BULLYING IN HEALTHCARE ORGANISATION: ORGANISATIONAL REHABILITATION AND SELF MANAGEMENT STRATEGIES

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ABSTRACT

This paper reviews and highlights the research evidence on prevalence and causes of bullying with public health messages. Bullying, a significant occupational health problem worldwide, is not uncommon in healthcare organizations. It refers to the aggressive behaviour from one or more people on their fellow colleague, over duration of time leading to a situation where the target finds it difficult to defend or escape the situation. An annual prevalence of nearly 40 percent in UK workforce has been reported. The causes of bullying appear to concentrate on the personality of the victim and psychosocial factors at work. The clear demarcation between bullying (which is undermining and destructive) versus constructive supervision (which is developmental, building and supportive) must be highlighted. Management of workplace bullying requires concerted organizational rehabilitation strategies, besides individual self management strategies to address the root causes.

Keywords: Bullying, Occupational health and safety, Organizational behaviour

BULLYING IN THE HEALTHCARE ARENA---FACTS OR FALLACIES?

Do bullying occurs in the medical arena or do people in the healthcare profession bully others? The answer is---it certainly does and perhaps there is not much campaign/intervention to stop bullying. Bullying has been widely recognised as a problem in the nursing profession (Quine 2001) and in medical profession, where up to 37% of junior doctors had been bullied, whilst 84% had experienced at least one bullying behaviour in the preceding year (Quine 2002). Healthcare professionals are people supposedly trained to be

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empathetic and caring, but research evidence show that they are not immune from belting out punitive acts, violating of others’ rights, harassment and bullying.

Bullying can be defined as the systematic persecution of a colleague, a subordinate or a superior, which, if continued, may cause severe social, psychological and psychosomatic problems (Einarsen 1999). If involving more than one perpetrator, the term mobbing is usually used. Mobbing occurs when co-workers team-up to engage in a series of events of humiliation, exclusion, joint accusations, emotional abuse and harassment with an intention to force the targeted worker out of the workplace (Davenport et al, 1999) or to comply to the bullies’ demands. Bullying or also termed as harassment, abuse or victimisation is a significant occupational health problem worldwide, and is becoming a long neglected problem obscured by underreporting with no clear organisational remediation (Al-Daraji 2009).

Bullying is an increasing public health burden, with an annual prevalence of nearly 40 percent in UK workforce alone (McAvoy and Murtagh 2003). In Malaysia, there is no data to show its prevalence in healthcare organisations. The entrenched, hierarchical medical model with autocratic management (highly prevalent in most developing countries in the region of Asia-Pacific) --- may be a key facilitatory factor of this silent epidemic. Bullying rates are high in the healthcare organisations, existing in both the educational (Hicks 2000) and research environment (Stebbing et al. 2004). It is also widely recognised as a problem in the nursing profession (Quine 2001) and the medical profession, where up to 37% of junior doctors had been bullied, whilst 84% had experienced at least one bullying behaviour in the preceding year (Quine 2002). The British Medical Association alerted that 1 in 7 National Health Service (NHS) staff has reported being bullied by other health staff (BMA 2006).

An alarming ratio of one in 10 callers to the UK National Bullying Advice Helpline are health care professionals (Al-Daraji 2009; Quine 1999). Often, the bullied are from a lower category, younger, or newer member of the healthcare team. Evidence have shown that the incidents are higher on minority Ethnic groups (Giga, Hoel, and Lewis 2008; Cheema et al. 2005) who are also often less likely to take action against bullying (Hoosen and Callaghan 2004). At least in the developed countries, there has been some positive shift of perception in organisations. The paradigm shift from denying that bullying occurs into accepting that bullying is a problem is more acknowledged (Al-Daraji 2009). Unfortunately, within Asia and Asia Pacific region, such social phenomena are often not highlighted because of factors related to the social and medical hierarchy system and/ or the cultural ‘lost-of-face’ factor forcing the victim to suffer in silence and to avoid reporting the incidents.

**TRIGGERS OF PROLONGED BULLYING**

Many reasons have been speculated as to why bullying at workplace is a vicious cycle leading to a potent chronic public health burden with debilitating impact on organisational wellbeing and productivity. Bullying in the medical organizations is a neglected chronic phenomena, which often does not occur as a one-off episode/ event. The chronic nature leads to a continuous undermining of the victim which takes a toll on his/ her work productivity. Unfortunately, even in healthcare situations, the bullying can apparently occurs with the full knowledge of the management, often allied to the perpetrators for some tangible reasons. Causes of bullying often concentrate on the personality of the victim and/ or psychosocial
factors at work. Even the controversial nature of organisational chart can give rise to much ground for bullying to occur within any conflicting medical vs health disciplines---characterised by the constant violation on the autonomy of health professionals (supposedly of lower standing on the medical hierarchy system) within the entrenched medical model of the health system. Bullying is rampant even in some developed countries, but it can be highly prevalent in many developing and less developed countries within Asia.

The bullying incidents are often unreported as the victim does not or cannot come forward to report, and or whistle blower is afraid of jeopardising their position. Common reasons include---a belief that nothing would be done about it; fear of possible further victimization; being single-out by the judgemental management; concerns of being labelled a troublemaker, wrongly accepted as an admission of failure, and with a certain degree of learned tolerance that accepts the unacceptable behaviour (NHS Employers 2006) are many of the typical causes of prolonged bullying. However, one of the greatest fears is the associated real or perceived reprisals from the employer (or associates of the bully/ powerful professionals) that they may close ranks and subsequently compromise the career of the whistle blower (Field 2002).

CONSEQUENCES OF BULLYING

Bullying tends to stigmatise the targeted employee and leads to severe psychological trauma. Epidemiological data (n=8960; 80% women; response rate 67%) showed that workplace bullying is likely to contribute to subsequent common mental disorders (Lahelma et al. 2011). Feelings of being undermined, or humiliated, are common and are accompanied by physical-psychosocial symptoms (Kivimaki, Elovainio, and Vahtera 2000). The physical symptoms may include sleeplessness, tiredness, lifelessness, headache, inattention, trembling, sweating, indigestion, bodily pain, loss of appetite. The emotional symptoms may range from acute anxiety, depression, low self esteem, loss of confidence, feeling isolated, anger, agitation, mood swings, loss of interest, loss of motivation, absenteeism, and in chronic prolonged situation there is even suicidal thoughts or acts (Kivimaki, Elovainio, and Vahtera 2000). Specifically to gender, bullying in the form of verbal abuse was positively associated with confusion in women (Brotheridge and Lee 2010). Workplace bullying was also recently found to be strongly associated with psychotropic drug use (Niedhammer et al. 2010) and sickness absenteeism of the hospital staff (Kivimaki, Elovainio, and Vahtera 2000). It is thus unfortunate if management of healthcare organisations do not do their best to stop bullying at work.

INTERVENTION: ORGANIZATIONAL REHABILITATION AND SELF MANAGEMENT STRATEGIES

As a place where care and nurturing roles of human should be displayed, bullying at health organizations must be seriously tackled at both individual and organizational level in order to address the root causes. Rehabilitation of this chronic menace starts with awareness and public campaigns. The fundamental Hippocratic Oath provides a code of governance, ethically, not just for doctors but ideally for all healthcare providers towards each other.
Healthcare management needs to aggressively steer every employee from their bullying mentality, with themselves included. In line with the Hippocratic Oath of “I will prevent disease whenever I can, for prevention is preferable to cure”, this should be extended to address the bullying disease occurring at work—a much neglected disease in countries where human rights are often ignored, and where a more ‘elite’ discipline has the upperhand. In the west, most NHS trusts have anti-bullying policies, although, even these policies are often reported as ineffectively implemented (Hoosen and Callaghan 2004). Organisations need to learn from one another how to tackle this rising detrimental disease of workplace bullying. Annual audit of workplace bullying should be conducted in confidential manner to facilitate employees to willingly come forth to response to the surveys. The information on policy and guideline on workplace bullying should be widely publicised and disseminated so that criticism that it is only for show can be addressed to show that the organisation is serious and mean bussiness.

There are two separate yet distinct pathways that must be implemented. Firstly, organization must take steps to stop any bullying before it has become a culture of the organization. This is not uncommon as perpetrator(s) is usually powerful and long staying employee who also often holds managerial positions. In the UK, drastic measures adopted by BMA, include calls for zero tolerance on bullying (BMA 2006) with provision of regular reports on bullying and harassment in the workplace (BMA 2006). Key messages on bullying as highlighted by Mistry and Latoo (2009), can be translated into public health message for healthcare organization to promote in their workplace. These key Public health messages included:

- Bullying is subjective—-if you feel bullied then you are bullied.
- Being bullied leads to health-detrimental emotional and physical symptoms.
- Bullying in healthcare setting is a tip-of-iceberg scenario because of underreporting.
- The causes are focus on the personality of the victim and psychosocial factors at work.
- Bullying has implications at a personal, social, and organisational level.
- Consequences of bullying are complex, and are often embedded in the culture of the organization.
- Organisations need to be more proactive rather than reactive to this social menace.
- Management needs to raise awareness of workplace bullying as ‘unacceptable’.
- Strong media message of zero-tolerance of bullying within healthcare is a good start.
- Organisational rehabilitation strategies of in-house bullying must be initiated quickly.

Secondly, at the individual level, self management at the level of self monitoring, self evaluation and self reinforcement must be mapped out in order to ameliorate bullying, if this chronic burden cannot be eliminated. Every employee in healthcare needs to be better informed of what steps to take if they find themselves victims of a bully/ bullies at work. Self monitoring involves being aware and recording the warning signs which include the perception that one’s relationships at work is difficult or different, that their work are being hindered/ unfairly criticised/ sabotaged/ ridiculed; or finding oneself in situations whereby one seems to be questioning if the mistakes purportedly committed are really one’s fault; that they are persistently being attacked (BMA 2006). The UK, NHS, outlined steps to be taken by
an employee who feels bullied. These steps must be matched with a clear strategy for gaining support to break the bullying acts/ incidents. Table 1 is an outline of self management strategies to take by the bullied (adapted from Quine, 2001).

Table 1. Employee’s self management strategies

<table>
<thead>
<tr>
<th>Examples: If you received/faced ....</th>
<th>Self management steps to take (self monitoring, self evaluation and self reinforcement)</th>
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<tbody>
<tr>
<td>Initial verbal or physical harassment (bullying acts) aim to undermine you.</td>
<td>Self evaluate and confront verbally or in written form to ask the bully to stop or speak to a friend, colleague, supervisor or manager.</td>
</tr>
<tr>
<td>Persistent bullying acts although you have stated a request for it to stop.</td>
<td>Inform the manager/ human resource/ union official to speak to the bully. Consider a formal complaint in writing to the top representative.</td>
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<tr>
<td>Events where the bully belt out a punitive act or threats e.g. told you to resign, stop others getting to you, or block you from getting to others/ key tasks/ important meetings/ critical news/ informations. Eg pushing out your cupboards from the common wards into the corridor</td>
<td>Keep a record of any incidents and all informal actions taken (self monitoring).</td>
</tr>
<tr>
<td>Verbal or physical acts that affects your emotional or physical health.</td>
<td>Speak to general practitioner especially if your health is affected.</td>
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<tr>
<td>Order or demand for you to attend a formal investigation meetings (sometimes call a disciplinary hearing).</td>
<td>Contact bullying/complaints hotlines (if there is one) or your staff association. Have a colleague accompanying you to any formal investigation meetings.</td>
</tr>
<tr>
<td>Initiation by bullies and accomplices for you to be sent for counselling, or harassing that you are unfit to work or pressured till you are unfit.</td>
<td>Request that management refer you to an external agency for more support.</td>
</tr>
<tr>
<td>Constant reprimands from bullies and their ‘powerful’ allies.</td>
<td>Mediation may be on offer to encourage and help reach an informal outcome.</td>
</tr>
<tr>
<td>Ridicules (eg you are not good enough!) or obstruct (eg I want you to stop doing more research on the patients) or marginalized (given no important assignments, barred from external meetings).</td>
<td>Acknowledge you are more than your job or any professional title. Use your time and energy to focus on other scholarly activities and on networking with professional organizations outside the group or institution.</td>
</tr>
<tr>
<td>Detrimental publicity to crucial people or collaborator to cancel your talk/ invitations to you, to withdraw collaborations as a mean ‘to teach you a lesson’.</td>
<td>Be prepared that such undermining and gangsterism is common, report immediately and record (even if no action is taken) and seek proactive support.</td>
</tr>
</tbody>
</table>

In addition to the feelings of being undermined, or humiliated, bullying is also accompanied by physical-psychosocial symptoms that take a toll on the employee, the
organisation and society. The participation of the affected employee at work becomes dysfunctional and eventually this spills into their home and daily living activities. Therefore, self evaluation includes the evaluation the situation more holistically and this includes evaluations of the impact of bullying on overall health, as manifested in both physical symptoms and emotional symptoms (BMA 2006), and not just solely on its impact on work productivity. Self reinforcement upon taking self management steps include---i) giving oneself strokes for the positive actions taken to ii) stop the bullying, iii) maintain or work on raising one’s self worth and iv) reminds oneself so as not to spiral down into the pit of low self esteem (which is precisely what the perpetrator sets out to obtain, consciously or unconsciously against the target).

CONCLUSION

Bullying in health sectors is unfortunate but it is a real and an entrenched chronic menace with implications for public health. Greater employee awareness and ‘zero-tolerance’ policies is needed, especially in health organizations within the region of Asia Pacific, particularly those governed by a traditional, hierarchical medical model of approach.

The solutions adopted must be beyond those targeted at the individual level in order to eliminate the root sources and causes of bullying. More awareness and educational campaign for the problem to be handled seriously at the organisational level, and not just targeting at the individual level must be enforced.

Key messages on bullying as highlighted by Mistry and Latoo (2009) must be widely disseminated and publicised as they serve as public health strategies for healthcare organization serious in eliminating the burden of workplace bullying. Bullying is an important public health issue and timely measures are therefore needed to stop it. It is a risk for a lifetime of dysfunctional relationships and a key trigger for occupational dysfunction and lowered productivity. Bullying exact a toll on the bullied, the organizations and the society.

REFERENCES


