a greater emphasis on defining inappropriate than appropriate behavior which does not necessarily support the development of a positive working environment [152].

Formal workplace bullying policies should clarify the responsibility borne by the various employees [153] and these frequently emphasize the role of senior staff and supervisors in particular [151]. Policies should specifically identify specific bullying contacts and the procedure for making and investigating formal or informal complaints. Formal workplace bullying policies are not however only important for the victims of bullying, they provide managers with guidelines and advice about how to deal with bullying, which in turn may make them more willing and more competent to react appropriately. Furthermore, staff from all levels and union representatives should participate in the process of developing and implementing the policy; broad involvement is needed to emphasise the status of the process, and to increase awareness and acceptance of it throughout the organisation [153]. These policies should of course be communicated to employees at all levels when completed and regularly monitored.

Though organizations often encourage employees to report incidents of workplace bullying (and this is often articulated in formal policy) victims often find it difficult to report bullying or engage with the organizational support available [56]. Furthermore, when employees do report bullying behavior there are difficulties with the manner in which

bullying is addressed and few employees report that their line managers were helpful [154]. For example, complaints are often not investigated and those reporting bullying may be targeted further [57]. Therefore, appropriate mechanisms must be in place for employers to manage workplace bullying. It is important to acknowledge that the development of a formal workplace bullying policy is not sufficient and those occupational factors such as job insecurity and a lack of resources that contribute to workplace bullying should be addressed.

9   Conclusion

To conclude, healthcare professionals are at heightened risk of workplace bullying. Exposure to workplace bullying (e.g. personal insults, gossiping, unfair workload allocation) is associated with a range of negative consequences for the victimized employee, though the repercussions of these behaviors extend beyond the initial target to patients, colleagues, the organization and wider economy. Previous research has identified a range of organizational and individual factors which may increase the prevalence of workplace bullying though the field has been hindered by the lack of standardization and reliance on European and North American research.

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