Bullying in the NHS: Why do we fail, and what can we do?

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Bullying in the NHS

• Prevalence:
  • 22% Medical/Dental staff harassed, bullied or abused in last 12 months (NHS Staff Survey, 2017)
  • Medical/Dental staff: 23% experienced, 49% witnessed (Carter et al., 2013)

• Negative impact on individuals, bystanders, teams and organisations
  • Physical and psychological health (Meta-analysis: Verkuil et al., 2015)
  • Longitudinal evidence supports causal effect of bullying on mental health (reverse also supported; see Nielsen & Einarsen, 2018 for a review)
  • Work outcomes: absenteeism, job satisfaction, intention to leave, commitment (Nielsen & Einarsen, 2012 meta-analysis)
Patient Care and Financial Cost

• **Patient care:**
  - Rudeness affected diagnostic and procedural performance of medical teams (Riskin et al., 2015)
  - Bullied trainees more likely to report serious or potentially serious medical error (Paice & Smith, 2009)
  - Bullying implicated in reviews of poor patient care (Bowles, 2012; Francis, 2013; Kennedy, 2013)

• **Financial:** Estimated annual cost to NHS is £2.28 billion (Kline & Lewis, 2018)
  - Based on sickness/absence presenteeism, diminished productivity, compensation, legal costs, and employee turnover
“Certain consultants undermined junior members of the team, belittling their efforts, were sarcastic and made junior staff feel worthless...Minimal teaching but maximal criticism”

“Myself and other juniors would delay making a referral to other specialties for fear of ridicule [or] aggression”

“I have performed serious prescription errors due to bullying...It affected my performance badly and affected patient care.”

“I couldn’t sleep...I burst into tears at work...I just couldn’t think straight”

“This is the first time in my professional life that I’ve felt I’ve been in an organisation of lies and bullying, where people are frightened about what to do and what to say.”

(Carter et al., 2013; 2014)
The Challenge

• Persistent problem (bullied, witnessed)
• Significant barriers to reporting bullying
• Management lack of action
• High pressure environment
• Organisational change
Common responses to this challenge

- All NHS Trusts have a B&H /Dignity at Work policy
- Most have implemented training at some point

• Why is there still a problem?
  the interventions aren’t working
Policy...why does it fail?

• Individual and organisational barriers to reporting
• Uncertainty regarding the process
• Negative experiences of the process
• Zero-tolerance statements
• Vexatious complaints
Barriers to reporting bullying

• “I have been told that should I report any bullying behaviour ‘the doors of the [hospital] would be closed to me’”

• “It is generally not worth reporting unless your career is on the line as the process is soul destroying…”

• “The person concerned apparently already has a reputation for being ‘difficult’. Is more senior and established in the department.”
Individual barriers to reporting

• Career concerns: fear of speaking out being detrimental to career (Carter et al., 2013; Lewis, 2017)

• Make the situation worse or no change

• Not wanting to be viewed as a trouble maker

• Lack of trust

• Feelings of isolation and lack of support

• Self-doubt: making something out of nothing, or concern that others view situation differently / target-blame

• “Their word against mine”

• Emotional distress, ill-health, negative emotional experiences during the complaint process
Organisational barriers to reporting

• Complainant does not know what to expect
• Bullies more often are more senior
• Policies advise to raise concerns with management
  • Common for manager to be source of bullying
  • Management levels working closely together present perception of lacking independence
• Management lack of action or non-timely responses to complaints
• Non-adherence to policy
• Attributing the responsibility for resolving the issue to the target / perpetrator
  • Dismissing as a personality clash
  • Recommending resolution through mediation or facilitated meeting
Negative experience of the complaint process

• Formal complaint stage – has reached the ‘failure zone’ where there are few real winners (Raynor and McIvor, 2008)

• Norwegian study – only 14% of complaints led to the bully being relocated or dismissed (Einarsen, Mykletun, Einarsen, Skogstad, & Salin, 2017)

• Reporting a complaint can result in no improvement, and in some circumstances, worsening of job, psychological and health outcomes for the complainant (Langhout, Palmieri, Cortina and Fitzgerald, 2002).

• During the process – being unwell, emotional outbursts (anger/frustration) (Catley, Blackwood, Forsyth, Tappin and Bentley (2017)

• Un-sackable employees who are critical to the business found proven to display bullying but not dismissed (Hubert, 2003)

• Target expectations rarely met (Catley et al, 2017)
Complaints processes that fail to tackle bullying

• Various explanations for ineffective complaint processes - abusing the process or failure to manage; inaction could be considered intentional or a lack of capability:
  • Procedures so ineffective that few complaints ever get processed
  • The organisation is so proficient at defending themselves against complaints that no cases are ever proven

• Consequence - future employees stop even attempting to raise a complaint
• Organisations need to evaluate policy usage at a process and outcome level
Zero-tolerance statements

• Problematic for organisations to adopt the ‘zero-tolerance’ approach

• Conceived differently:
  • Genuine intent (absolute): where bullying behaviours should never occur
    • Potentially making the process more adversarial
  • Symbolic: which signals to its stakeholders that it takes the issue seriously
    • Scope for softening in situations where no intent to cause harm, perpetrator unaware of the impact of their behaviour, or situations which do not meet the threshold for dismissal.

• May raise expectations of perfect behaviour all of the time and that those ‘proven’ will be dismissed

• Organisation risks credibility loss if zero-tolerance approach not lived up to

• Healthcare organisations have had zero-tolerance statement for years, little evidence of being effective as a deterrent
Malicious/ vexatious complaints

• Vexatious complaints are allegations not made in good faith; complaints made for personal gain or to foster malicious false allegations

• Typically featured in organisational policies

• Complaints fabricated with possible intent of deliberately trying to harm others

• Can act as a form of undermining of management (i.e. upward bullying)

• Despite their widespread inclusion within polices there has been no examination of frequency or impact of vexatious complaints in practice (Thompson & Catley, 2018)

• Risk that the concern of vexatious complaints hinders legitimate examination of complaints
Should we reconsider the policy and the complaint

• Current focus on dealing with individual bullies and initiating corrective actions

• Neglects the systemic nature of bullying where environment plays a critical role

• Blame placed on individual’s bad behaviour; that leaders are often the product of years of training, development programmes and socialisation within specific Trust cultures is omitted

• Alternative management approaches common in Aus/NZ focus on workplace bullying as a health and safety concern which is detrimental to the whole organisation
Intervention Approaches

• Code of conduct
• Team building
• Mediation
• Confidential peer support officers
• Coaching and mentoring
• Counselling
• Training (bullying awareness, policy, conflict management)

• Lack of intervention studies
  • Difficult, complex problem, need multi-level approach, hard to isolate effect of intervention
Consider bullying training you have attended...

• Who attended and engaged with the training?

• Voluntary or mandatory?

• Perceived as valuable?

• One off session or integrated into multiple training packages (leadership development, medical education)?
Training: Why does it fail...?

• Lack of engagement from individuals who need it the most
• Often voluntary
• Not always valued by seniors
• Awareness raising session
  • Need to build skills and confidence to challenge
• Typically one-off, rather than integrated across organisational systems and training
  • Selection, promotion, appraisal, leadership development, exit interviews
Training: What can we do?

• Train a **critical mass** of staff (or focus on leaders/managers)
• Tailored and **relevant** (e.g., scenarios)
• Develop a **common understanding** of bullying
• Increase **awareness of impact** of negative behaviours and **encourage monitoring** of own behaviours
• Increase **confidence to challenge behaviours** (as target or bystander) through practice in safe environment
• Provide **language/script** to have difficult conversations
• Incorporate **follow-up sessions** and **peer support** and monitor success
• Emphasise **impact on patients** (and trainee learning)
• **Incentives**: training required for promotion

**Context**: Leadership support and effective role-modelling
Bullying Interventions: Good Practice

- Strategic, multi-level approach (organisational/team/individual)
- Ongoing senior leadership commitment and role-modelling
- Bullying policy: clear, relevant, accessible, consistent enforcement
- Proactive monitoring and feedback (e.g., surveys)
- Effective training, critical mass of staff
- Focus on leaders and managers
- Develop active bystanders (Thompson et al., accepted for publication)
- Ongoing promotion and publicity

_Illing, Carter, Thompson, Crampton, Morrow, Howse, Cook, Burford (NIHR HS&DR, 2013)_