Bullying in the hospital environment: an issue for us and our patients

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An individual's behaviour affects others in both positive and negative ways. This article discusses different types of negative behaviour patterns and how this may impact on our patients.

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Introduction

The behavior of an individual affects others for good or bad [1,2], which in the context of healthcare may be of major importance. It is therefore distressing to realize that bullying appears endemic in the healthcare environment [3,4].

Definitions

A wide range of negative behaviours may adversely impact upon individual wellbeing and patient care. However just as different causes of hypoxia may need a range of different treatments (in addition to supplemental oxygen), different unprofessional behaviors may need to be addressed in many ways. It is thus important to understand what behaviors may occur. A range of definitions are available but may be summarized as follows:

(1) Harassment: is illegal in many countries, including the UK [5]. It is recognized to be 'unwelcome, uninvited behaviour related to a proscribed characteristic, with the purpose of violating individual dignity or creating a hostile environment'. Proscribed characteristics include age, sex, race, religion, disability, sexuality, marriage, and pregnancy
(2) Bullying: may be seen as illegal if it includes failure to comply with local health and safety at-work requirements. It is defined by unreasonable behavior, repeated over time, which intimidates, offends, threatens, degrades, insults, or humiliates. It can be physical, psychological, or social and depends on the victims' perception and not the perpetrators' intent [6].
(3) Undermining: a range of definitions are available. The general medical council defines it as 'behaviour that subverts, weakens or wears away confidence or self-esteem', whereas Health Education England also includes features such as 'persistently negative feedback', 'feedback in front of others', and 'feedback poorly matched to the resilience of the individual' [7]. Staff may find these definitions challenging in the context of the need to potentially provide robust performance management. In acute clinical situations, information may need to be provided in a timely manner where the presence of others cannot be avoided. Moreover, it can be difficult to assess the resilience of a particular individual at a particular point in time. However, it is crucial to effective learning (which will support successful patient care) that trainer behavior is seen to be professional and supportive, even when criticism may be appropriate
(4) Bad behavior: a very human event. Most people will admit to not always behaving in a totally optimal fashion. This is often related to factors outside the situation, related to the deficiency portions of Maslow's hierarchy of needs [8]. Thus, it is more difficult to behave well if you have unmet physiological (hungry, thirsty, tired, or cold), safety (financial or physical worries), or belonging (deteriorating family or friendship ties) needs. This needs to be personally acknowledged, so as to focus more carefully on working relationships when at risk of behaving badly.

Outcomes

The effects of poor behavior of any nature can have negative effects on a variety of levels:

(1) Patients: it is well recognised that unit culture can adversely affect the outcome for patients. In the UK, The Francis Report of 2013 (http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report) documented the causes of increased mortality and morbidity occurring within a district general hospital over a number of years. This and previous reports placed great emphasis on the culture of fear, secrecy, and bullying related to reporting practices and outcomes, with leaders focused more on money saving than patient care, to the detriment of all.
(2) The victim: it is tempting to believe 'the victim is at fault' and inexperienced staff just need to 'grow up'. However, there is evidence to suggest that consultants are at least as likely to suffer [9]. As bullying (and even bad behaviour) is associated with a deterioration in both technical and nontechnical skills of experienced staff, this is of considerable importance [10].
(3) The perpetrator: he/she is likely to receive a lower level of support in clinical practice than would otherwise be the case. Within medical environments, stressed individuals perform worse and make more mistakes. Staff members are more likely to leave, further increasing the stress on the staff members supporting the bully [11].
(4) Staff bystanders: individuals who are not themselves bullied are also at risk from disrespectful behavior. They report a higher likelihood of intention to move to an alternate post, and are less likely to engage in effective team practice [12].
(5) The manager: staff often assume that the management is solely responsible for 'sorting out issues', expecting them to set the culture. However, what little research there is in this area suggests that managers may characterize behavior differently from frontline staff, potentially leading to inaction (with subsequent lack of change) [13].
(6) The unit: where a unit becomes known as dysfunctional, it becomes increasingly challenging to retain and appoint staff. This leads to an increased level of stress on current staff and an increased rate of absence owing to sickness.
(7) The hospital: facilities that are understaffed are at increased risk of poor outcomes. This is likely to reduce both financial input (as patients choose to be treated elsewhere) and available resources (both staff and equipment). The outcome is reduced activity, increased adverse events, and finally closure.

Plans

Culture does not change overnight; it must be worked on. As with every 'new' idea, there will be slow adopters as well as fast adopters. In wanting to enhance working environments, this must be taken into account. The situation must be accepted and investigated, before change is likely. Considering the situation as a quality improvement process and utilizing a PDSA cycle (plan–do–study–act) may help [14].

Step 1 (plan)

Acknowledge your department/hospital has an issue that needs to change. Without support from within, change will be very challenging, if not impossible, to achieve. Any change needs to be planned.

Issues frequently come to a head when finance is involved. An ability to retain or appoint staff of sufficient quality is a common driver for change. Good staff vote with their feet and move to more supportive environments unless the pay and/or facilities are of such a high standard as to mitigate behavior and cultural issues.

Steps 2 and 3 (do and study)

Assess what the problem actually is and make changes to address this. Bad behavior by all may be a sign of excessive stress with no chance for a break. This is potentially addressed by small changes in environment, such as provision of a rest area (away from patients) close to the working space. Alternatively, a single bully may be overwhelmed with work and cope poorly with junior staff, particularly when facing a difficult challenge. This may require individual review of the work plan, employment of more staff, and training to manage stress.

Situation review may be attached to training programmes by requiring completion of an assessment form that includes information about observed behavior.

Step 4 (act)

Enhance the culture. This will take time and require the input of everyone, from most senior manager to most junior trainee within a unit. It may well be that (often small) structural changes are necessary to maintain a good working environment. These may include provision of seating areas where hot and cold drinks are available for staff close to their

working areas. However, all staff must take responsibility to engage while ensuring that they and physicians behave in a professional manner with everyone around them. This will include apologizing for the inevitable lapses in our own behavior, but doing so with the same degree of publicity as that in which the poor behavior occurred.

As physicians, we must take the lead in this, as much as in clinical care. If we are not seen to treat allied health professionals and support staff in an appropriate manner (and apologise publically when we occasionally fail) we lead our units down paths to failure. Only where we all aim to behave professionally ourselves and intervene when we see others behaving unprofessionally can a culture be changed. We must strive to ensure we do not let unprofessional behavior pass unmentioned. This is not easy, but worthwhile changes rarely are.

Conclusion

Bullying and harassment is common in healthcare systems worldwide. It is vital that physicians engage with cultural changes, which should be seen as part of our personal risk management strategy, ensuring the best possible outcome for our patients. Such change is likely to take time, but rapid adopters can aid this process.

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Conflicts of interest

There are no conflicts of interest.

References

1 Savage BM, Lujan HL, Thipparthi RR, DiCarlo SE. Humor, laughing, learning and health! A brief review. Adv Physiol Educ 2017; 41:341–347.

2 Lelsy HB, Ahmad M. Altering workplace attitudes for resident education (AWARE): discovering solutions for medical resident bullying through literature review. BMC Med Educ 2016; 16:127.

3 WMA statement on bullying and harassment within the profession October 2017. Available at: https://www.wma.net/policies-post/wma-statement-on-bullying-and-harassment-within-the-profession/. [Last accessed 2018 Apr 12].

4 Rosta J, Aasland OG. Perceived bullying among Norwegian doctors in 1993, 2004 and 2014–2015: a study based on cross-sectional and repeated surveys. BMJ Open 2017. Available at: http://bmjopen.bmj.com/content/bmjopen/8/2/e018161.full.pdf.

5 Equality Act (2010). Available at: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf.

6 GMC National Training Survey 2014. Available at: https://www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010. pdf.

7 HEE Multiprofessional Faculty Development. Available at: http://www.faculty.londondeanery.ac.uk/educational-team-development/managing-bullying-harassment-and-undermining/view.

8 Maslow's hierarchy of needs by Saul McLeod. Available at: https://www.simplypsychology.org/maslow.html.

9 Shabazz T, Parry-Smith W, Oates S, Henderson S, Mountfield J. Consultants as victims of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences. BMJ Open 2016. Available at: http://bmjopen.bmj.com/content/bmjopen/6/6/e011462.full.pdf.

10 Riskin A, Erez A, Foulk TA, Kugelman A, Gover A, Shoris I, *et al.* The impact of rudeness on medical team performance: a randomized trial. Pediatrics 2015; 136:487–495.

11 Carter M, Thompson N, Crampton P, Morrow G, Burford B, Gray C, Illing J. Workplace bullying in the NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting. BMJ Open 2013; 3: e002628.

12 Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, Healy GB. A culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Acad Med 2012; 87:845–852.

13 Johnson SL, Boutain DM, Tsai JH, Beaton R, de C astro AB. An exploration of managers' discourses of workplace bullying. Nurs Forum 2015; 50:265–273.

14 http://qualitysafety.bmj.com/content/early/2016/12/16/bmjqs-2016-006245.short. (accessed today). A primer on PDSA: executing plan-do-study-act cycles in practice,