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

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Bullying in the NHS

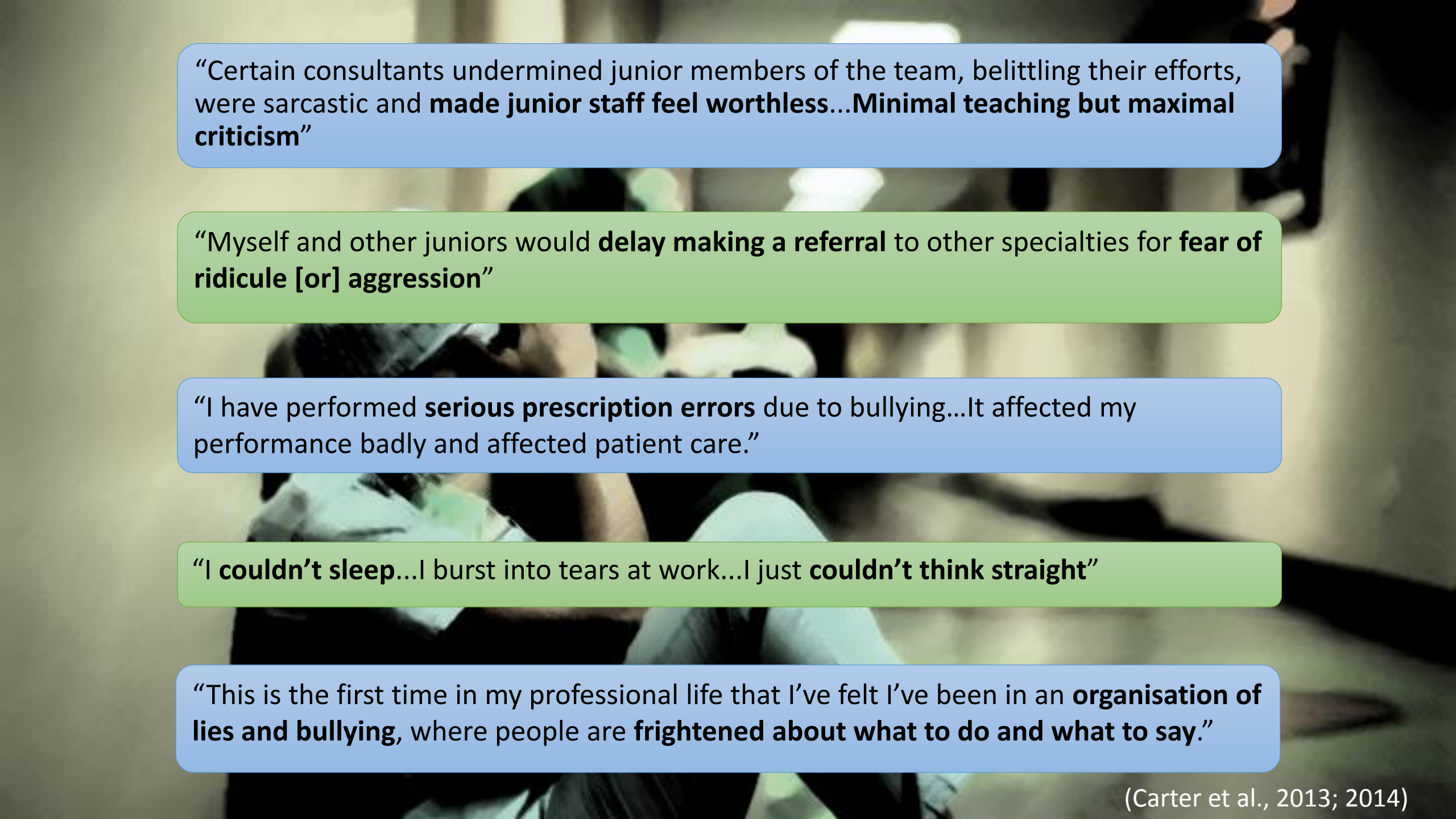
- **Prevalence**:
  - 22% Medical/Dental staff harassed, bullied or abused in last 12 months (NHS Staff Survey, 2017)
  - Medical/Dental staff: 23% experienced, 49% witnessed (Carter et al., 2013)

- **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)

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