

A survey of workplace bullying in a health sector organisation

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Abstract

The purpose of this study was to explore the frequency, nature and extent of workplace bullying in a health care organisation in New South Wales. The survey methodology achieved a 79% response rate ($n=311$). Overall, 155 respondents (50%) reported that they had experienced one or more forms of bullying behaviour in the past 12 months. The largest reported source of workplace bullying was peers or fellow workers (49%), followed by clients (42%) and managers or supervisors (38%). Only 36% of respondents who had been bullied had formally reported the episode. The level of bullying reported was unexpectedly high and will require development of strategies to address the issue.

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What is known about the topic?

Workplace bullying has increasingly been identified as a serious occupational health and safety issue in health care.

What does this paper add?

A survey questionnaire found a high level of bullying behaviour in a NSW health service organisation. The largest reported source of workplace bullying was peers or fellow workers and few of the victims had formally reported the bullying incident.

What are the implications for practitioners?

There may be unidentified bullying behaviour in our health care organisations. It is easier to prevent bullying than to treat it, but organisations should systematically address both preventing workplace bullying and providing adequate systems to manage established bullying.

What is workplace bullying?

Workplace bullying has increasingly been identified as a serious occupational health and safety issue. This paper describes the results of a survey of workplace bullying conducted in a health service organisation. The survey was informed by a review of the relevant literature described below.

Most commentators agree that workplace bullying is widespread, covert and insidious and can have serious long-term effects on victims, organisations and the perpetrators themselves (Farrell 1999; Cusack 2000; Mayhew & Chappell

2001a). Recognition and management of bullying in the workplace is complicated by lack of consistent definition. Several agencies have created their own definitions, for example, the Victorian WorkCover Authority has proposed the following definition in its draft Code of Practice for the Prevention of Bullying and Violence in the Workplace:

Workplace bullying is the repeated, unreasonable behaviour directed towards an employee, or group of employees, that creates a risk to health and safety (Victorian WorkCover Authority 2001).

'Unreasonable behaviour' is defined as behaviour that a reasonable person would expect to victimise, humiliate, undermine or threaten them; and 'health' includes mental and physical health (Victorian WorkCover Authority, 2001). NSW has recognised that workplace bullying is a

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significant issue in the health sector with the publication of a discussion paper on bullying in the health workforce (Mayhew & Chappell 2001a).

Rayner and Hoel (1997) defined five categories of workplace bullying:

- Threats to professional status (eg, belittling, humiliation);
- Threats to personal standing (eg, teasing, insults);
- Isolation (eg, withholding information);
- Overwork (eg, impossible deadlines, unnecessary disruptions); and
- Destabilisation (eg, meaningless tasks, shifting of goal posts).

Michelson (2001) argued that taking too narrow a view of bullying works against real organisational change. Michelson defines bullying as:

... repeated attempts to manipulate and destabilise an employee's professional or personal standing ... spreading malicious rumours, social exclusion or isolation, withholding important information ... requiring workers to perform meaningless tasks ... setting impossible deadlines, excessive and intrusive surveillance ... and workplace expectations of self-sacrifice.

Most definitions of workplace bullying focus on the negative effect on the recipient, not the intention of the bully or the persistence of the bullying behaviour (Quine 1999). Despite the lack of a legal definition, workplaces have a legal responsibility to protect their employees from harassment, including bullying.¹

¹ Bullying involving physical assault or threat of assault is a criminal offence in all States. In NSW, depending on the type of bullying, claims can be made under the *NSW Occupational Health and Safety Act 2000*, the *NSW Anti-Discrimination Act 1977* or the unfair dismissal provisions of the *NSW Industrial Relations Act 1996*. Employers have a duty under the *NSW Occupational Health and Safety Act 2000* to identify, assess and eliminate or control hazards, including those from workplace violence. Under common law, employers who do not take suitable precautions to protect workers from workplace bullying may be liable for any physical or psychological injury suffered by the victim.

How common is workplace bullying?

In part because of problems with definitions, comprehensive and unequivocal data on the prevalence of workplace bullying do not exist. However, studies across the industrialised world suggest that physical violence in the workplace is rare, but verbal abuse and bullying are common (Cusack 2000). A recent European review of bullying concluded that at least 10% of employees can be considered as currently subjected to workplace bullying (Hoel, Sparks & Cooper 2001). This is in addition to verbal or physical violence perpetuated by clients or people external to the organisation. The European Parliament has identified a bullying incidence of around 8% per year (European Parliament 2001). Within Australia, a national poll in 1998 reported that 35% of people had been verbally abused by a co-worker and 31% by a manager (Roy Morgan 1998). In 2000, a survey of 3000 workers conducted by the Australian Council of Trade Unions reported that 54% of workers had experienced intimidation in the workplace, mostly from supervisors or managers (Australian Council of Trade Unions 2002).

Within the health workforce, studies have documented that nurses (Carr & Kazanowski, 1994; Farrell 1999; Quine 2001) and junior doctors (Quine 2002) experience high levels of bullying. A study of a community health trust in the UK in 1996 found that 38% of employees had experienced one or more types of bullying within the previous year (Quine 1999). The perpetrators of violence in health workplaces have commonly been identified as nursing managers, colleagues, doctors, patients and patients' relatives (Birman 1999). Mayhew and Chappell (2001a) suggested that nurses may be more vulnerable to bullying than other health care workers for three reasons: they are predominantly female; they may be oppressed by physicians, administrators and more senior nursing staff; and they may perceive themselves to be comparatively powerless. Workers with substantial face-to-face contact with clients appear to be at higher risk of violence (Mayhew & Chappell 2001b). As this influences job satisfaction, occupations such as nursing with high face-to-face contact with clients can experi-

ence shortages because of bullying (Birman 1999). A further consequence is that there is a significant relationship between bullying and burnout among health care professionals (Einarsen, Mathieson & Skogstad 1998).

Who gets bullied and why?

Anyone may be a bully or a victim of bullying. Although there is a preponderance of supervisors or managers reported as bullies, a significant level of bullying has been documented between peers or co-workers, and from workers to their managers (Cusack 2000). Most studies reported a pattern of male bullies and female victims, although some report women being bullied by both men and women, whereas men tend to be bullied by men only (Mayhew & Chappell 2001a). The target may be more successful or popular than the perpetrator (Mayhew & Chappell 2001a), or may be 'different' in some way, such as different racial origin (Lemos & Crane Pty Ltd 2001). Gender and cultural background may influence confidence and assertiveness and whether or not appropriate action is taken to deal with bullying (Queensland Working Women's Service 1999).

Michelson (2001) argues we need to move beyond considering bullying as an individual's problem towards the idea of the organisation as the bully. Bullying does not occur independently of organisational policies, activities, pressures and reward systems (McCarthy 1999). The European Parliament (2001) has reported there is a close link between internal violence and work stress associated with greater competition, reduced job security and precarious employment. (In many studies, the terms bullying and internal violence are used interchangeably.) Organisational culture and particular management styles can influence the potential for workplace bullying (Sheehan, McCarthy & Kearns 1998). Indeed, workplace culture may normalise intimidatory behaviour if low level violence has been tolerated or ignored by senior management for some time and perpetrators believe their behaviour is acceptable (Mayhew & Chappell 2001a). There is some evidence that a supportive work environment may act as a

coping strategy or moderator, buffering the individual from the damaging effects of work stressors such as bullying (Quine 1999).

A core difficulty within organisations is distinguishing between poor management that contributes to a violent culture and inappropriately coercive behaviour by an individual. Mayhew and Chappell (2001a) suggested that bullying can be differentiated from poor management in that bullying usually arises from malicious intent rather than genuine attempts to enhance performance, and bullying behaviour is repeated, escalating in intensity over time.

Methods

The purpose of the survey was to establish the frequency, nature and extent of bullying within our organisation. Our organisation is a Division within an Area Health Service of New South Wales, located in Sydney — not strictly part of the NSW Department of Health, but closely aligned. The organisation employs about 400 staff in six units, with the largest unit employing three quarters of the staff and organised into about 24 smaller teams. We provide a range of services for the local community (including community health, public health and health promotion) with a broad population health approach.

We drafted a questionnaire (for respondent self-completion) based on available literature about workplace bullying. A broad working definition of bullying was chosen, prefaced by the question "In the last 12 months have you experienced any of the following while employed within the Division?" Options included "physically threatening behaviour; intimidating behaviour, such as belittling, sneering, shouting or ordering; use of abusive or degrading language; unwanted sexual references, advances or comments; unwanted mocking or teasing, sarcasm or jokes; being bullied because of your race, age, gender, sexuality or perceived disability; pressure of impossible/unreasonable demands; feeling constantly watched or under surveillance; fear of speaking up about conditions/behaviours; being unfairly isolated or excluded from a group; feel-

ing that your workplace is oppressive or hostile; tones of voice or facial expressions which leave you feeling 'put down'; and other forms of bullying (identified by respondent)". Respondents could tick more than one option.

The questionnaire included questions on the social, emotional and workplace effects of bullying, whether or not the bullying had been reported, and the reasons and outcomes. The questionnaire asked whether the respondent felt they had ever bullied or had been perceived as bullying. Basic non-identifying demographic data was obtained, including the length of service within the organisation and management responsibilities.

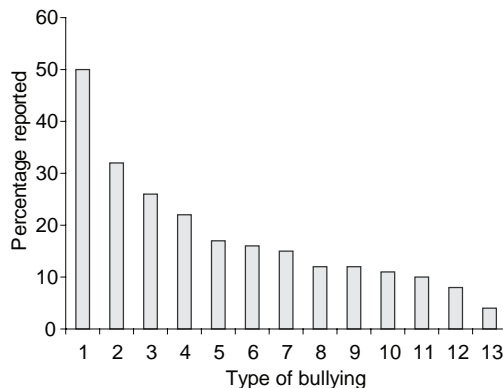
The survey was conducted as an anonymous postal survey to maximise the response rate and provide an opportunity for staff to openly disclose their experience of bullying behaviour. A disadvantage of this anonymity was that we were unable to determine in what units or areas bullying was reported, thus precluding provision of assistance to individual employees and making it more difficult to target remedial efforts. Advice about what to do if bullying was being experienced and telephone numbers for the Department of Human Resources and the Employee Assistance Program were included in a covering letter. The Area Health Service Ethics Review Committee approved the survey.

The survey and return envelopes were distributed with pay slips over three pay cycles, with different coloured paper used for each of the pay cycles. The covering letter explained the purpose of the survey and stressed that completing the survey was voluntary and confidential. Data entry was outsourced to a commercial computer centre. Analysis was conducted by the authors using Epi InfoTM Version 6 and Microsoft Excel.

Results

Three hundred and eleven staff members returned a completed survey (79% response rate). Of the respondents, 64 were male (21%) and 246 were female (79%) (one respondent missed out this item). Compared with the demo-

I Type of bullying reported by respondents



Type of bullying

- 1 Any bullying reported
- 2 Intimidating behaviour, such as belittling, sneering, shouting or ordering
- 3 Tones of voice or facial expressions that leave you feeling 'put down'
- 4 Pressure of impossible/unreasonable demands
- 5 Use of abusive or degrading language
- 6 Fear of speaking up about conditions/behaviours etc
- 7 Unwanted or mocking teasing, sarcasm or jokes
- 8 Feeling constantly watched or under surveillance
- 9 Feeling that your workplace is oppressive or hostile
- 10 Physically threatening behaviour
- 11 Unwanted sexual references, advances or comments
- 12 Being unfairly isolated or excluded from a group
- 13 Being bullied because of your race, age, gender, sexuality or perceived disability

graphics of the organisation, men were slightly more likely to return a questionnaire than women (16% of Division staff are male, 84% are female). Most respondents were 30 to 50 years of age, with 22% more than 50 years and 13% under 30 years. The largest proportion of respondents had worked for the organisation for more than 5 years (47%); 26% of staff had worked for the organisation for 2 to 5 years; 13% for 1 to 2 years; and 14% for less than 12 months. Most respondents were involved in

face-to-face clinical work with clients (60%); 23% described their work as mostly management, administration or clerical; and 16% as public health/health promotion, reflecting the distribution of staff in the organisation. The response rate was not significantly different between occupational groups. Sixty-six (21%) of the respondents reported roles that involved managing staff.

Overall, 155 respondents (50%) reported they had experienced one or more forms of bullying behaviour in the last 12 months while employed within the organisation. The most commonly reported behaviour was intimidating behaviour, such as belittling, sneering, shouting or ordering (32% of respondents), followed by tones of voice or facial expressions that leave you feeling 'put down' (26% of respondents). The types of bullying reported are illustrated in Box 1.

There was no significant difference between those who reported being bullied and those who did not according to gender, age or management responsibilities. Respondents whose work predominantly involved face-to-face work with clients were one-and-a-half times more likely to report being bullied than those whose work did not predominantly

involve face-to-face client work (Odds ratio (OR), 1.7; $P=0.02$). Bullying was reported by 29% of staff who had worked in the organisation for less than 12 months; 63% of staff who had worked in the organisation for 1 to 2 years; 53% of those who had worked in the organisation for 2 to 5 years; and 50% of those who had worked in the organisation more than 5 years.

The largest source of bullying was peers or fellow workers (49% of staff who had been bullied), followed by clients (42%), their manager or supervisor (38%), and staff managed by the respondent (8%). Other sources of bullying included senior management, other managers, specific staff members, and the organisational culture. It was possible for respondents to report bullying from more than one source; there were 250 sources of bullying reported from 155 respondents. Box 2 identifies the type of bullying by the source.

The type of bullying most likely to be experienced from peers or fellow workers was tones of voice or facial expressions which leave you feeling 'put down' (27%) and intimidating behaviour such as belittling, sneering or shouting (21%). Sixty percent of respondents who reported being

2 Type of bullying by source (number of responses)*

	Manager/ supervisor	Staff managed by me	Fellow workers (peers)	Clients
Physical threat	1	2	33	2
Intimidation	6	33	40	8
Abusive language	0	12	41	4
Sexual references	1	8	21	3
Teasing or sarcasm	0	21	12	2
Bullying due to racism, age, sex, etc	0	11	8	0
Unreasonable demands	1	17	18	17
Constantly watched	1	14	4	2
Fear of speaking up	1	20	1	9
Unfairly isolated	3	19	0	0
Feeling oppressive workplace	4	23	1	6
Feeling 'put down'	5	42	7	8
Other	0	4	0	2

* Multiple responses allowed

bullied by peers or fellow workers cited two or more types of bullying.

The most common type of bullying experienced from clients was use of abusive or degrading language (26%), followed by intimidating behaviour such as belittling, sneering or shouting (26%), and physically threatening behaviour (21%). Seventy-four percent of respondents cited two or more forms of bullying by clients.

From managers, respondents most commonly reported tones of voice or facial expressions which leave you feeling 'put down' (20%), followed by the pressure of unreasonable demands (19%), intimidating behaviour such as belittling, sneering or shouting (17%), and fear of speaking up about conditions/behaviours etc (17%). For these respondents, 70% reported two or more forms of bullying.

Bullying from staff managed by the respondent most commonly took the form of intimidating behaviour such as belittling, sneering or shouting (4%) and tones of voice or facial expressions which leave you feeling 'put down' (3%). Fifty percent of these respondents reported two or more types of bullying being employed.

Respondents who reported 'other' sources of bullying most commonly reported the pressure of unreasonable demands (11%).

As a result of being bullied, respondents ($n = 155$) reported feeling stressed or depressed (70%), feeling angry, helpless or fearful (61%), considering looking for alternative employment (35%), being reluctant to attend work (35%), feeling ill (13%), changing work practices (10%) and claiming leave (7%). Other outcomes included feeling vengeful, annoyed, hurt or frustrated (2%), seeking counselling (2%), avoiding the situation (2%), and debriefing with other staff (1%).

When respondents who reported they had been bullied were asked whether they had talked informally with anyone at work about the behaviour, of 155 respondents, 88% indicated that they had, and 8% had not. However, only 36% of respondents (56 people) had formally reported the behaviour. When a formal report was made, it was predominantly to a manager (42 respond-

ents; 27%). Reports were occasionally made to another employee's manager, the Director of the Department, a staff counsellor or a union. Only one person reported bullying to the Human Resources Manager. Formal reporting led to effective action to change the situation in 20% of cases, and did nothing to change the situation in 34% of cases. In 30% of cases, reporting led to some changes being made but did not completely resolve the situation. In 7% of cases it made the situation worse.

Of those staff who reported being bullied and did not formally report the behaviour (95 respondents), 52% believed reporting would not change the situation, and 29% believed it could make the situation even worse.

There was no significant difference between those who formally reported bullying and those who did not according to gender or area of work. Respondents older than 50 years were more likely to formally report bullying than respondents less than 50 years (OR, 4.1; $P < 0.05$).

Asked if they thought it was possible that in the last 12 months they had bullied another staff member or been perceived as bullying, 16 respondents (5%) answered yes, 248 (80%) answered no, and 11 (3.5%) were unsure.

The survey allowed open-ended comments and 99 staff (32% of respondents) made comments, which were grouped into eight themes. These themes were: reiteration of the seriousness and long-term effects of bullying; reports of personal experiences of bullying or awareness of other staff being bullied; feeling unsupported or inadequately supported by management; feeling supported by management and having managers ensure that issues were addressed and resolved; reporting being happy at work and not experiencing or encountering bullying in their workplace; recognition of the differing perceptions of what constitutes bullying and comments about the confusion/conflation between strong management practices and bullying; comments about the survey being a worthwhile and appreciated initiative; and reports of bullying outside the parameters of the survey. Respondents also suggested possible solutions to bullying such as

team building, in-service training, celebrations across disciplines, peer debriefing, more meetings with upper management to create a channel of trust, assertiveness training for staff, regularly bringing up the issue of workplace bullying, mandatory training sessions on bullying and addressing staff shortages.

Discussion

While a broad definition of bullying was used, there was an unexpectedly high level of bullying behaviour reported. Peers and fellow workers were reported as the most common source of bullying within the Division, followed by clients, with the most common forms of bullying detected being intimidating behaviour, inappropriate tones of voice and facial expressions, and the pressure of impossible or unreasonable demands.

The survey asked for any experience of workplace bullying rather than repeated experiences of bullying, which may have contributed to the relatively high prevalence reported. Despite most definitions of workplace bullying incorporating the notion of repeated, persistent behaviour, most prevalence studies ask about any experience of bullying within a given time frame. We believe the prevalence rate detected here therefore can be reliably compared with other studies with similar methodology.

Staff engaged in face-to-face clinical work with clients were most likely to be bullied, although gender, length of service, age and management status were not significantly associated with being bullied. Most staff who reported being bullied reported they had suffered physical or emotional consequences, and a significant minority reported work-related consequences as a result of the behaviour. Current formal reporting mechanisms for bullying were both under-utilised and inadequate, indicating a need to review these procedures.

A number of organisations have developed strategies to address workplace bullying. It is easier to prevent bullying than to treat it, but

organisations should systematically address both preventing workplace bullying and providing adequate systems to manage established bullying. Mayhew and Chappell (2001a) suggested that the ideal proactive strategy to prevent workplace bullying is for the Chief Executive Officer/Manager to lead by example and support the introduction of system-wide, comprehensive policies, procedures and practices that 'design out' internal violence in all its forms. Demonstrated top management commitment to a policy of zero tolerance is of core importance, with this commitment included in mission statements (Mayhew & Chappell 2001a). A violence prevention policy and training should make every employee aware that covert violence is unacceptable and should lead to a sense of responsibility for identifying and preventing it (Mayhew & Chappell 2001a). Training to reduce the level of internal violence may include appropriate ways to manage staff, techniques to identify a bully, and strategies to cope with inappropriately coercive behaviour, thus empowering staff to manage the negative behaviour of others and to identify mechanisms that encourage perpetrators to change their behaviour.

For staff currently being bullied, there need to be guidelines on appropriate action. Various authors (eg, Victorian WorkCover Authority 2001) have recommended that workplace codes of conduct/grievance procedures may be helpful and there should be a system where investigations are independent of the perpetrator. The process must be transparent and seen to be fair, and the penalties for violation need to be applied consistently across all levels in the hierarchy and in all units of the organisation. Individuals who have been targeted should document every incident of bullying, noting whether there were witnesses to the behaviour. In addition to these formal procedures, Mayhew and Chappell (2001a) suggested that often issues can be resolved informally. If a bully is made aware of their behaviour and the effect, change may be forthcoming. It may be most productive to pursue a 'no-blame' conflict resolution strategy within organisations.

Conclusion

Half the employees of our organisation reported that they had experienced one or more forms of bullying behaviour in the last 12 months. This may be an overestimate of bullying as we did not assess repeated bullying, but *any* workplace bullying experience. The largest source of bullying behaviour was from peers or fellow workers (49%), followed by clients (42%) and managers or supervisors (38%). Only 36% of respondents who had been bullied had formally reported it to anyone. Despite using a broad definition, the level of bullying reported was unexpectedly high and has now resulted in the development of a range of strategies to address the issue.

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