UTS UNIVERSITY OF TECHNOLOGY SYDNEY

# Graduate Health Management Trainees' Perceptions of Workplace Bullying Behaviours: An Australian Perspective

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under the supervision of Professor Joanne Travaglia and Dr Deborah Debono

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## Certificate of Original Authorship

I, Sharlene Anne Chadwick, declare that this thesis, is submitted in fulfilment of the requirements for the award of Doctor of Philosophy in the Centre for Health Service Management, Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Date: 14 February 2021

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## List of Abbreviations

| | |
|---|---|
| ABF | Activity Based Funding |
| ACHSM | Australasian College of Health Service Management |
| AHPRA | Australian Health Practitioner Regulation Agency |
| AMA | Australian Medical Association |
| AWB | Australian Workplace Barometer project |
| CICM | College of Intensive Care Medicine |
| EAP | Employee Assistance Program |
| EOC | Essentials of Care |
| FWC | Fair Work Commission |
| GHMP | Graduate Health Management Program |
| GHMT | Graduate Health Management Trainee |
| HREC | Human Research Ethics Committee |
| IHI | Institute for Healthcare Improvement |
| JMO | Junior Medical Officer |
| LSQ | Learning Style Questionnaire |
| MBA | Medical Board of Australia |
| MeSH | Medical Subject Headings |
| MLA | Modern Language Association |
| NHS | National Health Service |
| NSQHS | National Safety and Quality Health Service Standards |
| NSW | New South Wales |
| OHS | Occupational Health and Safety |
| PRISMA | Preferred Reporting Systematic Reviews and Meta-Analysis |
| RAM | RAND/UCLA Appropriateness Method |
| WBB | Workplace Bullying Behaviours |
| WHO | World Health Organization |
| WHS | Workplace Health and Safety |

## List of Publications and Presentations arising from this Research

### A. Referred Publications

**Chadwick, S.** and Travaglia, J. (2017). Workplace bullying in an Australian health context: a systematic review. *Journal of Health Organisation and Management, 3*(3): 286–301. https://doi.org/10.1108/JHOM-09-2016-0166.

This paper has received attention in the following ways:

- 16 requests for full text (including UTS library).
- Cited four times as 'project reference'.
- Doe, F., Puplampu, B.B. (2019). Coercive management behaviour causes scale: validation and reliability. *International Journal of Organisational Analysis, 27*(3): 729-744. https://doi.org/10.1108/IJOA-08-2018-1508.
- Mubarak, Fozia and Mumtaz, Sana. (2018). The impact of workplace bullying on project success as mediated through individual organisational citizenship behaviour: a study in Pakistan. *Cogent Business and Management, 5*(1): Article 1532278. https://doi.org/10.1080/23311975.2018.1532278.
- Behboohdi-Moghadam, Zahra et al. (2018). Workplace harassment through the experiences of Iranian women: a qualitative study, 2017. *Iran Journal of Psychiarty and Behavioural Sciences, 12*(3): e66945. DOI: 10.5812/ijpbs.66945.
- Morris, J., Canaway, R., & Bismark, M.M. (2017). *Reducing, identifying and managing vexatious complaints. Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency*. Melbourne School of Population and Global Health, The University of Melbourne.
- Invited as peer-reviewer for *International Journal of Nursing Studies*.
- Invitation to submit further articles to *International Journal of Clinical Medical Research*.
- Invited as peer-reviewer for *Heliyon* journal.
- Invitation to publish research findings as a book from Lambert Academic Publishing.

**Chadwick, S**. and Franklin, N. (2013). The impact of workplace bullying in nursing. *Australian Nursing Journal, 21*(1): 31.

This paper has received attention in the following ways:

- Hartin, P., Birks, M., and Lindsey, D. (2019). Bullying in nursing: is it in the eye of the beholder? *Policy, Politics and Nursing Practice, 20*(2): 82–91. https://doi.org/10.1177/1527154419845411.
- Mamman, B et al. (2018). Newly qualifies graduate nurses' experiences of workplace incivility in Australian hospital settings. *Collegian, 25*(4): 591–599. https://doi.org/10.1016/j.colegn.2018.08.003.

- Adams, A.M. (2018). The perceived and experienced role of the nurse unit manager in supporting the wellbeing of intensive care unit nurses: an integrative literature review. *Australian Critical Care, 32*(4): 319-329. https://doi.org/10.1016/j.aucc.2018.06.003.
- Koharchik, L. (2018). Nursing instructor incivility towards students. *The American Journal of Nursing, 118*(7): 64–66. https://doi.org/10.1097/01.NAJ.0000541442.76122.e4.
- Nagata, M and Suzuki, K. (2018). Vocational intention of nursing staff working at nursing care service office. *Bulletin of Department of Health Sciences*, Graduate School of Medicine, Akita University.
- Oyama, Y. et al. (2018). Factors related to the actual state of separation intention of a new nurse and vocational career maturity. *Bulletin of Department of Health Sciences*, Graduate School of Medicine, Akita University.
- Aul, K. (2017). Who's uncivil to who? Perceptions on incivility in pre-licensure nursing programs. *Nurse Education in Practice, 27*: 36-44. https://doi.org/10.1016/j.nepr.2017.08.016.
- Chadwick, S. and Travaglia, J. (2017). Workplace bullying in an Australian health context: a systematic review. Journal of Health Organisation and Management, 3(3): 286–301. https://doi.org/10.1108/JHOM-09-2016-0166.
- Booth, C. (2017). *Nurse educators' perceptions of nursing students' bullying behaviours in traditional and online education settings: a phenomenological study*. Unpublished dissertation proposal, Doctor of Education, Northcentral University.
- Gee, G. (2017). How does shift work on placement affect healthcare students' lives?' *Fields: Journal of Huddersfield Student Research, 3*(1). https://doi.org/10.5920/fields.2017.03
- Osborne, N. (2016). *An exploratory study on how workplace bullying is conceptualised in the Australasian media*. Unpublished Master of Business dissertation, Auckland University of Technology.
- Gantt, G. (2016). *Being bullied in the workplace and impaired professional performance: the lived experience of nurses*. Unpublished Doctor of Philosophy in Nursing dissertation, University of Phoenix.
- Aul, K. (2015). A comparison of perceptions of incivility among nursing students and faculty in pre-licensure nursing programs. Unpublished Doctor of Philosophy dissertation, Robert Morris University.

**B. Referred Presentations or Published Abstracts and Posters**

- Chadwick, S. Workshop presentation. International Association of Workplace Bullying and Harassment Conference. Dubai, UAE, June 2020.[*]

[*] Postponed to April 2021 due to COVID-19 pandemic.

- Chadwick, S. Workplace bullying in the Australian health context: a health management trainees' perspective. Oral presentation. APAC Forum – Concurrent session, Gold Coast, Australia, September 2017.
- Chadwick, S. Dealing with workplace bullying in the health context – the development of a professional learning module. Poster presentation. APAC Forum, Gold Coast, Australia, September 2017.

**C. Invited Presentations**

- August 2014 – Gold Coast – QUT – WorkSmart Conference. Keynote Speaker.
- July 2014 – UNSW – 'Impacts of Workplace Bullying' – findings from research.
- July 2013 – Wagga Wagga – Medicare Locals. 'Impacts of Workplace Bullying.'

**D. Seminar or other public presentation**

- April 2016 – Gold Coast – Australian and New Zealand Mental Health Association – No2Bullying. Conference Chair, Keynote Speaker and Program Advisory Committee.
- June 2015 – Gold Coast – Australian and New Zealand Mental Health Association – No2Bullying. Conference Chair, Keynote Speaker and Program Advisory Committee.
- April 2014 – Gold Coast – Australian and New Zealand Mental Health Association – No2Bullying. Conference Chair, Keynote Speaker and Program Advisory Committee.
- May 2013 – Sydney – ACHSM – Knowledge Series Seminar – 'The Impacts of Workplace Bullying.'

## Abstract

Workplace bullying is a significant issue in healthcare and unprofessional behaviour is widespread in the Australian healthcare system. The purpose of this thesis is to understand workplace bullying from the perspective of graduate health management trainees (GHMTs) undertaking a two-year training program that includes work placements in healthcare settings.

There is sparse literature on perceptions of workplace bullying among GHMTs in Australia. This study aims to address this gap by specifically exploring this phenomenon. Addressing and researching this gap in the literature is important, as GHMTs have a future role in influencing systemic change, policies, education and practice. As their careers advance, GHMTs will also be key decision-makers and be expected to promote a positive and cooperative workplace culture.

The study was conducted in two phases. Phase one used qualitative methods with focus groups and individual interviews with participants to answer the research questions. Respondent validation interviews were also undertaken to ensure the validity of the findings. Phase two used both quantitative and qualitative methods with an international expert reference group to provide feedback and comment on a provisional anti-bullying learning framework developed specifically for this study as a result of the findings from phase one.

Two overarching domains emerged from the findings in phase one: (1) perceptions of workplace bullying; and (2) strategies for dealing with workplace bullying. Five themes are identified under the domain perceptions of workplace bullying: (1) level of awareness of workplace bullying; (2) behaviours that constitute workplace bullying; (3) causes of workplace bullying; (4) consequences of workplace bullying; and (5) the nature of workplace bullying. Four themes are identified under the domain strategies for dealing with workplace bullying: (1) dealing with workplace bullying; (2) positive relationships; (3) reporting of workplace bullying; and (4) training needs.

Recommendations are proposed for future research and practice that may impact on health professionals and patient safety. Long-term, sustained change in healthcare settings for dealing with workplace bullying are evidenced through the development, implementation and evaluation of policies and procedures. The delivery of anti-bullying

training and professional development for staff will also be a key metric in assessing the efficacy of systemic change within the healthcare profession. Findings from this study have substantive and methodological implications for researchers studying workplace bullying in healthcare settings.

# Preface

## I Origins of the thesis

Workplace bullying is a significant issue in healthcare and unprofessional behaviour is widespread in the Australian healthcare system (Westbrook et al 2018; Coursey et al 2013; House of Representatives Standing Committee on Education and Employment 2012; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Bryant et al 2009). This thesis builds on, and is grounded in, the researcher's ongoing interest and experience in bullying behaviours and education. Qualitative approaches are used to explore graduate management trainees' perceptions of workplace bullying in the health sector.

This study is situated in a period of challenge for the healthcare sector in Australia and for emerging managers. Emerging health managers are working longer hours, are under more pressure to perform and fear losing their jobs through organisational restructures and changes to workforce needs (Liven and Goussinsky 2018; Van den Brande et al 2017; Branch, Ramsay and Barker 2013; Buchanan et al 2013). Their roles are becoming more complex, and interactions across multiple levels of management and organisational functions and organisational dynamics can be challenging (Buchanan et al 2013). The delivery of healthcare relies on the capacity and competence of the workforce and, therefore, on the ability of healthcare organisations to manage and engage their workforces effectively (Meier and O'Toole 2002). There is increasing recognition of the impact of management and leadership behaviours on organisational performance (Buchanan et al 2013; Pfeffer 2005). The purpose of this thesis is to understand workplace bullying from the perspective of graduate health management trainees (GHMTs). Recommendations for future research and practice that may impact on health professionals and patient safety will also be explored.

## II Personal reflections

The reasons behind my personal desire to explore and investigate workplace bullying in a health context are many. I have been an educator for over 30 years, beginning my career as a secondary teacher, firstly in rural NSW and then in the Sydney metropolitan area. After 10 years, I moved into a role with a non-for-profit organisation where I was responsible for managing the development, delivery and evaluation of professional

learning and development programs and frameworks for teachers and students across Australia in both the public and private sector. These programs focused on social and emotional learning and mental wellbeing. Mental health and wellbeing in education and healthcare is a major concern in many countries and an area of interest to me. Mental health is a state of wellbeing in which every individual realises their potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community (WHO 2011). This work introduced me to 'bullying' as a phenomenon among students in schools, and so began my research journey and postgraduate studies. These have afforded me the opportunity to publish articles, present and keynote at conferences, represent on advisory panels and write books on the topic of bullying in schools over many years.

In recent times, as workplace bullying has emerged as a significant issue in society in general, and across most, if not all industries, my research interest has turned from exploring bullying in schools to workplace bullying. My interest in bullying behaviours in healthcare settings has arisen from my experience over the last eight years working for both a non-for-profit health management college and, more recently, a large higher-education provider within a medicine and health faculty, managing professional education in health. During my time at the health management college, I developed and managed a graduate health management trainee program and had observed over the years how young, emerging health leaders were impacted by unacceptable behaviours in some of the healthcare settings in which they were working. This piqued my interest in exploring workplace bullying in a health context within Australia from a graduate health management trainee's perspective. I was also interested in exploring what I already knew about 'bullying' and to challenge my assumptions and my unconscious biases.

### III Catalyst for the undertaking the study

This study stems from the fact that I have witnessed, and been the recipient of, workplace bullying on a systematic and personal level over years. It is often said that we teach what we know, and even with all of my theoretical knowledge on how to deal with bullying and the skills I have developed over the years to recognise bullying behaviours, I was impacted by the bullying behaviour perpetrated by a few in positions of power. It became clear that there were no support structures in place in the organisation and I had no avenue to raise issues of concern or grievances, as the person with whom I had the grievance was the

same person responsible for dealing with grievances. In the end, like so many people, I felt I had few choices and needed to walk away from a job I loved in order to protect my own mental wellbeing. The powerlessness and hopelessness I felt was the catalyst for me to explore workplace bullying further.

The desire to explore power differentials and develop strategies for how to minimise their impact was of personal interest to me. The complex, multifaceted and ever-dynamic nature of bullying made this study challenging. There are many overlapping, and even contradictory, areas in terms of defining workplace bullying, identifying what behaviours constitute workplace bullying, developing strategies for dealing with workplace bullying and addressing the paucity of relevant literature.

**Figure A:** Study components.

My own reason for undertaking this study was to better understand workplace bullying and to clarify my own assumptions. In addition, I wanted to explore the potential for developing a learning framework to guide the approach to professional development needed to effect organisational culture and change behaviours in healthcare settings. Identifying key concepts and thinking around the issue of workplace bullying were informed by my personal and professional experiences. Figure A highlights my initial ideas about the structure of the study by way of a mind-map; thus, began my exploration of workplace bullying and the research presented in this thesis.

# Chapter 1: Introduction – Researching the Perceptions of Workplace Bullying Behaviours

## 1.1 Introduction

This thesis explores graduate health management trainees' perceptions of workplace bullying in the health sector. Graduate health management trainees (GHMTs) undertake a two-year training program that includes work placements in healthcare settings designed to develop a range of skills, knowledge and capabilities in managing healthcare services. Studies demonstrate that workplace bullying is a significant issue in healthcare, and one that warrants an increased research focus (Allen 2015; Coursey et al 2013; House of Representatives Standing Committee on Education and Employment 2012; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Bryant et al 2009).

There is sparse literature regarding the perceptions of workplace bullying among GHMTs in Australia (Amrein 2012; House of Representatives Standing Committee on Education and Employment 2012), and this study aims to address this gap by specifically exploring this phenomenon. Emerging health managers are working longer hours, are under more pressure to perform and fear losing their jobs through organisational restructures and changes to workforce needs (Liven and Goussinsky 2018; Van den Brande et al 2017; Branch, Ramsay and Barker 2013; Buchanan et al 2013). This has led to an increased prevalence of workplace bullying and stress in their work environments (Royal Australasian College of Surgeons 2019; Branch, Ramsay and Barker 2013; Van Rooyen and McCormack 2013; Glaso and Notelaers 2012; Piotrowski 2012; Balducci et al 2011; Hoobler et al 2010; Balducci et al 2009; Bryant et al 2009).

The literature currently explores the causes of workplace bullying in healthcare, such as lack of management leadership (Fontes et al 2019; Drabek and Merecz 2013; Gaffney et al 2012; Einarsen et al 2011; Agervold 2009; Bartos et al 2008); hierarchical structures (Johnson et al 2015; Glaso and Notelaers 2012; Balducci et al 2011; Caponecchia and Wyatt 2011; Felblinger 2009; Sheehan 2004); lack of workplace support (Allen 2015; Cleary, Walter, Horsfall and Jackson 2013; Chang and Lyons 2012; Balducci et al 2011; Agervold 2009; Bartos et al 2008); informal power (MacCurtain et al 2018; Shallcross et al 2013;

Hutchinson et al 2010; Agervold 2009; Balducci et al 2009; Westues 2004); and the social environment (Johnson 2015; Franklin and Chadwick 2013; Jenkins 2013; NSW Health 2013; Anderson 2011; Einarsen et al 2009; Chiaburu and Harrison 2008). However, this literature does not investigate how health management trainees perceive, experience and conceptualise workplace bullying, particularly in an Australian context. Given their role as future leaders in this sector, where they will influence organisational culture and staff experiences – including workplace bullying – this is a significant gap.

## 1.2 Defining workplace bullying

This section presents a discussion and background on the broad definitions of workplace bullying, both in Australia and internationally. It also highlights common behaviours included under workplace bullying, provides an understanding of the various interpretations and perceptions of workplace bullying and discusses the deficiencies of some of these definitions.

A universal, commonly agreed-upon definition of workplace bullying does not exist in Australia, although there is consensus on the most accepted inclusions in the definition. The fact that workplace bullying is difficult to define is of interest when exploring GHMTs' perceptions, experiences and conceptualisations of workplace bullying. The definition of bullying is wide and relies on individual perception (Kumar 2012). Typically, bullying at work is regarded as repeated unreasonable behaviour, where the behaviours cause, or have the potential to cause, harm (Boyle and Wallis 2016; Branch and Murray 2015; Caponecchia and Wyatt 2009; Workcover NSW 2008; Einarsen et al 2003; Worksafe Victoria 2003) and usually takes place between members of the same organisation. There are various definitions of workplace bullying, although it is generally agreed that it is behaviour which is repeated and persistent and can take the form of verbal abuse, conduct which is threatening, intimidating and/or humiliating, sabotage that interferes with work, or a combination of these (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012).

### 1.2.1 Workplace bullying in healthcare settings

Healthcare settings are particularly susceptible to workplace bullying (Westbrook 2018; NSW Public Service Commission 2014; NSW Health 2008), which has significant

consequences for staff and patients. Workers in healthcare settings who are experiencing bullying report higher levels of work-related stress (Royal Australasian College of Surgeons 2019; Westbrook 2018; Van den Brande et al 2017; Drabek and Merecz 2013; Kumar 2012; Johnson 2011; Cleary et al 2009; Review Equal Opportunities 2004; Turney 2003), depression and anxiety (Royal Australasian College of Surgeons 2019; Westbrook 2018; Branch, Ramsay and Barker 2013; Van Rooyen and McCormack 2013; Glaso and Notelaers 2012; Kumar 2012; Piotrowski 2012; Balducci et al 2011; Hoobler et al 2010; Balducci et al 2009; Bryant et al 2009) and lower levels of job satisfaction (Livne and Goussinsky 2018; Westbrook 2018; Becher and Visovsky 2012; Kumar 2012; Bellot 2011; Hoobler et al 2010).

### 1.2.2 Workplace bullying versus conflict

The difference between normal conflict in the workplace and bullying behaviours is a matter of the frequency of incidents, power imbalance and the length of time the behaviour has been enacted (Johnson et al 2015; Caponecchia and Wyatt 2011; Einarsen et al 2011). Conflict is a disagreement between two or more employees who perceive they have different goals or opinions about a range of issues, including work practices (Branch, Ramsay and Barker 2013; Einarsen et al 2011; Einarsen et al 2009). Conflict can occur naturally as we interact with each other; not agreeing with other colleagues is a normal part of work life and usually arises in the moment as people with the same relative amount of power view the same situation from different perspectives (Caponecchia and Wyatt 2011; Einarsen et al 2011). In these instances, the level of emotion each person feels will be relatively equal and both parties can feel angry and frustrated. At times emotions can escalate, and people might say something they later regret (MacCurtain et al 2018; Branch, Ramsay and Barker 2013; Agervold 2009; Einarsen et al 2009). Although this does not constitute workplace bullying, when people are in conflict and emotions are heightened, they may perceive themselves as being on the receiving end of workplace bullying (Jenkins 2013; Einarsen et al 2009). Most people involved in conflict are working towards a resolution (Hutchinson 2009).

### 1.2.3 Definitions of workplace bullying

Workplace bullying is also defined as any behaviour that is repeated, systematic and directed towards an employee or group of employees that a reasonable person, having regard to the circumstances, would see as unreasonable, including behaviour that is victimising, humiliating, undermining or threatening and that creates a risk to health and

safety (Royal Australasian College of Surgeons 2019; Boyle and Wallis 2016; Safe Work Australia 2016; Branch, Ramsay and Barker 2013; Jenkins 2013; Safe Work Australia 2013; Caponecchia and Wyatt 2011; Einarsen et al 2011; Branch 2008; Knox Haly 2008; Workcover NSW 2008).

'Repeated' refers to the persistent or ongoing nature of the behaviour and can include a range of different types of behaviour over time (Jenkins 2013; Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009). 'Systematic' refers to having, showing or involving a method or plan (Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009). Whether behaviour is systematic or not will depend on an analysis of the circumstances of each individual case with the general guideline in mind (Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009). 'Risk to health and safety' includes the risk to the emotional, financial, mental or physical health of the person(s) in the workplace (Royal Australasian College of Surgeons 2019; Royal College of Nursing 2018; Workcover NSW 2008).

Workplace bullying can be obvious and aggressive or subtle and more difficult to identify (Branch, Ramsay and Barker 2013; Kumar 2012; Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009). Examples could include abusive, insulting or offensive language (Branch, Ramsay and Barker 2013; Kumar 2012; Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009); behaviour or language which frightens, humiliates, belittles or degrades, including criticism which is delivered with yelling and screaming (Safe Work Australia 2016; Adams et al 2013; Branch, Ramsay and Barker 2013; Safe Work Australia 2013; Kumar 2012; Caponecchia and Wyatt 2011; Einarsen et al 2011; Cleary et al 2009; Einarsen et al 2009); teasing or regularly making someone the brunt of practical jokes (Safe Work Australia 2016; Safe Work Australia 2013; Knox Haly 2008); displaying material which is degrading or offending (Van Rooyen and McCormack 2013; House of Representatives Standing Committee on Education and Employment 2012; Cleary et al 2009; Hauge et al 2009); and spreading gossip, rumours and innuendo of a malicious nature (Branch, Ramsay and Barker 2013; Kumar 2012; Caponecchia and Wyatt 2011; Einarsen et al 2011; Einarsen et al 2009).

Workplace bullying involves an imbalance of power between individuals, situations or societal perceptions due to position or length of time within an organisation (Johnson 2015; Branch, Ramsay and Barker 2013; Kumar 2012; Caponecchia and Wyatt 2011;

Einarsen et al 2011; Einarsen et al 2009; Branch 2008). An imbalance of power can also occur between peers (Branch, Ramsay and Barker 2013; Einarsen et al 2011; Einarsen et al 2009). In some cases, employees acting as a group can garner sufficient power to engage in workplace bullying towards a manager (Branch, Ramsay and Barker 2013; Shallcross et al 2013; Einarsen et al 2011; Sheehan and Griffiths 2011; Bryant et al 2009; Sheehan 2004). This is referred to as mobbing (Shallcross et al 2013; Sheehan and Griffiths 2011; Sheehan 2004; Westues 2004) and the concept of upward bullying has emerged in recent years (Franklin and Chadwick 2013; Sheehan and Griffiths 2011; Agervold 2009; Bartos et al 2008).

## 1.3 Origin and purpose of the study

During the past decade there has been increased attention on bullying behaviours in workplaces (Livne and Goussinsky 2018; Allen 2015; Lahelma et al 2012; Kelly 2011; Einarsen 2000). There is evidence of negative consequences associated with workplace bullying for both the individual and the organisation, which has led a growing number of researchers to study this phenomenon (Allen 2015; Johnson 2011; Lovell and Lee 2011; Cleary et al 2009; Turney 2003). However, it is difficult to clearly determine how, and how often, workplace bullying occurs in the context of healthcare. Research to date has varied in design, definition of what constitutes workplace bullying, and the methods used to collect data and measure workplace bullying incidences and prevalence (Boyle and Wallis 2016; Allen 2015; Johnson 2015; Caponecchia and Wyatt 2012). Nonetheless, studies demonstrate workplace bullying is a significant issue (Fontes et al 2019; Westbrook 2018; Caponecchia and Wyatt 2012; House of Representatives Standing Committee on Education and Employment 2012) that needs to be addressed to develop enhanced understandings of the concept, its effects and implications in, and for, the workplace.

Increasing demands on time, resources and energy, in addition to incidents of workplace bullying, have resulted in health managers experiencing burnout at higher rates and a subsequent increase in staff turnover (Perlo et al 2017; Van den Brande et al 2017; Drabek and Merecz 2013; Einarsen 2011; Law et al 2011). The Institute for Healthcare Improvement (IHI) in the USA has developed a framework for improving joy in work which highlights recent literature on theory and evidence about factors, such as management behaviours, system designs, communication patterns, operating values and technical supports, that seem associated with better or worse morale, burnout, and satisfaction in

work. The white paper published in 2017 states: 'senior leaders are accountable for developing a culture that encourages and fosters trust, improvement, and joy in work. They ensure that improving joy in work is a responsibility at all levels of the organisation, beginning with healthy, effective teams and systems' (Perlo et al 2017, p.20). Work environments where there is a culture of a lack of trust and where staff experience limited enjoyment in their work may lead to an increased prevalence of workplace bullying.

### 1.3.1 Impacts of workplace bullying

Described as a form of psychological violence, workplace bullying can result in significant damage to an individual's health and wellbeing, and, in extreme cases, can lead to suicide (ABC News 2019; Westbrook 2018; Franklin and Chadwick 2013; House of Representatives Standing Committee on Education and Employment 2012; Kelly 2011). Such behaviour can also undercut the productivity of an entire organisation, which incurs financial costs to employers and the national economy (Royal Australasian College of Surgeons 2019; Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012) and society as a whole. Research has indicated the targets of workplace bullying are significantly more likely to experience decreased job satisfaction, lower self-esteem, depression and post-traumatic stress disorder, and witnesses of such behaviours may suffer similar effects (Perlo et al 2017; Van den Brande et al 2017; Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012). Employers are also impacted by negative consequences of workplace bullying, including high turnover and absenteeism of staff, lower productivity, poor staff morale and even increased financial costs due to legal claims, worker's compensation and managers' time (Royal Australasian College of Surgeons 2019; Perlo et al 2017; Drabek and Merecz 2013; Einarsen 2011; Law et al 2011).

### 1.3.2 Workplace bullying and health management

Workplace bullying is also a form of harassment, which is recognised as a management issue for employers (Safe Work Australia 2016; NSW Public Service Commission 2014). Workplace bullying is fundamentally a health and safety issue, with trade unions in Australia now agreeing it is an important factor that needs to be addressed (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of

Representatives Standing Committee on Education and Employment 2012). Most knowledge of bullying behaviours is based on the school context, as research into the prevalence, impacts and prevention of school-based bullying is well regarded and extensive (Rigby 2010; Cross et al 2009). However, workplace bullying is receiving increased attention internationally as it is not a rare or isolated phenomenon. International workplace bullying prevalence rates indicate a range from 4.1% in Sweden (Rahm et al 2019) to 15% in the United Kingdom (Kelly 2011) to 21.5% in the United States (Lahelma et al 2012).

The development and enhancement of a safe and supportive work environment is a broad concept and its effective implementation will involve a range of integrated and collaborative strategies (MacCurtain et al 2018; Balducci et al 2011; Bellot 2011; Cleary 2009). A whole-of-organisation approach ensures employees are supported by their organisations' workplace policies and grievance and mediation procedures (Cowan 2012; Einarsen 2011; Johnson 2011; Bryant et al 2009; Knox Haly 2008). Organisational – and, more importantly, leadership – practices can sustain and strengthen management practices (Johnson et al 2015; Branch, Ramsay and Barker 2013; Einarsen et al 2011; Bryant et al 2009) and the level of supervision and enhance prevention strategies (Cleary, Walter, Horsfall and Jackson 2013; Bartos et al 2008).

### 1.3.3 Workplace bullying in Australia

Knowledge about workplace bullying in Australia is limited, and national definitions, policies and frameworks are yet to be developed. It is suggested that the incidence of bullying in Australian workplaces is increasing and is not exclusive to one jurisdiction, one industry or one type of worker (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012). According to research, one in five people are bullied at work and in some industries, such as health, welfare and education, the figure is even higher, ranging from 25% to 50% (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012). Further, there is no literature examining the perceptions of GHMTs regarding workplace bullying, which highlights the significance of the current study. Addressing and researching this gap in the literature is important, as health management trainees have a future role in influencing systemic change, policies,

education and practice. As their careers advance, management trainees will also be key decision-makers and be expected to promote a positive and cooperative workplace culture. The literature on workplace bullying emphasises an imbalance of power and positional power (Sheehan and Griffiths 2011; Agervold 2009; Bartos et al 2008). Management trainees are usually younger, at the lowest level of the organisational hierarchy and new to an organisation, and this may impact on how they experience and respond to workplace bullying.

## 1.4 Brief historical perspective of workplace bullying legislation

In this section, a brief overview of the historical perspective of workplace bullying is provided to give context to how challenging and complex it is to ensure consistency across jurisdictions in implementing policy to address workplace bullying. Australian occupational health and safety (OHS) has been regulated by the States and Territories since the 1970s in the form of Acts and Regulations as a result of the Robens Report (British Journal of Industrial Medicine 1973) in the United Kingdom. Over time there have been a range of Acts and Regulations outlining key duties for both employers and employees. Workplace bullying was viewed as an occupational health and safety issue and employers were responsible for providing safe working environments and eliminating risks to employees' health. Employers had a statutory duty of care to protect their employees' health, safety and welfare. Employees also have a corresponding duty to take reasonable care for their own health, safety and welfare and for that of others (Safe Work Australia 2016; Safe Work Australia 2013).

### 1.4.1 Legislation in Australia

Comprehensive legislation in Australia specifically dealing with workplace bullying has never existed (Branch, Ramsay and Barker 2013; Coursey et al 2013; Chiaburu and Harrison 2008). As a result, many employers and employees fail to understand their rights and obligations when dealing with workplace bullying or responding to complaints (Cowan 2012; Law et al 2011; Sheehan and Griffiths 2011; Bryant et al 2009; Cleary et al 2009). The lack of jurisdiction for workplace bullying has led to employees bringing claims through a range of legal avenues, such as anti-discrimination law, criminal law, trade practices law, common law (i.e. breach of contract) and industrial law (i.e. unfair

dismissal) (Cowan 2012; Law et al 2011; Sheehan and Griffiths 2011; Bryant et al 2009; Cleary et al 2009).

The *Crimes Amendment (Bullying) Act* was passed in Victoria, Australia, in 2011 and covers all forms of workplace bullying, including abusive language and threats. This was the first law of its kind in Australia and made workplace bullying in Victoria a crime, carrying a penalty of up to 10 years in gaol (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012).

An emerging trend of viewing workplace bullying as a work health and safety (WHS) issue has a number of deficiencies in addressing the legislation (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012). WHS legislation is a wrong against the state rather than an individual and individuals are not able to initiate prosecutions. In 2011–12 there were 12,000 workplace bullying-related inquiries made to regulators in Victoria and New South Wales (NSW), yet only a few have been prosecuted. Individuals are able to make a worker's compensation claim in relation to injuries sustained at work as a direct result of bullying, although this action does not prevent the bullying from taking place (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012).

A national review into workplace bullying was announced in 2012 by the then-Prime Minister Julia Gillard, and a parliamentary inquiry was conducted by the House of Representatives Standing Committee on Education and Employment. The report of this inquiry, *Workplace Bullying: We Just Want It To Stop*, tabled later that year, considered more than 300 submissions from a variety of stakeholders. A total of 23 recommendations to address workplace bullying were outlined in this report (House of Representatives Standing Committee on Education and Employment 2012) with the Commonwealth government proposing an amendment to the *Fair Work Act 2009* (Cth) through the Fair Work Amendment Bill 2013. The proposed reforms included allowing employees who suffer from workplace bullying the right to make application to the Fair Work Commission (FWC) to deal with their dispute (House of Representatives Standing Committee on Education and Employment 2012). Other proposed reforms included promoting a national definition

of workplace bullying; developing national training standards to improve responses to workplace bullying complaints; developing a national advisory service for employers and employees; and that Safe Work Australia implement a Code of Practice for managing the risks of workplace bullying (Safe Work Australia 2016; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012).

The Commonwealth government supported 19 of the 23 recommendations and, under the reform, workplace bullying is defined in the *Fair Work Act* as 'repeated, unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety' (Safe Work Australia 2013). The legislation also recognises that workplace bullying does not include performance management conducted in a reasonable manner. In Australia, new national laws regarding workplace bullying came into effect in January 2014.

## 1.5 Theoretical underpinnings

This section outlines the educational theoretical underpinnings in this study. This thesis draws on key educational and learning theories as a base for exploring the perceptions of workplace bullying and as a means to explain how these behaviours are learned and perpetuated. Positioning learning theories is important in the context of this study as evidence suggests that, at its core, bullying is a learned behaviour used in response to stress (Westbrook 2018; Franklin and Chadwick 2013; Einarsen et al 2011; Finne et al 2011; Rigby 2010; Cross et al 2009; Hauge et al 2009) and that people learn behaviours through observations as outlined by Kolb (2009). There is also evidence to suggest that these behaviours can be unlearned and replaced with positive and acceptable behaviours (Westbrook 2018; Franklin and Chadwick 2013; Einarsen et al 2011; Finne et al 2011; Rigby 2010; Cross et al 2009; Hauge et al 2009). This is important in this study because organisations need to ensure they are providing the necessary training and adequate support for managers in regard to dealing with workplace bullying. In this study, a provisional anti-bullying learning framework was developed to provide guidance in developing training programs and build capacity in an organisation to address workplace bullying.

### 1.5.1 Experiential learning model

Knowledge is a dynamic, evolving phenomenon. Kolb's (2009) work outlined the assumption that knowledge is established as a result of our experiences. As Von

Glasersfeld states, 'we do not know the world until we experience it' (cited in Mousley 2002, p. 4). Figure 1.1 below outlines Kolb's experiential learning model. This study draws on the model of experiential learning to understand how perceptions of workplace bullying correlate to an individual's experience of the behaviour and, therefore, could have implications for how GHMTs respond to workplace bullying.

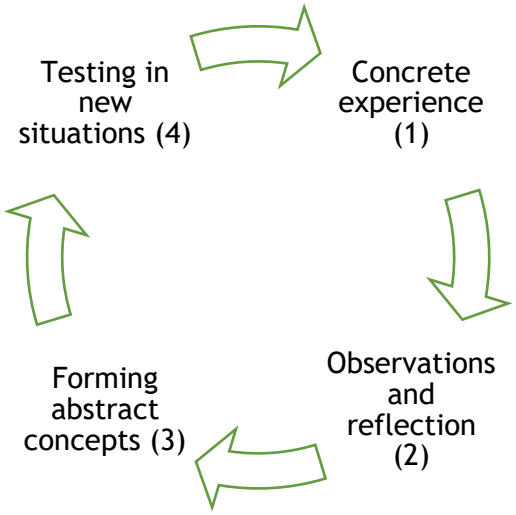


**Figure 1.1:** Experiential learning model (adapted from Kolb 2009).

The work of Billett (2004; 2001) is also significant to this study as it applies to workplace learning and the basis for the development of the provisional anti-bullying learning framework. Billett states that 'what directs individuals to engage in the demanding tasks of learning new knowledge and refining what they already know is premised on their interest and agency' (Billett 2004, p. 4). That is, knowledge and understandings are developed through discussions among people with similar experiences. Workplace learning is an important theory in relation to this study given that workplace bullying is a learned behaviour and, at the very least, is allowed to flourish in healthcare settings. A culture within healthcare settings can also be created wherein workplace bullying is accepted due to the powerlessness and isolation felt by staff (Salmivalli and Voeten 2004).

This thesis also examines practices and ways of working in healthcare settings that may lead to workplace bullying. Vygotsky (1980) views knowledge as something that develops between people and their activity. His premise is that knowledge develops through social groups as they interact using pre-existing cultural tools (i.e. language, symbols or objects). Common understandings, concepts, patterns of interaction and tools are shared.

The work of Lave and Wegner (1991) suggests that situated cognition is a theory of social practice and participation is a critical element. They highlight the notion of communities of practice, whereby groups have their own way of thinking and working. Brown, Collins and Duguid (1989) emphasise that people who actively apply knowledge to different contexts are able to build increasing understandings about the world they live in.

### 1.5.2 Social contexts theory

There is evidence that positions bullying behaviours in terms of relationships occurring in social contexts (Franklin and Chadwick 2013; Askew et al 2012; Cowan 2012; Rigby 2010; Bryant et al 2009; Cross et al 2009) and the development of emotional competence is seen as a key skill for dealing with workplace bullying. Emotional competence is the extent to which one is aware of, and able to act on, one's own and others' emotions, as well as the ability to regulate emotional experience within oneself (intrapersonal) and to be effective in interactions with others (interpersonal) (Humphrey et al 2010). Knowledge is about an awareness of self, our world and our interactions, and the theory of enactivism looks at knowledge more holistically, positing that we are part of a social context – that what we know, what we do and who we are cannot be separated (Maturana and Varela 1980). Enactivism theory describes knowledge as action, created by shared meanings and understandings.

Social relationships also act as buffers from stress and challenging situations, increasing a sense of belonging, purpose and self-worth. Activity theory suggests learning is a social activity and that if people are engaged and are socially active, then learning will take place. Vygotsky (1980) outlines the zone of proximal development to make the distinction between actual and potential cognitive development. If the zone of proximal development is unattainable, learning will not take place. Other barriers to learning are evident if language is unfamiliar, learning tools are incomprehensible, interaction is exclusive or people are not part of a social group (Jane 2002; Lave and Wegner 1991). People take on the meanings of the environments they interact with and, hence, are enculturated (Jane 2002; Lave and Wegner 1991). The development of quality learning environments that build a range of skills for GHMTs is a key factor. Skills focusing on being responsible; critical and reflective thinking; listening to others; solving problems in creative ways; communicating clearly; participating in discussions; arguing thoughtfully; and working

collaboratively towards a common goal (Cohen 2006) are the foundation for engaging emerging managers.

### 1.5.3 Situated cognition theory

Expanding on this theory is situated cognition theory. Lave and Wegner (1991) discuss the notion of legitimate peripheral participation whereby people who participate on the periphery in groups also learn. From this context individuals develop greater confidence and understanding and are more likely, over time, to participate at greater levels and adopt differing roles. This is relevant to GHMTs, who are participating in a highly structured learning program and who are also working across many different units and work streams over the two years.

Learning is part of the social practices in our workplace environments and occurs due to our participation. This shapes our behaviour and patterns of interaction while enabling individuals to contribute, in turn, to their social contexts. Enactivist theory describes the interconnectedness of knowledge, identity, self, others, and environment in learning (Jane 2002). Learning is the transformation of knowledge, the continual change that allows individuals to function in the world. Staff who witness workplace bullying can often feel anger, guilt, fear, powerlessness, and sadness towards the person being bullied (Batsche and Porter 2006); at times, they can also experience the same negative feelings as those being bullied. It is in within these learning contexts this study on researching GHMTs' perceptions and experiences of workplace bullying is positioned.

## 1.6 Research questions

This section articulates this thesis's six key research questions. The research questions serve two purposes: (1) to determine what type of research will be conducted; and (2) to identify the specific objectives the study will address. The main aim of this research is to explore the broad question of GHMTs' perceptions and experiences of workplace bullying. A total of six research questions are posed to address the overall aim. After an extensive review of the literature, and identification of gaps (Chapter 2), the following research questions were developed.

RQ1: How do graduate health management trainees define workplace bullying behaviours?

RQ2a: What types of behaviours do graduate health management trainees consider to be workplace bullying?

RQ2b: What types of bullying behaviours have graduate health management trainees observed in their role as a health manager?

RQ3: What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?

RQ4: How do health managers support staff to encourage reporting of workplace bullying?

RQ5: What approaches (if any) does their organisation have in place for dealing with workplace bullying?

RQ6: What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers?

## 1.7 Significance of the study

This section outlines the wider implications for this study and how it contributes to the international body of evidence regarding workplace bullying. This section justifies the importance of examining workplace bullying in a health context from GHMTs' perspectives and the implications for management and leadership practices and patient care and safety. This study, based on Australian data, is significant for four key reasons. Firstly, survey results across Australian healthcare settings indicate the level of incident reporting of workplace bullying continues to remain static. Secondly, unprecedented responses to alleged workplace bullying have seen the revocation of accreditation of three teaching hospitals in NSW in a six-month period during 2018–2019. Thirdly, the number of reported suicides among health professionals between 2001 and 2012 was over 369 (more recent figures are difficult to verify). Finally, the cost of Australian workers' compensation claims regarding incidents of workplace bullying is estimated to be over $9 million per annum. Understanding how GHMTs experience and conceptualise workplace bullying is a key component in developing interventions that will target workplace bullying and support health management trainees in developing effective strategies to deal with, respond to and prevent workplace bullying. Developing effective strategies to deal with workplace

bullying will have an impact on the level of reporting in healthcare organisations and will also impact on the culture of the organisation.

### 1.7.1 Impact on staff wellbeing

The NSW Public Service Commission's 'People Matter' employee survey (2018) found that more than 13,700 health workers (18% of survey respondents) reported being bullied in the previous 12 months. This compares with 20% of public sector employees in Victoria (Victorian Auditor-General 2016) and is consistent with the NSW 2016 score and the figure of 11% reported for the UK Civil Service in 2017 (UK Cabinet Office 2017). Respondents in the 'People Matter' survey who reported being bullied were less positive about the employee experience than others and were negative about teamwork; manager relationships; and reporting and sharing a different view to colleagues (NSW Public Service Commission 2018; Victorian Auditor-General 2016). This aligns with the survey's finding that people are most commonly bullied by a fellow worker at their level (27%) or by their line manager (23%) (NSW Public Service Commission 2018; Victorian Auditor-General 2016).

A survey of Australian Junior Medical Officers (JMOs) in 2018 found that a toxic culture of bullying and harassment among public healthcare workers is threatening the welfare of patients (NSW Health 2018) with less than half the respondents (43%) agreeing their hospital had a culture that effectively dealt with workplace bullying. A recent report from the Australian Commission on Safety and Quality in Healthcare (2019, p. 73) states: 'developing a culture of safety is an essential task for health service organisations as they strive to eliminate the factors that contribute to medical errors, patient harm, and unsafe conditions'. In an unprecedented response to allegations made against senior medical staff at Westmead Hospital in Sydney, Australia, the College of Intensive Care Medicine (CICM) revoked the hospital's training accreditation in November 2018 due to its inability to provide a safe teaching environment for trainee doctors (NSW Health 2018). In June 2019, the CICM revoked the accreditation of St George's Hospital in Sydney due to multiple workplace bullying claims from trainee and junior doctors. The CICM also withdrew two trainee doctors from Tamworth Hospital, NSW, in June 2019 over concerns for their welfare. The CICM president, Dr Raymond Raper, was quoted in media articles as saying, 'there may well be something about intensive care that makes it particularly problematic' (Sydney Morning Herald 20 June 2019).

In September 2019, an investigative report into a death of a patient at the remote Broken Hill Hospital, NSW, highlighted what senior medical staff viewed as mismanagement and poor structures and organisation that led to patient safety issues (Four Corners 9 September 2019) and the subsequent resignation of the chief executive.

An audit report in 2016 by the Australian Medical Association (AMA) investigating safe working hours found that one in two doctors (53%) are working rosters that place them at significant risk of fatigue, to the extent that it could impact on performance and affect the health of the doctor and the safety of the patient (AMA 2016). The report also noted that this statistic had not changed since 2011. Professor Ian Hickie, Co-Director, Brain and Mind Centre, has stated that doctors and nurses would desert the public system for the private sector unless the culture of blame was stamped out. 'This not only affects the people providing care, but the patients are affected as well' (Aubusson 2018, p. 1). AMA NSW president Dr Kean-Seng Lim said that 'when health providers are bullied or intimidated it is going to affect their capacity to provide quality care for patients' (AMA Media Release 6 November 2018). A report from the Australian Health Practitioner Regulation Agency (AHPRA) on the results from a national survey conducted by the Medical Board of Australia (MBA), released in February 2020, indicated that one in three trainee doctors in Australia have experienced or witnessed workplace bullying in the past 12 months. The same survey found that only half of the reported incidents of workplace bullying reported by trainee doctors were followed up by their healthcare organisation.

### 1.7.2 Increase in suicide rates

An article published by Swannell (2019) highlights that there were 369 suicides by health professionals in Australia between 2001 and 2012, although more recent figures are difficult to determine. Swannell (2019) has also called for widespread systemic change as the increased suicide risk in the medical profession – particularly among doctors, junior doctors and medical students – is linked to the rate of burnout. An anonymous doctor was quoted saying: 'I think there are still a lot of systemic issues going on inside teaching hospitals in Australia that are impacting upon junior doctors and their mental wellbeing.' Beyond Blue (2013), an Australian organisation working to address issues associated with depression and other related mental health disorders, argues increasing job insecurity and competitive pressures are adding to existing levels of stress, burnout and mental health issues among junior doctors. Increased reporting of these issues by junior doctors, in the

context of more widespread acknowledgment that sexual harassment, gender discrimination and workplace bullying are unacceptable (Choo et al 2019), has also added to stress levels. Many medical colleges and hospital employers are attempting to address these issues, although there is little research about the effectiveness of their interventions (Petrie et al 2018; Westbrook 2018) and the conditions that led to this stress have not changed.

### 1.7.3 Patient safety

Evidence from the UK National Health Service (NHS) suggests that 85% of nurses have witnessed or been the target of workplace bullying (Lewis 2006), and a survey conducted in 2018 found that 25% of staff had experienced harassment, bullying or abuse from colleagues or managers (Donnelley 2019), with suggestions that a target-driven culture has created a dysfunctional and hierarchical environment that encourages unacceptable behaviour. Almost 30% of NHS staff said they had been bullied by patients or their families in the past year, with 25% reporting abuse by other workers (Merrick 2018) and 12% of calls on a daily basis to the UK National Workplace Bullying Advice Line are from healthcare professionals (Kumar 2012). In 2019, the NHS released an oversight framework that included four metrics as a result of staff surveys examining workplace bullying and harassment, teamwork and inclusivity. The oversight framework document indicates a 'strong link between compassionate and inclusive leadership cultures and good organisational performance, including on finances, patient experience and staff engagement' (Lintern 2019, p. 1).

### 1.7.4 Cost of workplace bullying to organisations and individuals

Workplace bullying has a 'cost' to organisations in terms of financial outlay, productivity and morale, as well as a 'cost' to individuals in regard to their health and wellbeing. A submission from the Royal Australasian College of Surgeons to a state government inquiry into workplace fatigue and bullying in South Australian hospitals stated that reported incidents of workplace bullying had been increasing (Dillon 2019; Royal Australasian College of Surgeons 2019), with workers' compensation claims equating to 10,943 days lost from work or a cost of just over $9 million per annum. An unnamed nurse who contributed to the submission was quoted as saying 'the emotions triggered by the ongoing bullying compounded the physical fatigue already being experienced hugely' (Dillon 2019, p. 1). In November 2019, a senior doctor and member of the leadership council of the NSW

medical union was widely criticised for his comments regarding women in the healthcare sector after suggesting the workforce is increasingly vulnerable because of the increasing number of women in healthcare.

The purpose of this doctoral study is to develop a comprehensive understanding of GHMTs' perceptions and experiences of workplace bullying. Evidence demonstrates that workplace bullying in healthcare settings has a negative impact on people and the organisation (Dillon 2019; Royal Australasian College of Surgeons 2019; Johnson et al 2015; Parand et al 2014; Marden et al 2010). This negative impact is also associated with harm to patients, staff and the wider community (Royal Australasian College of Surgeons 2019; Perlo et al 2017; Van den Brande et al 2017; AMA 2016; Drabek and Merecz 2013; Einarsen 2011; Law et al 2011; Lovell and Lee 2011). There is ample literature in describing workplace bullying among nurses (Oh et al 2016; Lowenstein 2013; Becher and Visovsky 2012; Gaffney et al 2012; Cleary, Hunt and Horsefall 2010; Hutchinson et al 2009; Bartholomew 2006; Lewis 2006) and doctors (NSW Public Service Commission 2018; Petrie et al 2018; Victorian Auditor-General 2016; Broome and Williams-Evans 2010; Laschinger et al 2003), including junior, middle and senior managers (Choo et al 2019; Donnelley 2019; Magee et al 2014; Khademi et al 2012); however, we know relatively little about workplace bullying from GHMTs' perspective. Management trainees are often vulnerable to workplace bullying due to their lower position in the hierarchy of an organisation. Exploring management trainees' perceptions and experiences of workplace bullying is of significance because until we do so there is limited opportunity to influence the culture of healthcare organisations. In future, GHMTs will need to manage incidents of workplace bullying for themselves and their staff to ensure there is a decrease in the harm associated with workplace bullying to patients, staff and the wider community.

In order to address workplace bullying in a health context, we need to understand and answer the key research questions posed for this study. Understanding GHMTs' perceptions and experiences of workplace bullying will inform policy and practices in the future and provide a framework for effective leadership in healthcare settings. This knowledge will likely impact on the culture of safety and patient care, increase retention of staff, improve staff wellbeing, and decrease the harm to individuals experiencing workplace bullying in healthcare organisations.

The health sector in Australia is under pressure to adapt and change, with increasingly limited resources, the introduction of Activity Based Funding (ABF), performance targets for senior managers and executives and the recognition that traditional roles and systems are no longer appropriate (Van den Brande et al 2017; Branch, Ramsay and Barker 2013). There is also an increased emphasis on knowledge, greater reliance on new technologies, more use of just-in-time production and management and more frequent organisational change and restructures (Livne and Goussinsky 2018; Adams et al 2013; Piotrowski 2012; Spence Laschinger 2012; Dollard et al 2007). The Special Commission of Inquiry: Acute Care Services in New South Wales Public Hospitals Report (Garling 2008) made a range of recommendations for NSW public hospitals, including in relation to workplace bullying and clearly identifying acceptable behaviours in the workplace. Recommendation 43 states that NSW Health should 'implement a comprehensive training program for all staff and managers in … principles, to be completed within three years' (Garling 2008, p. 421). The Garling report also states that 'improving the working environment for NSW Health staff will contribute to better patient care and improved staff morale' (Garling 2008, p. 413). The implications of this comprehensive report led to rapid and widespread reform throughout the sector and, in turn, brought about additional stresses for employees and managers. Such rapid change has also led to confusion and ambiguity about roles and responsibilities and in turn may create the environment and opportunities for the abuse of power through workplace bullying (Van den Brande et al 2017; Spence Laschninger 2012; Balducci et al 2011; Einarsen et al 2011; Agervold 2009; Rutherford 2004).

### 1.7.5 Work health and safety

Workplaces provide dignity and a sense of identity and sense of self-worth (Bothma et al 2015; Lucas 2015; Lee 2008; Hodson 2001). Workplace bullying has an impact on individual and social conceptions of self (Australian HR Institute 2019; Bothma et al 2015). It is a dynamic and complex phenomenon; its causes are often multifaceted and affect every aspect of an individual's health and wellbeing (Westbrook 2018; Drabek and Merecz 2013; Becher and Visovsky 2012; Bellot 2011; Johnson 2011; Hoobler et al 2010; Cleary et al 2009; Review Equal Opportunities 2004; Turney 2003). Workplaces have a legal responsibility to address the issue of bullying (Safe Work Australia 2016; Victorian Auditor-General 2016; Safe Work Australia 2013). Despite the potential legal ramifications and penalties which may be imposed, however, many employers are largely unaware of their

legal responsibilities in relation to workplace bullying (Safe Work Australia 2016; Victorian Auditor-General 2016; Safe Work Australia 2013).

Workplace bullying is a form of harassment that is becoming recognised as a management issue for employers (Safe Work Australia 2016; Victorian Auditor-General 2016; Safe Work Australia 2013). Trade unions are now agreeing that workplace bullying is an important factor which needs to be addressed. An increasing number of Australians are being bullied at work (House of Representatives Standing Committee on Education and Employment 2012; Australian Workplace Barometer 2011; Productivity Commission 2010) and it is a significant issue which has gained a high degree of recognition in academic and other literature. Its potential damage and cost are undisputed (Safe Work Australia 2016; Victorian Auditor-General 2016; Safe Work Australia 2013; Productivity Commission 2010). Studies identified in the literature review for this study demonstrate workplace bullying is an emerging issue which needs to be addressed (Westbrook 2018; De Cieri et al 2015; Branch, Ramsay and Barker 2013; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Bryant et al 2009). Bullying is most often seen as occurring in a social context. The organisational culture, the actions and interactions of employers and employees, and even the characteristics of the physical environment have some influence (Viejo 2016; Johnson et al 2015; Sikka et al 2015; Buchanan et al 2013; Pfeffer 2005).

Recent advances in technologies and social engagement in the online world are extending into the workplace (Safe Work Australia 2016; Safe Work Australia 2013; Van Rooyen and McCormack 2013; House of Representatives Standing Committee on Education and Employment 2012; Cleary et al 2009; Hauge et al 2009; Knox Haly 2008). Workplace bullying is increasingly occurring through online technologies, which requires employers to respond appropriately and develop appropriate policies and procedures (Westbrook 2018; Shallcross et al 2013; Sheehan and Griffiths 2011).

### 1.7.6 Effective practices for addressing workplace bullying in healthcare

In this study a provisional anti-bullying learning framework was developed as a result of the qualitative data collected via focus groups and interviews conducted with GHMTs. This provisional anti-bullying learning framework emerged from an exploration of existing frameworks. John Hopkins Hospital in the USA recently developed a Continuum of Disruptive Behaviours at Work (2018) to standardise and assist hospital staff in discussing, identifying and responding to concerning behaviours. The continuum includes nine

categories of concerning behaviours and describes how these behaviours can impact on staff and patient safety. The NHS (2019) has developed an oversight framework to provide standard and transparent methodologies for monitoring, escalation and formal and informal action within organisations for incidents of workplace bullying. In addition, the NHS framework focuses on leadership and culture at an organisational and systemic level.

The first step in dealing with the complex issue of workplace bullying is to acknowledge that it occurs by raising awareness (Franklin and Chadwick 2013; Kumar 2012). The provisional anti-bullying learning framework developed for this study provides five guiding principles and effective practices which could support the development of a training program. An expert reference group was established to review the provisional framework incorporating these principles and practices. They were asked to respond to a series of questions via an online survey as part of their review and feedback to determine the efficacy of the provisional framework in relation to the outlined guiding principles and effective practices for healthcare settings. This strengthened the reliability and validity of the current study, contributing to existing knowledge and providing for recommendations for future research studies. The provisional framework included key features to: prevent or reduce workplace bullying; develop universal, whole-of-organisation multifaceted approach; increase awareness of workplace bullying; develop whole-of-organisation detailed policy addressing workplace bullying; promote positive organisational culture; and support skill development – professional development which addresses workplace bullying (Dutton et al 2013; Franklin and Chadwick 2013).

The key to initiating change in relation to workplace bullying is to appreciate that such behaviours are learned (Franklin and Chadwick 2013; Lewis 2006). As a result, new behaviours need to be learned in order to replace those previously demonstrated (Jenkins 2013; Hutchinson et al 2010; Bryant et al 2009). A range of skills are necessary to deal effectively with workplace bullying; these include conceptual skills (i.e. reasoning, planning, problem-solving and adaptability); relational skills (i.e. communication, assertiveness, leadership, teamwork); and personal attributes (i.e. self-esteem, values) (Glaso and Notelaers 2012; Gumbus 2011; Lovell and Lee 2011; Broome and Williams-Evans 2010).

Many workplace training organisations offer targeted training to empower senior management to meet a legislative duty of care and review policies and structures.

Interventions which include restorative practices, emotional intelligence and interpersonal skills training may also be able to effectively deal with workplace bullying (Westbrook 2018; Gillen et al 2017; Victorian Auditor-General 2016; De Cieri et al 2015). However, relatively little is known about the efficacy of such programs due to limited research (Westbrook 2018; Gillen et al 2017; Victorian Auditor-General 2016; De Cieri et al 2015). While targeted training may be effective at one level, there is a gap in providing information to raise awareness, to develop understandings and a culture for change in workplace bullying in the health context among emerging health managers (Westbrook 2018; Gillen et al 2017; Victorian Auditor-General 2016; De Cieri et al 2015).

This study also utilised evidence-based educational theory (Kolb 2009; Billett 2004; Billett 2001; Lave and Wegner 1991; Vygotsky 1980), as described in a previous section, to investigate perceptions of workplace bullying and the potential to change these behaviours through the development of a range of skills. It is envisaged that the provisional anti-bullying learning framework developed for this study may be the focus of further research. This provisional framework could be developed for implementation in a variety of health entities and, due to its flexibility, could also be utilised in other contexts and workplace settings.

## 1.8 Phases of the study

In this section a brief overview of the two phases of the study is presented. Phase one used qualitative methods, with focus groups and individual interviews with participants to ascertain their responses to the six research questions. In phase two, an expert reference group was established to provide feedback and comment on a provisional anti-bullying learning framework developed as part of this study. Phase two used both qualitative and quantitative methods. Figures 1.2 and 1.3 provide an overview of the two phases of the study and the key elements. These phases will be discussed in detail in Chapter 3.

### 1.8.1 Phase one of the study

Phase one (Figure 1.2) focused on the ethics approvals and recruitment of participants for the qualitative data sets: focus groups and individual interviews. After the focus groups and individual interviews were conducted, data analysis was undertaken to identify themes.

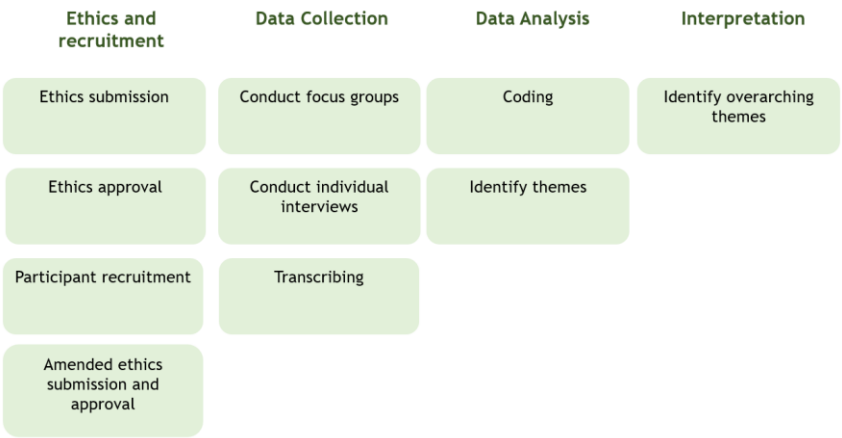


**Figure 1.2:** Overview of study phase one.

### 1.8.2 Phase two of the study

Phase two (Figure 1.3) focused on the ethics approvals and recruitment of participants for the survey and the development of a provisional anti-bullying learning framework which may guide the future development of an education intervention to decrease the incidence of workplace bullying. After the survey was conducted the data were collated and best practice models were identified.

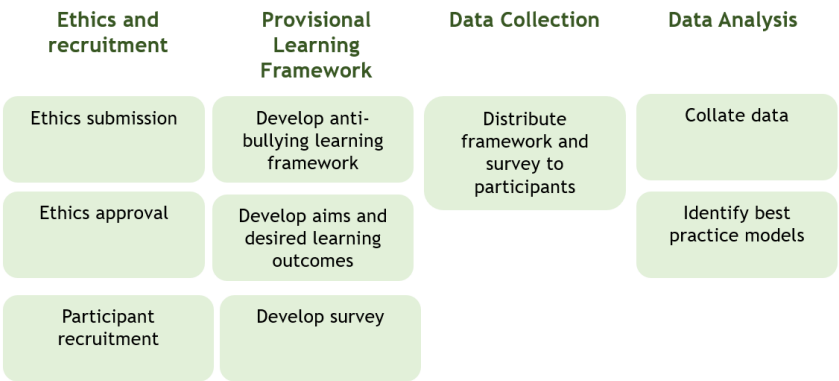


**Figure 1.3:** Overview of study phase two.

## 1.9 Organisation of the thesis

This thesis is organised into eight chapters. Chapter 2 presents a review of the published literature and provides a comprehensive review of both national and international studies. The research methodology, design and strategy are presented in Chapter 3, which provides a detailed articulation of the research procedures and the design, recruitment, data collection and analysis methods used.

The results of the study are included in Chapters 4 and 5, focusing respectively on the findings over two overarching domains. Chapter 4 outlines the results regarding perceptions and experiences of workplace bullying among GHMTs. Chapter 5 outlines the results in relation to identified strategies for dealing with workplace bullying arising from this study. Phase two results from the expert reference group on best practice models and the provisional anti-bullying learning framework are discussed in detail in Chapter 6.

A detailed discussion of the study and the emergent and consistent themes is provided in Chapter 7. A discussion of both the findings and a number of unexpected results arising from this study is also presented. In addition, a comprehensive discussion of the implications for healthcare management is provided. This chapter also includes an update of recent studies and surveys since this study commenced. Chapter 8 provides the conclusions and implications for future research into workplace bullying in a health context.

## 1.10 Conclusion

This chapter provides background to the growing issue of workplace bullying over the past decade, both nationally and internationally, and positions the significance of this study by providing a historical perspective. Key theoretical underpinnings were discussed to provide a structure for exploring the perceptions of workplace bullying and as a means to explain how these behaviours are learned and perpetuated. These theoretical underpinnings support the development of a provisional anti-bullying learning framework. The importance of examining workplace bullying in a health context is justified by outlining four key reasons that have implications for management and leadership practices and patient care and safety in Australia. A discussion on defining workplace bullying was provided and the six research questions and two phases of the study were outlined.

The next chapter will critically evaluate the published literature on workplace bullying within a health context and with a focus on Australian sources where possible. This chapter will also provide evidence to support the identification of a significant gap in the literature, namely GHMTs' perceptions and experiences of workplace bullying, which positioned this study.

# Chapter 2: Literature Review – Workplace Bullying in the Health Sector

## 2.1 Introduction

Most knowledge of workplace bullying behaviours (WBB) is based on the extensive and well-regarded research undertaken in the school context (Vie et al 2011). Over the years, a number of studies have been conducted in the Australian school context. For example, in Slee et al (2008), real-life experiences of individuals subjected to covert bullying in schools were explored, and in 2009, the prevalence and impact of covert bullying was examined in Cross et al.'s 'Australian Covert Bullying Prevalence Study'. Both studies clearly demonstrate the problems that are caused by bullying in schools and led to an increase in studies focused on prevention, intervention and management (Rigby 2010). In 2011, the National Safe Schools Framework (NSSF) was released in Australia. It provided a comprehensive range of evidence-informed practices to guide schools in preventing and responding to incidents of harassment, aggression, violence and situations of bullying.

Workplace bullying has received much less attention, but research in the area is steadily increasing (Fontes et al 2019; Einarsen and Nielsen 2018; Van den Brande et al 2017). Workplace bullying is a form of harassment and is recognised as a management issue for employers (Safe Work Australia 2016; Safe Work Australia 2013). It is fundamentally a health and safety issue, with trade unions in Australia now agreeing workplace bullying is an important factor that needs to be addressed (Lovell and Lee 2011).

A version of this chapter has been published as Chadwick and Travaglia (2017), 'Workplace bullying in the Australian health context: a systematic review', *Journal of Health Organisation and Management, 31*(3): 286–301. This chapter describes an updated review which was undertaken in November 2019 to reflect and capture additional literature from 2015 to 2019. The review covered a wide range of literature from databases such as Medline, Embase, CINAHL and Informit. These databases were selected as they focus primarily on research in the health and medical sector. The breadth of the research into 'bullying' in general is significant, and criteria were applied to review the relevant literature available via these databases. A total of 107 studies fulfilled the criteria of workplace bullying in the health context and have been included in this review (Appendix

1). A total of 81 (75%) studies were included from full-text reviews of database searches. A total of 26 (24%) studies were included from additional sources, of which 11 (42%) were from online searches, five (19%) from grey literature and 10 (38%) from a snowball approach.

A narrative review method (Noble and Smith 2018; Onwuegbuzie and Frels 2016) was selected to provide a critical point of view of current knowledge of the issues pertaining to workplace bullying in a health context. This review includes substantive findings as well as theoretical and methodological contributions to the research topic. A section summarising the primary studies and evidence based on the identified articles is also provided in this review. The researcher's extensive experience and existing theories and models provide the opportunity for self-knowledge, reflective practice and acknowledgement of shared educational phenomenon. This summary includes definitions of workplace bullying, data on the prevalence of workplace bullying, contributing factors towards workplace bullying and organisational structures and barriers to reporting.

## 2.2 Method

### 2.2.1 Overview of method

This review was conducted in accordance with the PRISMA (Preferred Reporting Systematic Reviews and Meta-Analyses) (Moher et al 2009) method to review the literature on workplace bullying in the Australian health service context. An initial exploratory background search using the key word 'bullying' yielded over 70,000 articles in Medline alone. The purpose of this initial search was to ascertain what research was available, where it was located, the amount of research available and the relevance to the Australian health context. Progressive focusing and refining of the search parameters, investigating key points for contention, history, policy and legislative background, resulted in the decision to restrict the year range to 2008–2019. This was in part due to the volume of related articles in the search field and refining the inclusion criteria to enable the review of a more manageable number of articles. In addition, it was determined that findings for this study would be more relevant using the most recent and current research into workplace bullying in the health context. The following databases were used for searches: Medline (publications from 2008 to 2019); Embase (2008–2019); CINAHL (2008– 2019); and

Informit – health collection (Australia) (2008–2019). The same year/date range, 2008–2019, was applied to additional sources identified for this literature review.

The keywords bullying; harassment; workplace; workplace bullying and workplace violence were then used in a title search in Medline, Embase, CINAHL and Informit, yielding 27,802 articles. This was used to decrease the volume of articles and to refine the inclusion criteria to enable the review of a more manageable number of articles.

These searches were conducted in the medical databases Medline (60% of studies in the initial search), Embase (11%), CINAHL (28%) and Informit - health collection (1%). Additional studies were identified through other online searches using the key words identified, and also searching the websites of government agencies and authorities (e.g. Fair Work Australia, Safe Work Australia). These yielded 36% of studies in the initial search. Grey literature contributed to 25% of studies in the initial search and included a range of reports and parliamentary inquiries. A total of 39% of studies in the initial search were conducted via the snowball method, pursuing references of references; this was useful in identifying sources from obscure locations and exploring new research as it emerged.

**Table 2.1:** Key words searched

| Key words searched | • bullying |
|---|---|
| | • harassment |
| | • workplace |
| | • workplace bullying |
| | • workplace violence |

### 2.2.2 Search strategies

The search strategy involved researching the key words in academic and health databases that contained journals in healthcare, health service research and organisational management, and also involved identifying additional records through online searches, searches of grey literature and the snowball method. A review of the literature used the conventional Medical Subject Headings (MeSH) browser (Higgins et al 2019; Higgins and Green 2011) to clarify scope; search for evidence; appraise primary studies and extract data; synthesise evidence and draw conclusions; and disseminate, implement and evaluate. The primary objective of the search strategy was to investigate the phenomenon of

workplace bullying in a health context, with an emphasis on the Australian setting where possible.

The following exclusion criteria (Table 2.2) were applied to the title, abstract and full text searches after duplications were removed.

**Table 2.2:** Exclusion criteria

| Exclusion criteria | Description |
|---|---|
| Under 22 years of age | Depending on how age was described in the study, studies were excluded when participants were not over the age of 22; or no age was mentioned or the article referred to children and/or young people. |
| Not in a health context and/or environment | The paper described contexts and/or environments not related to a health context (e.g. schools, universities). |
| Focus on clinical and surgical practices | The paper described specific clinical and surgical practices and not related. |
| Not specific to workplace bullying | The paper described incidences outside the workplace. |
| Program focus | The paper described a specific health-based program or procedure (e.g. diabetes prevention program, obesity programs). |
| No evaluation | The paper described an event or program but did not evaluate the program. |
| Not a study | The paper was not a study (e.g. review paper, conference abstract or discussion piece) and did not have references or an author. |

According to the World Health Organization's (WHO 2014) definition, adolescence is between 10 and 19 years; however, with recent research into neuroscience it is recognised adolescence now has three stages. The age range 18–22 is classified as late adolescence; therefore, this upper range was chosen as the minimum age for inclusion as GHMTs have completed, at a minimum, an undergraduate degree and would generally be no younger than 22 years of age.

### 2.2.3 Search findings

A total of 27,802 publications were identified through all search fields, as outlined previously. After duplicates were removed, 13,914 articles remained to be screened using exclusion criteria to review titles and abstracts for eligibility and relevance (Figure 2.1). This resulted in 7,520 articles remaining. Full texts for these articles were then reviewed

using the same exclusion criteria for eligibility and relevance. A total of 107 studies met the criteria of workplace bullying in the health context and have been included in this review. A total of 81 (75%) studies were included from full-text reviews of database searches. A total of 26 (24%) studies were included from additional sources, of which 11 (42%) were from online searches, five (19%) from grey literature and 10 (38%) from the snowball approach. Steps involved in the review process were not always linear; studies were returned to on numerous occasions to determine eligibility and relevance. Studies were included and then extracted at various stages as the criteria were refined and abstracts reviewed.

Due to the extensive nature and volume of references from databases, the initial search findings for this literature review were restricted to the years 2008–2014. An updated review was conducted to capture literature from 2015 to 2019. Table 2.3 below outlines the findings from the selected databases from 2008 to 2019; Table 2.4 below indicates the findings from other sources 2008–2019.

**Table 2.3:** Search findings for selected databases

| Search terms | Number of references<br>Publication dates 2008–2019 | | | | |
|---|---|---|---|---|---|
| | Medline | Embase | CINAHL | Informit health collection | Total |
| 1. Bullying | 2657 | 1604 | 3097 | 123 | 7481 |
| 2. Harassment | 1140 | 192 | 1112 | 26 | 2470 |
| 3. Workplace bullying | 12482 | 381 | 845 | 115 | 13823 |
| 4. Workplace violence | 355 | 824 | 2777 | 72 | 4028 |
| Total | 16634 | 3001 | 7831 | 336 | |

**Table 2.4:** Search findings for other sources

| Other sources | Number of references<br>Publication dates 2008–2019 | |
|---|---|---|
| | Details | Total |
| Other online searches | Various internet search engines were accessed from webpages which might provide references. Of these numerous books and conference proceedings were included. | 131 |
| Grey literature (reports) | A number of reports and publications from government departments such as Fair Work Commission Australia, Safe Work Australia and Parliamentary Committees were reviewed. | 92 |

| | | |
|---|---|---|
| Snow-ball method (other references) | Identified key researchers in the field lead to a range of references being reviewed from their literature. | 142 |
| | | 365 |

### 2.2.4 Review process

PRISMA is an evidence-based minimum set of items aimed at assisting researchers to report a wide array of systematic reviews (Moher et al 2009). PRISMA provides a model to support authors to provide a transparent and complete reporting of this type of research. It has been mainly used with systematic reviews and meta-analysis of randomised trials, and can also be used as a basis for reporting reviews of other types of research (e.g. diagnostic studies, observational studies). PRISMA is not a quality assessment instrument for systematic reviews, although it may be useful for critical appraisal purposes (Moher et al 2009). See Figure 2.1 below for the PRISMA flowchart for this study.

A total of 107 studies were identified for the purposes of this literature review, and a summary of the evidence is detailed below. The identified studies assisted in synthesising and refining the researcher's understandings. The objective of reviewing the full texts of the included studies was to investigate the phenomenon of workplace bullying in a health context, with an emphasis within the Australian setting where possible. EndNote X7.0.2 was used as a reference manager to input references, abstracts and keywords.

### 2.2.5 Data extraction and analysis

Data was extracted from the identified studies using an Excel spreadsheet with a range of headings required for descriptive purposes for later analysis in the systematic review. A Summary of Findings table was developed, and the data extracted were defined by the key research questions, the topic being explored and the inclusion and exclusion criteria.

The extracted data was then analysed based on the unique concepts and themes central to a full understanding of the topic, workplace bullying. A concept map was developed to identify how the different sources related to each other. The analysis and synthesising of the information provided the researcher with understandings to determine what is already known about workplace bullying; an overview of the key concepts related to workplace bullying in healthcare settings; to identify any gaps in the literature related to workplace bullying in healthcare settings; and to provide a solid background to this study's

investigation. The findings from this analysis and synthesis are detailed in the following section.

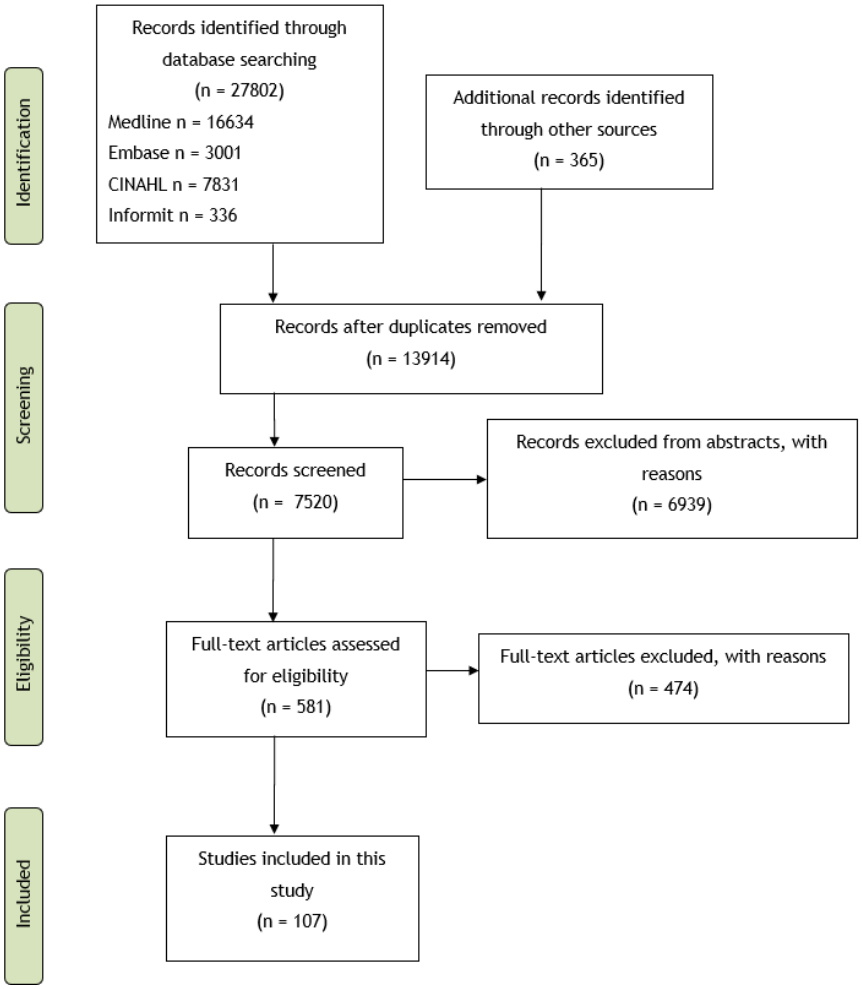


**Figure 2.1:** PRISMA diagram for inclusion in this review. Search parameters 2008–2019.

## 2.3 Findings and discussion

### 2.3.1 Prevalence rates

It is suggested the incidence of bullying in Australian workplaces is increasing and is not exclusive to one jurisdiction, one industry or one type of worker (Lovell and Lee 2011). According to research, one in five people are bullied at work and in some industries, such as health, welfare and education, the figure is higher, ranging from 25% to 50% (Lovell and Lee 2011). International prevalence rates indicate a large variance. For example, the lowest reported rate is 4.1% in Sweden (Rahm et al 2019) and the highest is 21.5 % in the

United States (Bryant et al 2009), while the United Kingdom falls in between, with the reported rate at 15% (Balducci et al 2009). Prevalence rates in Australia are difficult to determine as, to date, a consistent national evidence base has not been developed. The Australian Workplace Barometer (AWB) project (2009–2011) found 6.8% of Australian workers experienced bullying behaviours at work in the previous six months and 3.5% for longer than six months (House of Representatives Standing Committee on Education and Employment 2012). However, the prevalence of workplace bullying could be as high as 15% according to a report by the Productivity Commission (2010).

Many factors impact on prevalence rates, including how workplace bullying is defined, population size, and measurement and reporting systems, as well as cultural practices around workplace bullying. The evidence base needs to be improved as there are challenges in gathering statistics arising from lack of a common definition; self-reporting, which can produce both under- and over-reporting; lack of consistency in research and data; and the myriad regulators and commissions that require reports, resulting in unnecessary duplication (Askew et al 2012; Cleary et al 2009; Einarsen et al 2009; Hauge et al 2009).

### 2.3.2 Lack of definition of workplace bullying

Knowledge about workplace bullying in Australia is limited and national definitions, policies and frameworks are yet to be developed. Although there is no single, universal definition of workplace bullying, it is generally accepted to consist of repeated, systematic, interpersonal abusive behaviours that negatively affect the targeted individual (Boyle and Wallis 2016; Branch and Murray 2015; Branch, Ramsay and Barker 2013; Cowan 2012; Piotrowski 2012; Samnani and Singh 2012; Branch 2008; Rutherford 2004).

Workplace bullying is a multidimensional phenomenon. Issues relating to psychological health, including stress, depression, anxiety and suicide ideation, are becoming increasingly important (Van den Brande et al 2017; Allen 2015; Finne et al 2011; Lovell and Lee 2011; Vie et al 2011; Broome and Williams-Evans 2010; Balducci et al 2009; Bryant et al 2009; Dollard et al 2007). Situational factors such as positional power and authority, role ambiguity, role conflict and interpersonal conflicts are emerging as predictors of workplace bullying (Van den Brande et al 2017; Nielsen 2013; Van Rooyen and McCormack

2013; Rocker 2012; Balducci et al 2011; Casida and Parker 2011; Agervold 2009; Hauge et al 2009).

Bullying behaviours are widely considered to be about relationship issues, intention to harm, frequency and an imbalance of power, as evidenced by the significant body of research into school-based bullying behaviours (Rigby 2010; Cross et al 2009). Contributing to the complexity of definitions for workplace bullying are the varied terms used to describe bullying, including mobbing, workplace harassment, workplace aggression, emotional abuse and even psychological abuse (Sheehan and Griffiths 2011; Bryant et al 2009). The phenomenon also encompasses peer victimisation and group intimidation.

### 2.3.3 Types of workplace bullying behaviours

Workplace bullying can be defined as repeated and unreasonable behaviour directed towards a worker or a group of workers which creates a risk to health and safety (Safe Work Australia 2016; Safe Work Australia 2013). 'Repeated behaviour' refers to the persistent nature of the behaviour and can involve a range of behaviours over time. 'Unreasonable behaviour' means behaviour that a reasonable person, having considered the circumstances, would see as unreasonable, including behaviour which is victimising, humiliating, intimidating or threatening (Boyle and Wallis 2016; Safe Work Australia 2016; Safe Work Australia 2013; Knox Haly 2008). With continuing ambiguity in definitions of workplace bullying, such behaviours are largely left up to interpretation. At their core, any behaviours which are deemed upsetting, hurtful or even humiliating can be categorised as bullying.

Workplace bullying can be subtle and covert and employees may therefore not be able to readily identify behaviours as workplace bullying. Consequently, employees may not feel they can easily report or describe these incidents (Allen 2015; Johnson et al 2015; Caponecchia and Wyatt 2011). They may also feel embarrassed or fearful of the repercussions and consequences of reporting workplace bullying, particularly against a manager or more senior person in the organisation (Fontes et al 2019; Safe Work Australia 2016; Franklin and Chadwick 2013; Safe Work Australia 2013; Lovell and Lee 2011). Adding to the reluctance to report incidents of workplace bullying is the suggestion that individual employees may not perceive supportive practices to be in place and that management is unlikely to address the issues and redress the behaviour (House of Representatives Standing Committee on Education and Employment 2012; Caponecchia and Wyatt 2011;

Einarsen et al 2009). Research indicates that workplace bullying is often managed inadequately and complaints from employees are frequently dismissed (House of Representatives Standing Committee on Education and Employment 2012; Caponecchia and Wyatt 2011; Einarsen et al 2009).

Examples of behaviour, whether intentional or unintentional, which may be considered to be workplace bullying if they are repeated, unreasonable and create a risk to health and safety include, but are not limited to: abusive, insulting or offensive language or comments (Safe Work Australia 2016; Adams et al 2013; Safe Work Australia 2013; Cleary et al 2009); unjustified criticism or complaints (Safe Work Australia 2013; Cleary et al 2009); deliberately excluding someone from workplace activities (Safe Work Australia 2013; Cleary et al 2009; Rutherford 2004); withholding information which is vital for effective work performance (Safe Work Australia 2016; Safe Work Australia 2013; Askew et al 2012; Cleary et al 2009); setting unreasonable timelines or constantly changing deadlines (Safe Work Australia 2016; Safe Work Australia 2013; Cleary et al 2009); setting tasks which are unreasonably below or beyond a person's skill level (Safe Work Australia 2016; Safe Work Australia 2013; Cleary et al 2009; Rutherford 2004); denying access to information, supervision, consultation or resources to the detriment of the worker (Safe Work Australia 2016; Safe Work Australia 2013; Cleary et al 2009); spreading misinformation or malicious rumours; (Adams et al 2013; Safe Work Australia 2013; Cleary et al 2009;) and changing work arrangements such as rosters and leave to deliberately inconvenience a particular worker or workers (Safe Work Australia 2016; Adams et al 2013; Safe Work Australia 2013; Cleary et al 2009).

A single incident of unreasonable behaviour is not considered to be workplace bullying; however, it may have the potential to be repeated or to escalate and therefore is said to require attention. Workplace bullying can take the form of direct or overt acts such as verbal abuse, accusations and public humiliation, or it can be indirect or covert and more subtle in nature, such as rumour-spreading, gossiping and social exclusion (Van Rooyen and McCormack 2013; House of Representatives Standing Committee on Education and Employment 2012; Cleary et al 2009; Hauge et al 2009).

### 2.3.4 Impact of workplace bullying

Described as a form of psychological violence, workplace bullying can result in significant damage to an individual's health and wellbeing, and in extreme cases, can lead to suicide

(Lovell and Lee 2011). Bullying and harassment have a significant impact on mental health, job satisfaction and intention to leave the workforce (Oh et al 2016; Drabek and Merecz 2013; Johnson 2011; Cleary et al 2009; Review Equal Opportunities 2004; Turney 2003). Such behaviour can also undercut the productivity of an entire organisation, which incurs financial costs to employers and the national economy (Adams et al 2013; Shallcross et al 2013; Sheehan and Griffiths 2011; Review Equal Opportunities 2004).

Research has indicated the targets of workplace bullying are significantly more likely to experience decreased job satisfaction, lower self-esteem, depression and post-traumatic stress disorder, and witnesses of such behaviours may suffer similar effects (McCormack et al 2014; Branch, Ramsay and Barker 2013; Van Rooyen and McCormack 2013; Glaso and Notelaers 2012; Piotrowski 2012; Balducci et al 2011; Hoobler et al 2010; Balducci et al 2009; Bryant et al 2009; Branch 2008).

Employers also are impacted by negative consequences of workplace bullying, including high staff turnover and absenteeism, lower productivity, poor staff morale and even increased financial costs due to legal claims, worker's compensation and managers' time (Becher and Visovsky 2012; Bellot 2011; Hoobler et al 2010). This review also found workplace bullying was frequently associated with intimidation and intolerance of dissent (Amrein 2012), which has contributed to the malfunctioning health sector.

## 2.4 Contributing factors

A range of factors contribute to the prevalence of workplace bullying in healthcare settings. These factors include lack of management leadership; hierarchical structures; lack of workplace support; informal power and the social environment. Figure 2.2 below outlines the interconnectedness of these factors.

**Figure 2.2:** Factors contributing to workplace bullying.

### 2.4.1 Lack of management leadership

Cultural and systematic factors can contribute to the increased risk of workplace bullying, as evidenced by the findings from an inquiry into the NSW Ambulance Service (Coursey et al 2013). This inquiry highlighted a highly dysfunctional environment; a nepotistic 'old boys' club; inept managers and poor management culture; poor working conditions; an inability of managers to deal with conflict; victimisation of staff; conflict between older and younger staff; and normalisation of workplace bullying. These factors created an environment that allowed disrespectful behaviours to emerge and escalate into workplace bullying. A risk management framework, in the form of WHS as currently termed in Australia, may be a legal requirement in some organisations to address workplace bullying as a health and safety issue; however, if managed well, this can be viewed as a proactive approach. Organisations which adopt this approach usually have systems and procedures in place to assess the degree of risk, implement steps to manage these risks and continually monitor and evaluate the risks (Branch, Ramsay and Barker 2013; Einarsen et al 2011; Bryant et al 2009). However, the first step is to engender commitment from management and senior executives. Leadership at all levels of the organisation (i.e. board, chief executive officer, or executive) needs to be motivated and engaged to prevent workplace bullying using a proactive and systemic approach as opposed to a reactive approach (Van Rooyen and McCormack 2013; Alterman et al 2011; Broome and Williams-Evans 2010; Felblinger 2009).

Workplace bullying may be symptomatic of broader issues within organisations (Becher and Visovsky 2012). Workplace bullying may be more about leadership and organisational

issues as well as interpersonal relationships within organisations (Van Rooyan and McCormack 2013; Becher and Visovsky 2012; Spence Laschinger et al 2012; Gumbus 2011). Lack of effective management skills is viewed as a significant factor contributing to workplace bullying, along with unrealistic expectations, authoritarian management, personality and even failure to address workplace bullying when it occurs (Drabek and Merecz 2013; Gaffney et al 2012; Einarsen et al 2011; Agervold 2009; Bartos et al 2008).

The literature also attempts to explain the contributing factors or motivations which can lead to workplace bullying. These include, but are not limited to: competitiveness (Cleary, Walter, Horsfall and Jackson 2013); compensation for deficiency (Cleary, Walter, Horsfall and Jackson 2013; Balducci et al 2011); protection of self-esteem (Chang and Lyons 2012; Balducci et al 2011); envy (Chang and Lyons 2012; Agervold 2009); performance appraisal or reward structures (Agervold 2009; Bartos et al 2008); lack of awareness (Spence Laschinger et al 2012; Bartos et al 2008); workplace changes; (Cleary, Walter, Horsfall and Jackson 2013; Chang and Lyons 2012); and management philosophy (Cleary, Walter, Horsfall and Jackson 2013; Bartos et al 2008).

### 2.4.2 Hierarchical structures

The concept of horizontal workplace bullying, and hierarchical workplace bullying has emerged in recent years (Biggio and Cortese 2013; Chiaburu and Harrison 2008). Horizontal workplace bullying is defined as bullying behaviours which occur between workers on the same level, in the same occupation. Hierarchical workplace bullying is defined as occurring by virtue of an individual's structural location within the workplace and the wider world of work. Interpersonal hierarchical workplace bullying is more prevalent in professions where power disparity is significant (Glaso and Notelaers 2012; Caponecchia and Wyatt 2011; Felblinger 2009). Workplace bullying can be seen in organisations where hierarchical systems and structures are the norm and where the organisation is resistant to change (Balducci et al 2011; Sheehan 2004). Factors such as competitiveness, autocratic managers, hierarchal organisations and environments with poor communication practices without formal policies encourage workplace bullying (Cleary, Walter, Horsfall and Jackson 2013; Gaffney et al 2012).

The hierarchical structure of organisations is seen to create an imbalance of power and can lead to the misuse of this power by managers. Individuals within these professions can be seen as inheriting power and prestige due to their occupations (McCormack et al 2014;

Sheehan and Griffiths 2011; Agervold 2009; Bartos et al 2008). Leadership styles can also contribute to workplace bullying. An autocratic manager may engage in workplace bullying simply by exerting their authority over others, making unreasonable demands or excluding workers from decision-making processes which are within their authority. Controlling managers may not realise some of the behaviours they are demonstrating are workplace bullying. Some managers will attempt to explain their behaviour as reasonable management practices or even blame the worker for being too sensitive (House of Representatives Standing Committee on Education and Employment 2012; Rocker 2012; Casida and Parker 2011).

Organisations with hierarchical management structures, high pressure and few policies are more likely to experience greater levels of workplace bullying (Biggio and Cortese 2013; Drabek and Merecz 2013; Cowan 2012; Samnani and Singh 2012; Balducci et al 2011; Bellot 2011; Casida and Parker 2011; Einarsen et al 2011; Cleary et al 2009). Exposure to workplace bullying is shown to have detrimental consequences for not only individuals but also organisations (Cleary, Walter, Horsfall and Jackson 2013; Alimo-Metcalfe et al 2008).

### 2.4.3 Lack of workplace support

The uncertainty and frequently changing nature of organisations can lead to some people deliberately working for their own personal end or gain (Chang and Lyons 2012; Balducci et al 2011). Individuals who are seen to break the social rules of the workgroup by performing better than expected may be targeted (Cleary, Walter, Horsfall and Jackson 2013). Employees who are perceived by others as having knowledge, skills or expertise which is difficult to replace or who are deemed to be favoured may also be targeted. This notion of favouritism can also be demonstrated through performance appraisals or reward structures (Agervold 2009; Bartos et al 2008). Conversely, performance appraisals can also be used as personal attacks on employees by inept managers. In some organisations a culture of blaming or establishing rigid rules, combined with changing organisational procedures, can lead to workplace bullying. Some managers demonstrate hostile behaviours towards individual employees or reinforce the inappropriate behaviours by their inaction (Cleary, Walter, Horsfall and Jackson 2013; Bartos et al 2008).

Formal positions of power can also contribute to workplace bullying. Managers in some organisations are promoted due mainly to their demonstrated skills at specific tasks and competencies, and some lack the relational and interpersonal skills required at more

senior levels. Others are promoted or in positions which are outside their skill set and, both of these can lead to a culture of workplace bullying (McCormack et al 2014; Cleary, Walter, Horsfall and Jackson 2013; Chang and Lyons 2012).

Inaccessible managers – those managers who are behind closed doors, rarely interact with employees or even physically absent from the workplace on a regular basis – can also foster a culture of workplace bullying. In addition, employees who find their jobs changing or moving from one area to another may experience difficulties in engaging and connecting with different people (Cleary, Walter, Horsfall and Jackson 2013; Chang and Lyons 2012). Currently there is high mobility within the healthcare workforce and this can lead to feelings of isolation.

### 2.4.4 Informal power

Informal sources of power also exist, such as power gained by length of experience, time employed by the organisation and access to influential networks (Agervold 2009). Mobbing behaviours are those which are based on strength of numbers and influential contacts (Hutchinson et al 2010; Balducci et al 2009; Westues 2004). The behaviours within the group are passive-aggressive and used as a deliberate strategy to cause harm with the intention of forcing the targeted worker to leave (Jenkins 2013; Rocker 2012; Sheehan 2004). Managers may be in a position of power but they could also be a target of mobbing – manipulative behaviour such as gossip, hearsay or rumours. The significance of the impact of workplace mobbing is not well understood although long-term psychological damage, loss of employment and loss of financial security are evident. Workplace mobbing is a result of a dysfunctional organisational culture (Shallcross et al 2013; Sheehan and Griffiths 2011; Sheehan 2004; Westues 2004).

### 2.4.5 Social environment

The social environments of organisations – the expectations, norms and beliefs – may contribute to workplace bullying. Individual groups, teams or departments within organisations may establish different norms and patterns of behaviours from the wider organisation (Franklin and Chadwick 2013; Jenkins 2013; Anderson 2011; Chiaburu and Harrison 2008). Conflict between group norms is considered to be a significant cause of workplace bullying (NSW Health 2013; Einarsen et al 2009), as individuals may challenge the behaviour or make a complaint and this in turn can lead to being targeted by the

group. The culture of groups, teams or departments is a challenge and a responsibility for managers. Emotional incidents such as workplace bullying are distinguishable and have a significant psychological impact on an individual across a range of areas. Research suggests poor physical, mental and emotional health can result from negative emotions experienced at work.

## 2.5 Strategies which can address workplace bullying

A range of skills have been identified to deal effectively with workplace bullying and its contributing factors. These key skills include communication, empathy, emotional intelligence, conflict resolution, interpersonal relationships, personal mastery, leadership, negotiation, stress management, team-building and problem-solving. These skills should be taught within a framework of a learning organisation (Glaso and Notelaers 2012; Gumbus 2011; Lovell and Lee 2011; Broome and Williams-Evans 2010).

While many organisations have a formal zero-tolerance policy towards workplace bullying, the practice is often quite different (Askew et al 2012; Broome and Williams-Evans 2010; Cleary et al 2009). Organisational focus on a regulatory approach of policy and legislation is not effective on its own (NSW Public Service Commission 2014). Research demonstrates a move towards restorative practices, such as shared responsibility and shared concern, will have longer-term impacts on reducing workplace bullying (Hutchinson 2014; Morrison 2007). These strategies include non-punitive responses, restorative circles and conferencing, and fostering pro-social work group behaviour (Jenkins 2013; Hutchinson et al 2010; Bryant et al 2009). Restorative approaches focus on workplace bullying as a human issue, not a breach of policy issue. A central component of restorative practices is the need to rebuild social relationships and repair the harm.

The complexity of workplace bullying needs to be acknowledged. It is critical to recognise that effective supervision and performance management is not workplace bullying, as this process is constructive and supportive (Safe Work Australia 2016; Safe Work Australia 2013; Askew et al 2012; Bryant et al 2009).

## 2.6 The paradoxical place of reporting workplace bullying

Further issues are evident with the reporting of workplace bullying. Reporting mechanisms can be influenced by legislative frameworks, the unions' role or social norms (Branch,

Ramsay and Barker 2013; Coursey et al 2013; Chiaburu and Harrison 2008). In addition, there are a range of reasons why people may not report workplace bullying. These can include being unsure of the procedures for reporting; the subtlety of the behaviours; fear of losing their job or how they will be perceived; embarrassment; the position of the person engaging in the workplace bullying; and the nature of the industry/sector (Cowan 2012; Law et al 2011; Sheehan and Griffiths 2011; Bryant et al 2009; Cleary et al 2009). The concept of whistleblower exists in the health sector, particularly in nursing, and can involve the reporting of unsafe and poor work practices as well as workplace bullying. The term is often used to describe advocacy to prevent harm but it can also have negative connotations, as some workplace cultures view whistleblowing as 'telling tales'. In some organisations, once bullying is reported facilitation occurs but nothing really changes, and the outcome is for the individual to leave the organisation, as workers feel this is the only way they are able to change the situation (Drabek and Merecz 2013; Cowan 2012; Glaso and Notelaers 2012). The literature also describes how workers feel disempowered due to the seniority of the person engaging in workplace bullying and the perceived inadequacy of internal grievance procedures. Managers also need the moral fortitude to respond appropriately and assertively to workplace bullying when it occurs (Cleary, Walter, Horsfall and Jackson 2013; Cleary et al 2009).

There is a paucity of data regarding the prevalence of workplace bullying, as collecting data is complex. One complexity is based on how workplace bullying is defined; another on how it is measured. Some studies use self-reporting with definitions of workplace bullying provided; others focus on indices of workplace bullying with a range of scoring methods. People are likely to either over-report or under-report workplace bullying (Branch, Ramsay and Barker 2013; Franklin and Chadwick 2013; Cowan 2012; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Nielsen et al 2008). In addition, cultural differences in the perception of workplace bullying and reporting procedures exist. A survey conducted by recruitment firm Drake International in 2009 found 25% of Australian workers had experienced workplace bullying in the previous six months and more than 50% stated they had witnessed some form of workplace bullying. Public sector authorities in Australia are starting to monitor workplace bullying by means of staff surveys, though the terms 'bullying' and 'harassment' are confused in some of the data. The 'Your Say Workplace Culture' survey is conducted bi-annually by NSW Public Health. In 2013, more than 43,000 staff and volunteers responded to the survey, representing 32% of NSW Health's total

workforce. A total of 67% of respondents indicated they had been exposed to repeated behaviour which was offensive, humiliating or threatening in the previous 12 months. Of these, 11% experienced these behaviours from a supervisor or manager while 13% noted colleague/s as the source (Law et al 2011).

## 2.7 Conclusion

The literature supports the need to develop definitions, policies, procedures and frameworks which could prevent, or at least, address workplace bullying. The studies reviewed have illuminated a range of strategies, when implemented effectively, could reduce the frequency of workplace bullying. Workplace bullying in the health sector affects the individuals involved, the organisations and the patients they serve (McCormack et al 2014; Branch, Ramsay and Barker 2013; Broome and Williams-Evans 2010; Felblinger 2009). The prevalence of workplace bullying throughout the medical workforce in Australia or elsewhere has received minimal research focus (Amrein 2012).

The health sector in Australia is under pressure, with increasingly limited resources, the introduction of ABF, performance targets for senior managers and executives and the recognition that traditional roles and systems are no longer appropriate (Branch, Ramsay and Barker 2013 cited in Einarsen 2018). There is also an increased emphasis on knowledge, greater reliance on new technologies, increasing use of just-in-time production and management and more frequent organisational change and restructures (Piotrowski 2012; Einarsen et al 2011; Felblinger 2009; Dollard et al 2007). The *Final Report of the Special Commission of Inquiry: Acute Care Services in New South Wales Public Hospitals. Sydney*, released in 2008 (NSW Department of Premier and Cabinet 2008) made a range of recommendations for NSW public hospitals, and this has led to rapid and widespread reform throughout the sector. However, such rapid change has also led to confusion and ambiguity about roles and responsibilities and, in turn, may create the environment and opportunities for the abuse of power through workplace bullying (Anderson 2011; Balducci et al 2011; Agervold 2009; Felblinger 2009; Rutherford 2004).

The review indicates whole-of-organisation and sector wide anti-bullying policies that clearly define workplace bullying are required. Defining what types of behaviours do and do not constituent workplace bullying is key, and these definitions need to be supported and endorsed by senior management and executives. It is the responsibility of employers

to provide a safe working environment and a means for reporting workplace bullying behaviours. Processes need to be implemented that include informal and formal strategies for prompt resolution when reported. The development of a respectful behaviour policy linked to existing codes of conduct, performance management policies and a range of other human resources policies and organisational directives can lead to the ongoing wellbeing of the organisation (NSW Health 2018; Australian Public Service Commission 2006).

A whole-of-organisation approach to creating safe and supportive work environments acknowledges the strong interconnections between wellbeing and cultural change. This approach is inclusive of all staff, regardless of position or seniority. Workplace bullying is less likely to occur in respectful and supportive workplace environments. Organisational culture also has a significant impact on workplace bullying. Workplace bullying can be entrenched in the culture of an organisation, department, unit or team and the way in which managers respond to incidents of workplace bullying is critical in dealing effectively with the issue. In some instances, the level of workplace bullying perceived to occur in an organisation can impact upon its reputation. Managers need to continually build positive relationships with and among staff and to give the issue of workplace bullying constant attention (Safe Work Australia 2016; Safe Work Australia 2013).

The primary studies indicate various individual factors, such as personal competencies and coping style, and contextual factors such as the availability and accessibility of affective social support, may differentiate those who deal effectively with workplace bullying from those who do not (Hager and Leadbeater 2016; Hutchinson 2014; Vaillancourt et al 2013). A shift towards positive relationship management, more relational language and a balance between prevention, intervention and crisis management is a way of demonstrating the organisations' desired outcomes align with the vision and culture.

Education and awareness-raising would be an important first step in addressing workplace bullying in the health sector as a prevention strategy. Targeted training within the workplace would address the issue of organisational cultures that encourage conformity and acceptance of workplace bullying. Such training may take the form of diversity workshops, rights and responsibilities workshops, training for managers and employees, training for contact officers (i.e. human resource personnel) and skills development training (i.e. communication, leadership, conflict coaching) (NSW Health 2018; Safe Work

Australia 2016; Safe Work Australia 2013; Australian Public Service Commission 2006; Australian Public Service Commission 2003).

Organisations, and managers within them, have a duty of care to ensure all employees are safe at work. This includes being safe not only from physical harm and hazards but also emotionally and psychologically. Employers are also legally required to act in every way practical to prevent workplace bullying; however, many employers are unaware of their legal responsibilities and uncertain as to what steps or procedures to implement to reduce the risk of workplace bullying. The process of naming workplace bullying as an important mental health issue will begin to address the problem. Assisting organisations to change attitudes towards workplace bullying is vital if we are to deal effectively with the increase in, and the impact of, workplace bullying in Australia (Safe Work Australia 2016; NSW Public Service Commission 2014; Safe Work Australia 2013; House of Representatives Standing Committee on Education and Employment 2012).

This chapter has reviewed the current literature on workplace bullying in a health context and described the review process. The literature highlighted key findings including the broad range of prevalence rates of workplace bullying in various countries; a lack of a consistent definition of workplace bullying; the many types of behaviours which constitute workplace bullying; and the range of impacts of workplace bullying on individuals and organisations. The literature also explored a range of contributing factors for workplace bullying in a health context, including: the lack of management leadership; hierarchical structures; lack of workplace support; informal power; and the social environment. These findings and factors in the literature formed the basis for developing the research methodology, design and strategy for this study which will be discussed in detail in the following chapter.

# Chapter 3: Research Methodology, Design and Strategy

## 3.1 Introduction

This chapter will outline the research methodology, design and strategy used in this study. A discussion of the methodological assumptions will follow, with an overview of the key research questions. Details will be provided about the two phases of this study and the key data sets, including the composition of each of the data sets. Ethics and research approvals obtained, and the reflexive process undertaken by the researcher, will be described. Table 3.7 provides a detailed overview of the research plan for the study.

The study investigated GHMTs' perceptions and experiences of workplace bullying. Knowledge about workplace bullying in the Australian healthcare context is limited (Branch, Ramsay and Barker 2013; Buchanan et al 2013; Amrein 2012; House of Representatives Standing Committee on Education and Employment 2012) and national definitions, policies and frameworks are yet to be developed. Given the paucity of published research on the perceptions of GHMTs regarding workplace bullying (Hammarberg et al 2016; Morgan 2013; Creswell 2009; Denzin et al 2009; Maxwell 2005), a qualitative approach was chosen as the most appropriate method to examine Research Questions 1–5 for phase one of the study. For phase two of the study both quantitative and qualitative approach were employed to examine Research Question 6 in particular.

Learning and development are critical processes for enhancing productivity and organisational performance (APS 2003) in healthcare settings. Assisting organisations to change attitudes towards workplace bullying is critical, and the provisional anti-bullying learning framework provides a mechanism for organisations to explore current and future practices in addressing workplace bullying. Some examples of programs attempting to address workplace bullying were minor additions to existing work safety programs (Gillen et al 2017; Safe Work Australia 2016; Safe Work Australia 2013). Magee et al (2014, p. 121) note that 'a lack of preparation for managers (particularly middle/line managers) and a lack of training … can contribute to cases of [workplace] bullying being ignored, sometimes unintentionally'.

The broad scope of the issue of workplace bullying necessitated the use of an inductive approach (Theophilus 2018; Morgan 2013; Bernard 2011; Thomas 2006). This approach allows the investigation of complex perceptions and experiences and the construction of an holistic understanding of workplace bullying from the perspectives of the participants. An inductive approach involves allowing the data to determine the themes. Figure 3.1 below describes the inductive approach, adapted from Morgan (2013), used in this study. Column one describes the inductive process, which aims to discover an approach to research design to allow for shifts in the data collection and analysis. Column two describes the researcher's relationship to the data, which is aimed at subjectively interpreting meaning from the data. Column three describes the purpose of context in the inductive approach. In this study the emphasis on workplace bullying generated detailed understandings in healthcare settings via in-depth interviews.

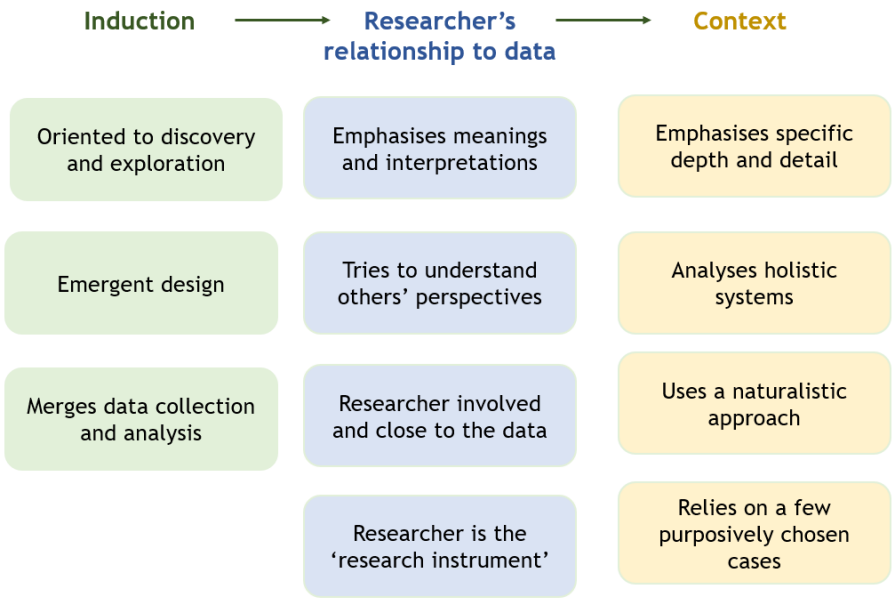


**Figure 3.1:** Inductive approach (adapted from Morgan 2013).

This study was framed within a constructivist paradigm (Brown, Collins and Duguid 1989; Rogoff and Lave 1984; Piaget 1967) – that is, the view that people acquire knowledge and learn from their experiences. The data from the focus groups and individual interviews were used to ascertain participants' perceptions and experiences and to describe and explain behaviours and attitudes toward workplace bullying in a health context. A provisional anti-bullying learning framework was developed for this study using a constructivist approach (Brown, Collins and Duguid 1989; Rogers 1951). The provisional

framework was designed with elements embedded to provide the opportunity for participants to build on their previous knowledge of workplace bullying and make associations with their experiences of workplace bullying, and to allow for new learning and knowledge of workplace bullying (Brown, Collins and Duguid 1989; Rogers 1951). Chapter 6 will detail the findings regarding the provisional anti-bullying learning framework.

Research methodology describes the process of discovering what can be known and represents an approach to matters central to a study (Creswell 2009). The methodology for this study was framed within a constructivist paradigm that determined the use of qualitative methods for the collection of the data. Behavioural and attitudinal change takes place within a person's mind (Brown, Collins and Duguid 1989; Rogoff and Lave 1984) and knowledge of workplace bullying is constructed internally from the external circumstances we experience, which are actively created by social relationships and interactions (Rogers 1951). This has relevance to this study on perceptions of workplace bullying, as how we conceptualise and experience workplace bullying is about how we have constructed this from our own lived experiences or observed behaviours. It is recognised that bullying behaviours are about relationship issues in a social context (Franklin and Chadwick 2013; Rigby 2010; Cross et al 2009); therefore, a constructivist approach was adopted.

## 3.2 Methodology

In this section the methodology for this study is outlined and a detailed overview of the phases of the study provided. This includes the ontological, epistemological and methodological assumptions underpinning this study. The study was undertaken over two phases. Figure 3.2 below provides an overview of the framework developed for the study and the relevant components. A detailed discussion of each phase will follow.

### 3.2.1 Research Paradigm

Ontological and epistemological assumptions are at the core of research studies and were considered for phase one of the study, which used a qualitative approach. Ontology focuses on the way we describe phenomena and the relationship between them, whereas epistemology is an understanding of how we know what we know (Begg 2002; Jane 2002; Mousely 2002); these were, therefore, appropriate research considerations in exploring

how GHMTs perceive and experience workplace bullying. Phase two of the study used both quantitative and qualitative approaches.

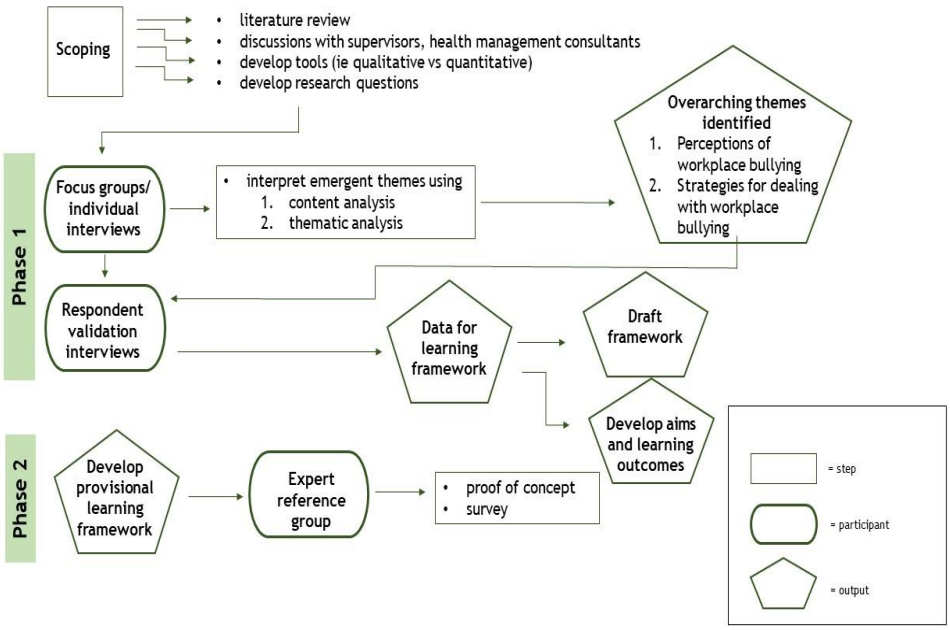


**Figure 3.2:** Overview of the framework of the study.

### *3.2.1.1 Ontological considerations*

A constructivist paradigm allows for multiple realities located within the meanings that individuals ascribe to their experiences and other phenomena (Brown, Collins and Duguid 1989; Rogers 1951). This is reflected in how the GHMTs conceptualise their perceptions and experiences of workplace bullying. A constructivist paradigm includes the conscious meaning individuals give to their direct lived experiences and the degree to which some experiences are more meaningful and significant than others (Begg 2002; Jane 2002; Billett 2001).

Knowledge is a dynamic, evolving phenomenon (Piaget 1967; Rogers 1951). Piaget's work has made a significant impact on the theory of constructivism by describing knowledge development as beginning with individuals gathering information from external stimuli and organising these into a complex of concepts, or a 'schema' (Rogoff and Lave 1984; Rogers 1951). Any new experience is either assimilated or accommodated into schemas, which we are constantly changing (Brown, Collins and Duguid 1989; Rogoff and Lave 1984).

Knowledge is established as a result of our experiences and how we make meaning from these experiences (Brown, Collins and Duguid 1989; Rogers 1951).

Piaget, one of the first theorists to use the term 'constructivist', focused on the concept of social interactions as a catalyst for knowledge; however, he remained firm in the belief that while the interactions were external, the individual's internal processes constructed the knowledge (Brown, Collins and Duguid 1989; Piaget 1967; Rogers 1951). The notion of mental models and interaction with other environments and people has evolved further in the theory of constructivism to social constructivism (Begg 2002; Billet 2001). This is now the most commonly held form of constructivism – that the individual interprets and constructs meaning based on their experiences and interactions (Jane 2002; Mousely 2002).

Qualitative research enables discussion of the meanings individuals place on their interactions with each other and the world (Somekh and Lewin 2006) through the use of specific language and word groups to describe their perceptions (Saldana 2013; Silverman 1998). This is relevant to this study in exploring how GHMTs describe their perceptions and experiences of workplace bullying. These participant discussions, both collectively and individually, provide social reality, define appropriate and inappropriate behaviours and enhance connectedness in organisations (Somekh and Lewin 2006).

#### *3.2.1.2 Epistemological considerations*

The study sought to discover new understandings and knowledge in the perceptions and experiences of workplace bullying amongst GHMTs in a healthcare context. An inductive approach (Morgan 2013) was used. Strategies to counter potential researcher bias included use of a reflexive journal to identify the researcher's beliefs, perspectives and predispositions. This will be discussed further in section 3.9. Qualitative researchers endeavour to understand people within their own framework, recognising that all perspectives are valuable (Hammarberg et al 2016; Creswell 2009; Denzin et al 2009; Maxwell 2005; Sofaer 1999).

#### *3.2.1.3 Methodological considerations*

The study was framed within a constructivist paradigm using both qualitative and quantitative methods. A quantitative approach was included for phase two of the study, as the researcher sought to test a proof of concept to either support or reject the

provisional anti-bullying learning framework and to provide important information for future development. Qualitative methods use texts which reflect a linguistic communication process (Creswell 2009; Wiersma and Jurs 2005); in phase one of this study, these texts describe the participants' perceptions and experiences of workplace bullying. Knowledge was derived through understanding the personally constructed narrative of participants' perceptions and experiences of workplace bullying. The discussion with GHMTs was able to elicit dimensions related to their values, expectations and motivations (Creswell 2009) which explained behaviours and attitudes towards workplace bullying in a health context.

## 3.3 Research design and strategy

Research design is a systematic mechanism to study a scientific problem and differs according to the context, purpose and nature of the research (Hammarberg et al 2016; Creswell 2009; Denzin et al 2009; Maxwell 2005; Sofaer 1999). The design of this study describes the study type, research questions, hypotheses and data collection methods (Creswell 2009). The purpose of research design is to ensure the data or evidence gathered enables the researcher to answer the research questions clearly and logically (Somekh and Lewin 2006). Research design also allows examination of evidence that can disprove the preferred explanations or provide an alternative explanation (Morgan 2013).

### 3.3.1 Research aims and objectives

The main aim of this research was to explore the broad question of GHMTs' perceptions and experiences of workplace bullying in NSW, Australia. A total of six research questions were posed during phase one to address the overall aim and explore how GHMTs conceptualise workplace bullying. After an extensive review of the literature, and identification of the gaps outlined in Chapter 2, the following research questions were developed.

RQ1: How do graduate health management trainees define workplace bullying behaviours?

RQ2a: What types of behaviours do graduate health management trainees consider to be workplace bullying?

RQ2b: What types of bullying behaviours have graduate health management trainees observed in their role as a health manager?

RQ3: What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?

RQ4: How do health managers support staff to encourage reporting of workplace bullying?

RQ5: What approaches (if any) does their organisation have in place for dealing with workplace bullying?

RQ6: What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers?

### 3.3.2 Research design

The study was conducted in two phases. Phase one used qualitative methods with focus groups and individual interviews with participants to answer the six research questions. Phase two used both quantitative and qualitative methods with an expert reference group to provide feedback and comment on a provisional anti-bullying learning framework developed specifically for this study. Findings from the focus groups, individual interviews and respondent validation interviews informed the development of the provisional anti-bullying learning framework aimed to address RQ6: What are the essential elements of a learning framework designed specifically for emerging health managers? Figure 3.3 below provides an overview of the research design. A detailed explanation of the research design and strategy for the two phases will follow.

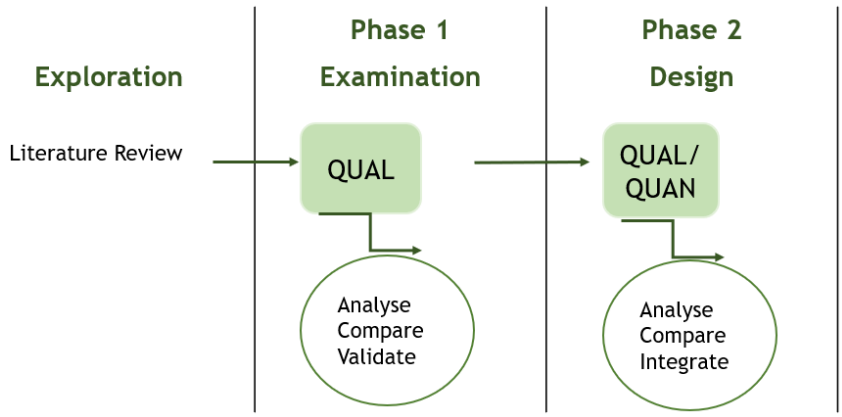


**Figure 3.3:** Research design.

## 3.4 Phase one – qualitative methods

Phase one of the study used qualitative research methods, specifically two focus groups and eight individual interviews. Respondent validation interviews were also undertaken with five participants after transcription, coding and analysis to ensure the validity of the findings. The following figure 3.4 below outlines the research approach to collecting data for phase one of the study – focus groups; individual interviews and respondent validation interviews.

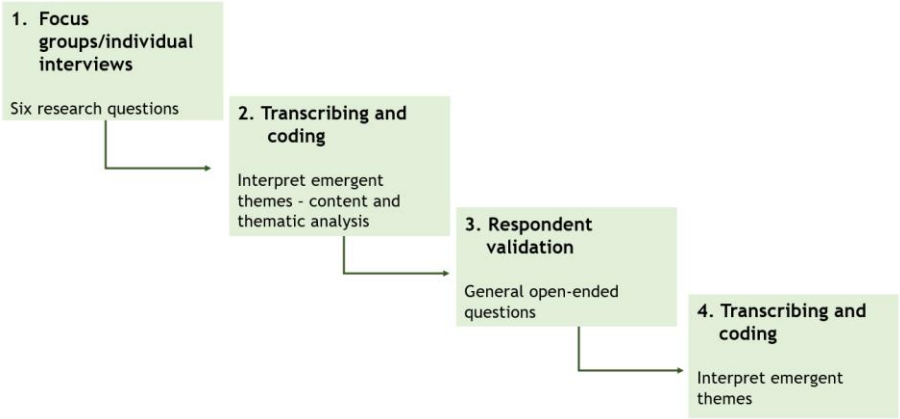


**Figure 3.4:** Research approach – phase one.

A qualitative research design was used for phase one of the study to understand the phenomena of workplace bullying from GHMTs' perspectives. Data were collected via two focus groups and eight individual interviews. Respondent validation interviews were also conducted. Morgan argues that 'a major strength of qualitative interviewing (is) it gives the researcher the opportunity to learn more about others' beliefs and meanings' (2013, p. 54). Qualitative research and, in particular, an inductive approach allowed for decisions to be made to enable deeper exploration of the questions posed and the analysis of the data as themes and ideas emerged (Morgan 2013). Knowledge and understandings about workplace bullying were developed through discussions among GHMTs with similar experiences. The understandings were developed due to their social interactions (Begg 2002; Jane 2002).

Focus groups were used to achieve insights into participants' experiences, attitudes and perceptions of workplace bullying. Focus groups were determined to be the most appropriate method for exploring GHMTs' perceptions of workplace bullying, as focus group participants have the opportunity to hear the opinions of others and can further

develop ideas that have already been proposed, challenge ideas or frame new ideas and suggestions (Morgan 2013; Creswell 2009; Denscombe 2003). Focus groups allowed the researcher to obtain detailed information about personal and group feelings, opinions and perceptions while the group dynamic and interactions between participants contributed positively to the discussion. Individual interviews, on the other hand, allowed for exploration of more sensitive issues and gathering of information on emotions, experiences and feelings. Individual interviews were also used in response to requests from several of those interested in participating, due either to their geographical location or because of the sensitive nature of discussions of workplace bullying. Individual interviews provided participants opportunity to disclose details in a one-on-one interaction in a private and confidential setting. Individual interviews provided the opportunity for the researcher to uncover in-depth information from the participants with more control over the interview process and to pose specific questions with individuals (Morgan 2013; Denscombe 2003). This is not always possible with focus groups. Table 3.1 below outlines a comparison between the use of focus groups and individual interviews which the researcher used as a basis for choosing the most appropriate methods for this study.

**Table 3.1:** Comparison between methods chosen (adapted from Morgan 2013)

| Characteristics | Focus groups | Individual interviews |
|---|---|---|
| Group dynamics | ✓ | X |
| Group influence | ✓ | X |
| Generation of ideas and discussion | ✓ | X |
| Discussion of sensitive topics | X | ✓ |
| Exploring hidden meanings | X | ✓ |
| In-depth probing | X | ✓ |

The study used a semi-structured approach for the focus groups, individual interviews and the validation interviews as this allowed flexibility to pose additional questions to further explore participants' ideas, attitudes, values, experiences and perceptions about workplace bullying based on what they were describing during these interviews. It also provided the researcher with some choices in the wording or re-wording of each question

if participants were not clear on the question or if English was the participant's second language (*n*=3). The use of semi-structured interviews for the focus groups allowed participants to be assisted by others in the group, where appropriate, while formulating a response regarding workplace bullying. Semi-structured interviews provided the researcher the opportunity to probe responses to questions, allowing for clarification of relevant or interesting points and exploration of sensitive issues and inconsistencies.

Participants' responses to research questions can be abstract or concrete, while explanatory responses involve developing causal explanations (Somekh and Lewin 2006). In this current study, for instance, participants were asked to describe occurrences of workplace bullying and reflect on their perceptions and experiences.

Qualitative research has its origins in anthropology, philosophy and sociology (Creswell 2009; Somekh and Lewin 2006; Maxwell 2005; Sofaer 1999; Silverman 1998) and is effective in the exploration of change or conflict. It is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live (Creswell 2009; Somekh and Lewin 2006; Maxwell 2005; Silverman 1998). The purpose of qualitative research is to understand the social reality of individuals, groups and cultures (Creswell 2009; Somekh and Lewin 2006; Maxwell 2005; Lindlof 2002). Qualitative research, at its core, describes the lived experiences, interactions and language of human beings (Wiersma and Jurs 2005; Lindlof 2002) and it is for these reasons that qualitative research was used in phase one of this study. Qualitative methods were used to garner insights and answers to questions about experiences, meaning and perceptions from GHMTs' responses.

Qualitative methods are traditionally utilised in social science research where the aim is to gather an in-depth understanding of, and the reasons for, the behaviour under consideration (Somekh and Lewin 2006). Qualitative methods are usually less structured and, therefore, can be more flexible than quantitative research (Hammarberg et al 2016; Creswell 2009; Denzin et al 2009; Maxwell 2005; Sofaer 1999). This study did not focus on the number of specific incidents of workplace bullying, as the body of literature supports the fact that workplace bullying does exist. Instead, this study sought to explore perceptions of workplace bullying from the perspective of an understudied, vulnerable, yet soon to be influential group, namely GHMTs. Qualitative methods were determined to be the most appropriate due to the ability to conduct descriptive analysis using an

inductive process, reasoning from the specific situation to a general conclusion (Wiersma and Jurs 2005).

### 3.4.1 Selection and recruitment of participants

Participants for phase one of the study, the focus groups (*n*=7) and individual interviews (*n*=8) were sampled purposively from the Graduate Health Management Program (GMHP) in NSW. Participants comprised a random selection of males and females from the GHMP. GHMTs (male and female) from the 2009, 2010, 2011, 2012, 2013 and 2014 GHMP cohorts were selected from the Australasian College of Health Service Management (ACHSM) database, which contains names and contact details of current and previous GHMTs (*n*=118) in NSW. A five-year time frame (2009–2014) was applied to identify recent graduands (*n*=60), as database contact details were only accurate for the previous five years. Participants for the respondent validation interviews were contacted from among those who had participated in either the focus groups or the individual interviews. Those who were available during the timeframe (30 October–30 November 2014) were selected (*n*=5).

Participants received an email invitation to participate from the ACHSM Office Manager circulated through the ACHSM database (Appendix 2). Emails were sent to the addresses contained within the ACHSM database (*n*=60) by the then ACHSM Office Manager. The email described the study and what was required of participants. Initially, 30 participants responded to the ACHSM Office Manager to express interest and willingness to participate. The researcher then followed up with further information to determine a suitable time to conduct the focus groups.

Those interested in participating responded via the email details supplied to request further information or to ask any questions. If requested, further information about the study was forwarded to participants by the ACHSM Office Manager. The researcher did not have any contact with the participants until they initiated email contact asking for further details or raising any queries. It was assumed only individuals who were interested in participating responded to the initial email.

However, once recruitment commenced several requests were received from participants preferring to participate in individual interviews. These requests were made, due in part, to the perceived sensitive nature of the discussions and the belief that some participants

may have known each other or worked in the same organisation. In addition, some participants lived and worked in geographical areas that precluded them from attending the focus groups in metropolitan Sydney. Therefore, an amendment was requested and submitted to the Human Research Ethics Committee (HREC) of The University of New South Wales to allow individual interviews to be undertaken if preferred (either face-to-face or via telephone). Approval for the amendment was granted in March 2014.

Participation in the study was completely voluntary and participants had the right to withdraw at any stage. No participant withdrew at any stage of the study.

## 3.5 Phase two – quantitative and qualitative methods

Phase two of the study was the development of the provisional anti-bullying learning framework (Appendix 3) informed after the data from phase one was analysed, to address RQ6: What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? An international expert reference group was established to provide comment and feedback on the provisional anti-bullying learning framework by way of a proof of concept. Figure 3.5 below outlines the research approach to collecting data for phase two of the study. A detailed explanation of the provisional anti-bullying learning framework and the expert reference group will follow.

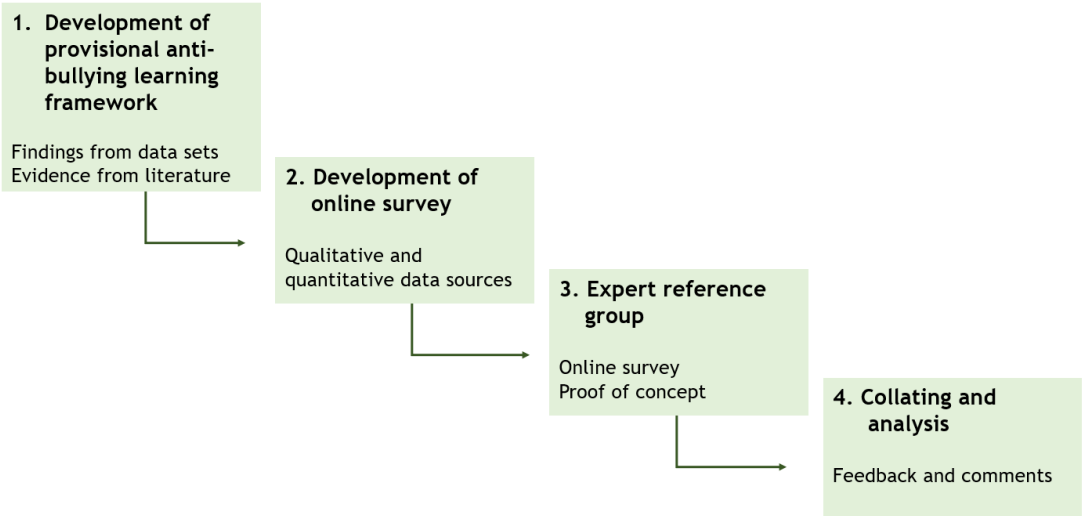


**Figure 3.5:** Research approach – phase two.

### 3.5.1 Development of the provisional anti-bullying learning framework

The findings from the three data sets in phase one of the study – focus groups, individual interviews and respondent validation interviews – were used to develop the provisional anti-bullying learning framework. The provisional framework was developed specifically for this study based broadly on Hickling's (2006) theoretical model of workplace bullying. The provisional framework was developed as a result of the emerging themes from phase one of the study which will be discussed further in Chapters 4 and 5, and supported by the literature that demonstrates awareness raising, and education may be key to dealing with workplace bullying in a health context (Cowan 2012; Balducci et al 2011; Caponecchia and Wyatt 2011; Einarsen 2011; Bryant et al 2009; Cleary 2009).

The provisional framework focused on five guiding principles, which emerged based on the exploration of existing frameworks, the published literature and phase one of the study. The five guiding principles were: (1) Leadership; (2) Inclusion; (3) Participation; (4) Support; and (5) Safety. The guiding principles related to a whole-of-organisation approach to building a positive workplace environment where the whole organisation is included, connected, supported, safe and respected. Critical to this is effective leadership to ensure cultural change across the healthcare setting. The guiding principles aim to deliver a consistent approach to cultural change by focusing on leadership and accountability, building the capability of the healthcare sector and creating a positive environment that supports both patient and staff safety. The guiding principles encompass effective governance; a range of approaches for prevention of workplace bullying; promoting learning environments; responding to workplace bullying; effective reporting processes and a consistent approach to investigating reports of workplace bullying. The literature demonstrates that one-size-fits-all strategies often fail, and that it is important to segment, target and position intervention strategies based on knowledge and insight about the relevant organisation, groups and individuals (Magee et al 2014). A finding from phase one related to the lack of awareness of what constitutes workplace bullying. The findings also indicated that GHMTs felt that healthcare organisations needed to develop and implement clear procedures and guidelines for dealing with workplace bullying and to invest in providing the necessary training for managers. The provisional framework is primarily targeted to emerging and middle managers in Australian healthcare settings to build awareness and promote positive behaviours in the workplace as well as to increase

the knowledge and skills of emerging health managers to prevent and manage workplace bullying as their careers advance.

Figure 3.6 describes the development process for the proof of concept for the provisional anti-bullying learning framework developed for this study.

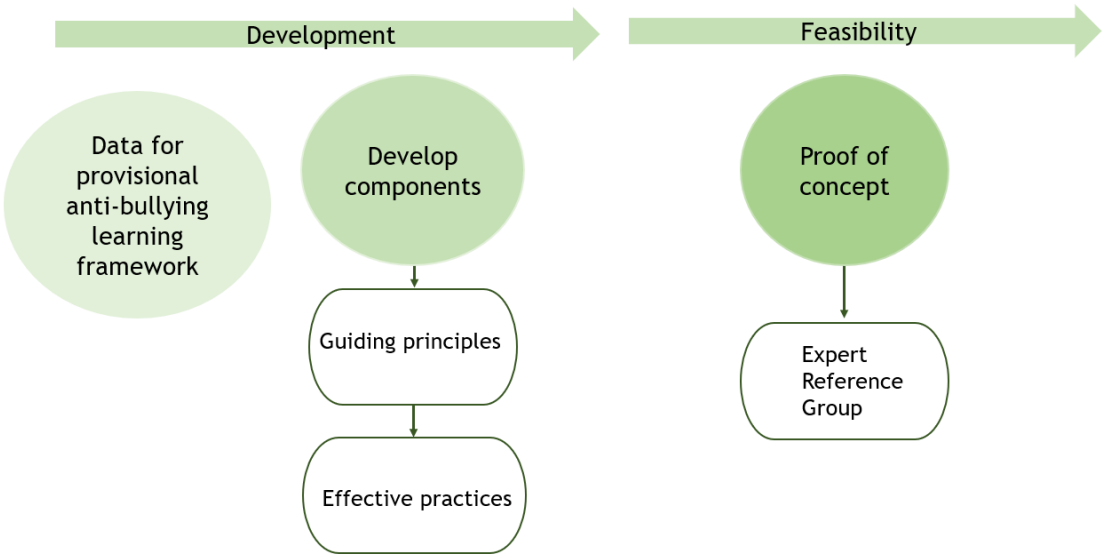


**Figure 3.6:** Development process for provisional anti-bullying learning framework.

### 3.5.2 Expert reference group

The expert reference group was established to provide feedback and expert comment on the provisional anti-bullying learning framework as a means of proof of concept (Kendig 2016) using a survey (Appendix 4) in two sections which employed both quantitative and qualitative methods. Kendig describes a proof of concept as "a phrase frequently used in descriptions of research sought in experimental studies" (p. 737). Quantitative research focuses on examining the relationship among variable factors (White and Millar 2014; Wong 2014; Polit and Hungler 2013; Moxham 2012) and was the most appropriate method for seeking feedback for phase two of the study in order to explore what the experts thought about the provisional framework. Quantitative methods are not suited to studies that aim to investigate how and why a phenomenon occurs. A descriptive online survey was used to gather data from the expert reference group regarding the key elements and guiding principles in the provisional framework. Open-ended questions were also used in the online survey to allow for the participants to expand their responses. The purpose of using a quantitative survey for one section was to elicit specific feedback on the provisional

framework's principles and practices. The use of a qualitative survey for the other section was to provide for broader comment regarding workplace bullying in healthcare settings from their experience and expertise. A proof of concept was appropriate in this study because the researcher wanted to explore the concepts, principles and practices contained in the provisional framework amongst a small group of experts. This proof of concept would provide findings as to whether these concepts, principles and practices have practical applications in addressing workplace bullying in healthcare settings.

The participants in the expert reference group were identified based on their expertise and international standing in health, workplace bullying and/or psychology as researchers, academics or practitioners, and were included to provide internationally relevant input to the provisional anti-bullying learning framework. This allowed the researcher to explore the concepts of workplace bullying in health contexts more broadly to provide a comparison between the Australian health context and an international context. A total of 16 experts were identified based on this criterion, and on the researcher's own knowledge in the area. Experts were invited (Appendix 5 from a range of countries to offer a comparison between their country of work and/or experience and an Australian health context. Potential participants received an email invitation (Appendix 5 outlining the purpose of the provisional anti-bullying learning framework. The final expert group comprised four international experts (from Australia, New Zealand, the United Kingdom and the Unites States of America) in the field of workplace bullying, health and/or research from a range of countries and provided written consent (Appendix 6).

A survey was developed using an online survey tool, SurveyMonkey and consisted of three sections: (1) demographic information; (2) specific feedback on the provisional learning framework; and (3) broader discussion regarding workplace bullying. The survey employed both quantitative and qualitative questions, with the inclusion of open-ended questions for a broader discussion. Section one provided for the collection of demographic information. Section two, which focused specifically on feedback on the provisional anti-bullying learning framework, used a quantitative approach. Section three required responses to a range of questions in regard to workplace bullying and used a qualitative approach. The experts were also asked to comment on the broader issue of workplace bullying, programs and strategies for dealing with workplace bullying in their experience and/or the country in which they currently work.

The researcher has had extensive experience in developing learning frameworks and evaluating learning modules over a period of 30 years and was able to draw on this experience to develop the survey. The survey allowed for open-ended comments to be made by the respondents to further explore workplace bullying and best practice models, both nationally and internationally. Points of comparison for similarities and differences were thematically analysed by comparing survey responses. The findings from the literature review, focus groups and interviews informed the development of a learning framework. A proof of concept research activity determines whether an idea can become a reality. It "verifies that concepts and theories applied to a project will have a real-world application" (Kendig 2016, p372). The use of proof of concept for the provisional anti-bullying learning framework was utilised to test the guiding principles and suggestions for effective practices focused on workplace bullying with a view to determining whether learning and development programs are effective in addressing and responding to workplace bullying in healthcare settings.

## 3.6 Research methods

### 3.6.1 Focus groups

The focus groups involved facilitating a small group discussion between selected individuals to ask questions about their perceptions, experiences, beliefs and attitudes towards workplace bullying in healthcare. Focus groups were chosen to explore and generate ideas in a group setting. Questions were asked in an interactive group setting where participants were able to engage with each other.

Powel et al (1996, p. 196) define a focus group as a 'group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the study of the research'. Focus groups allow the researcher to gain insights into the participants' shared understandings as they are more suited to elicit several perspectives on the same topic (Barbour 2007; Fontana and Frey 2000; Gibbs 1997). Focus groups are a form of group interviewing; however, they rely on the interaction within the group, rather than on the questions and responses between the researcher and participants (Hennick 2007; Fontana and Frey 2000; Gibbs 1997), and in this study it was important to explore a range of perceptions and experiences of workplace bullying among GHMTs. Participants' thinking was guided not only by the implied sequence of the

discussion questions but also by the inclusion of questions which indicated that the expression of personal views and opinions relating to the issue of workplace bullying was encouraged. Group discussion produced data and insights that would be less accessible without the interaction found in the group setting – listening to others' verbalised experiences stimulates memories, ideas, and experiences in participants (Hennick 2007; Lindlof and Taylor 2002; Fontana and Frey 2000). Group members discovered a common language to describe similar experiences for workplace bullying in the range of healthcare organisations in which they worked.

Focus groups allowed for a range of explanations for the phenomena of workplace bullying and this provided a wealth of data for analysis (Hennick 2007; Lindlof and Taylor 2002; Fontana and Frey 2000). Focus groups have strong validity and are low in cost and time compared with other methods of data collection. Due to the small number of participants involved in the focus groups they may not be a representative sample of a whole population (Barbour 2007; Fontana and Frey 2000; Gibbs 1997). Participants willing to be involved may be more articulate and confident as it is not easy to identify the most appropriate people to include and how comfortable the participants will be with each other. A defining characteristic of focus groups is that they foster interactive discussions with participants sharing, comparing and building on each other's contributions. As there was interactive discussion between the participants which allowed sharing, comparing and building on each others' contributions, the focus group of two meets the criteria for a focus group (Cameron 2005; Lindlof 2002; Fontana and Fey 2000; Silverman 1998).

Anonymity and confidentiality were issues facing the focus group discussions (Barbour 2007; Hennick 2007; Lindlof and Taylor 2002; Fontana and Frey 2000). Participants were encouraged to maintain the confidentiality (Appendix 7) of what was discussed during the session. The data were collected via two focus groups during 31 March–30 April 2014 at The University of New South Wales. Participants provided written consent (Appendix 8) and were provided with a handout of resources (Appendix 9) they could access if they felt the need to discuss anything further that may be of a sensitive nature. The focus group discussions were recorded using a digital voice recorder for later uploading and transcription.

The broad aim of the study was to explore GHMTs' perceptions of workplace bullying. A range of research questions were developed to answer this broad aim. Open-ended focus

group questions were developed to guide discussion. The composition of the focus groups is outlined in Table 3.6, below.

### 3.6.2 Individual interviews

Individual interviews were used to provide a different data collection approach to illuminate different aspects, perceptions and experiences from GHMTs regarding workplace bullying. This approach enabled the researcher to explore perspectives and experiences from an individual's point of view and to provide a comparison between perceptions and experiences from those who participated in the focus groups. Interviews were conducted over the phone and were considered by the researcher to be appropriate as individuals were able to share more depth of information (Lindlof and Taylor 2002; Gibbs 1997). Table 3.2, below, indicates the focus group and individual interview schedules.

**Table 3.2:** Focus group and individual interview schedule

| Focus group and individual interview schedule | |
|---|---|
| 1. | How would you define workplace bullying? |
| 2. | What types of behaviours would you consider to be workplace bullying? |
| 3. | What types of behaviours have you observed in your role as a health manager? |
| 4. | What are your perceptions of workplace bullying behaviours? |
| 5. | What importance does positional power have in bullying behaviours in the workplace? |
| 6. | Why do you think bullying behaviours occur in the workplace? |
| 7. | What do you think are the effects of bullying behaviours in the workplace? |
| 8. | How do health managers support staff to encourage reporting of workplace bullying? |
| 9. | How would you build positive relationships in the workplace? |
| 10. | What approaches/strategies do you think would be effective in dealing with bullying behaviours in the workplace? |
| 11. | What approaches/strategies (if any) does your organisation have in place for dealing with workplace bullying? |

A semi-structured approach was used for these interviews as this allowed flexibility to pose additional questions to further explore participants' ideas, attitudes, values and perceptions about workplace bullying. The data were collected via phone interviews from

31 March to 30 April 2014. The broad question focused on GHMTs' perceptions of workplace bullying.

Table 3.3, below, outlines the participant composition for the focus groups and the individual interviews in the study. Composition of each focus group ensured participants who may have been from the same workplace were in different groups. A total of 57% of the participants for the focus groups were women and 43% were men. For the individual interviews, 75% of the participants were women and 25% were men. This split is indicative of the GHMT cohort available for recruitment in the study.

**Table 3.3:** Participants in the study – focus groups and individual interviews

| Data set | Number of groups/interviews | Number of participants | Length of time |
|---|---|---|---|
| Focus Groups | Two groups | *n* = 5 participants<br>*n* = 2 participants | = range 60-minute duration per focus group<br>Mean = 61 minutes<br>Median = 71.30 minutes |
| Individual Interviews | 1:1 individual phone interview | *n* = 8 participants | = range 20–30-minute duration per interview<br>Mean = 18.42 minutes<br>Median = 19.58–20.43 minutes |

### 3.6.3 Respondent validation interviews

Respondent validation interviews were used to seek to improve the accuracy, validity and credibility of the study as a quality control process (Babour 2007; Lindlof and Taylor 2002; Gibbs 1997). Respondent validation interviews 'serve to decrease the incidence of incorrect data and the incorrect interpretation of data, with the overall goal of providing findings that are authentic and original' (Creswell 2009, p. 217) and provided the opportunity for the researcher to verify the accuracy and completeness of the findings, which improved the validity of the study.

The initial interpretation and analysis of the findings from the focus groups and individual interviews provided key aspects: under-reporting of workplace bullying in healthcare; positional power in hierarchical structures in healthcare; support for those experiencing workplace bullying; and effective strategies to deal with and address workplace bullying in healthcare settings. The researcher wanted to explore these aspects further with

participants. This led to the development of five key questions to be posed to these participants. The respondent validation interviews were conducted to provide feedback and to validate the researcher's interpretation of the data (Barbour 2007; Hennick 2007; Lindlof and Taylor 2002; Gibbs 1997).

Consideration of the measures of validity were used in determining the choice of methodology, research questions and the data analysis in exploring workplace bullying. Validity and reliability are evidenced by the consistency of the key words or phrases used by the participants for each question posed during phase one of the study (Hammarberg et al 2016; Creswell 2009; Denzin et al 2009; Maxwell 2005; Sofaer 1999). It is therefore essential to establish measures for validity. These could include member check, interviewer corroboration and peer debriefing (Somekh and Lewin 2006). The study used respondent validation interviews (member check) to ensure the validity of the findings from the focus groups and individual interviews. The transcription of the recordings was undertaken by an independent third party, as discussed further in this chapter.

Participants from the focus groups and the individual interviews were contacted to ascertain their willingness to be individually interviewed via phone to further explore the themes which had emerged from the findings. Those who responded and were available during the timeframe 30 October–30 November 2014 were selected (*n*=5). A total of five participants agreed to take part in respondent validation interviews and were provided with another Confidentiality Agreement for Participants (Appendix 7) requiring signed consent, as there was a six-month interval between data collection. Participants were reminded not to discuss or disclose any details to a third party. This agreement also reinforced the anonymity of their identity or their workplace. Participants were reminded not to use names during the discussion which may identify them, their colleagues or their workplaces.

Individual interviews were conducted to validate and explore findings and themes from the initial data collection. Based on the themes emerging from analysis of the data and informed by the literature review, the questions around the following issues were developed to explore the topic further: why workplace bullying is not reported; the repeated nature of workplace bullying; importance of positional power; access to further support; and strategies which may be effective to deal with workplace bullying. These themes were identified as emerging from the coding of the data, and also evidenced by

the literature (Samnani and Singh 2012; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Bryant et al 2009).

The data collection for the respondent validation interviews was conducted over a one-month period between 30 October and 30 November 2014. These were also recorded using a digital voice recorder for later uploading and transcription. This timeframe provided the opportunity for the researcher to conduct initial coding of the responses from the focus groups and individual interviews. Participants who had previously been involved were asked to provide further feedback for clarification and to explore emerging themes from the initial coding. Table 3.4, below, describes the questions posed for the validation interviews.

**Table 3.4:** Validation questions posed to participants

| Validation questions | |
|---|---|
| 1. | Why do you think there is a tendency to not report bullying behaviours in the workplace? |
| 2. | Does a behaviour need to be repeated for it to be viewed as workplace bullying? |
| 3. | What importance does positional power have in the role as a health management trainee? |
| 4. | Where could people go to access support outside of the workplace if they needed to? |
| 5. | What strategies do you think would be effective for dealing with workplace bullying? |
| 6. | What strategies do you think would be effective for emerging health managers? |

Table 3.5 outlines the participant composition for the respondent validation interviews in the study. A total of 40% of the participants for the validation interviews were women and 60% were men.

**Table 3.5:** Participants in the study – respondent validation interviews

| Individual interviews | Number of participants | Length of time |
|---|---|---|
| 1:1 phone interview | *n* = 5 participants | = range 20–30-minute duration per interview<br>Mean = 23.27 minutes<br>Median = 23.44 minutes |

Qualitative interviewing enabled the researcher to ask the participants to describe their perceptions and experiences regarding workplace bullying, and the researcher was

therefore able to treat each participant's experience within the health context being explored and other social and cultural influences in their lives.

### 3.6.4 Transcription

Recordings were uploaded to a password-protected laptop in an MP3 format using Windows Media Player immediately after the discussions or interviews. The file names for the recordings for the individual interviews were de-identified at this stage (i.e. identification codes substituted for names).

Transcription of the recordings into separate word documents using Microsoft Office 2013 was completed over a two-month period between 1 May and 30 June 2014. The names of the individuals in the focus group and the individual interviews were de-identified at this stage (i.e. identification codes substituted for names). The recordings were transcribed by Pacific Transcription to ensure the transcriptions were a true and accurate account of the discussions which had taken place.

### 3.6.5 Quantitative and qualitative survey – expert reference group

The international expert reference group was established in May 2016 to provide feedback and expert comment on the provisional anti-bullying learning framework (Appendix 3) developed specifically for this study as a result of findings from the focus groups, individual interviews and validation interviews. A modified RAND/UCLA Appropriateness Method (RAM) (Fitch et al 2001) was conducted with the expert reference group to assess the appropriateness of the provisional framework and to reach agreement on determining best practice guidelines for workplace bullying programs in healthcare settings.

Internationally recognised experts from a range of discipline backgrounds (including education, human resources, psychology and management) and countries, with either a doctorate or a postgraduate qualification in their specific discipline and at least 10 years' experience in their current roles, were invited to review the key concepts, effective practices and the guiding principles outlined in the provisional framework and to offer a comparison between their country of work and/or experience and an Australian health context. This study was situated in Australia and the literature identified a gap in the knowledge of GHMT's perceptions of workplace bullying in Australia. Invited experts were requested to be available during 1 August–30 September 2016 to participate in an online survey and were provided with an electronic copy of the provisional framework. Responses

to the survey were collected during this period. The data collection for the expert reference group was conducted over a two-month period, 1 August–30 September 2016.

A total of seven experts indicated they were available and willing to participate. Of these, four were able to complete the survey in the timeframes requested. These participants represented Australia, New Zealand, the United Kingdom and the United States of America. Table 3.6 outlines the composition of the expert reference group.

**Table 3.6:** Participants in the study – provisional anti-bullying learning framework

| Number of participants | Professional role | Professional discipline | Highest qualification | Data sources |
|---|---|---|---|---|
| *n* = 4 participants providing feedback | • Education<br>• Human Resources<br>• Psychology<br>• Management | • Research and Teaching (*n* = 3)<br>• Management Specialist (*n* = 1) | • Doctorate (*n* = 3)<br>• Masters (*n* = 1) | Online survey Individual responses – open-ended questions |

## 3.7 Analysis of data

The data collected was analysed using both content analysis (Saldana 2013; Vaismoradi, Turunan and Bondos 2013) and thematic analysis (Saldana 2013; Vaismoradi, Turunan and Bondos 2013), conducted using NVivo10 software. Approaches to analysis of qualitative research are diverse and numerous; however, content analysis and thematic analysis were used by the researcher as they were the most appropriate to answer the research questions (Saldana 2013; Vaismoradi, Turunan and Bondos 2013). The researcher listened to the recordings numerous times to gain a deeper understanding of the content and the key aspects discussed by the participants. The researcher also made extensive notes in a reflexive journal to capture the nuances of the themes. This formed the basis for content analysis and thematic interpretation of the data.

### 3.7.1 Content analysis

Content analysis was used as a quantitative method to systematically count the frequency of words from the texts from the qualitative data sets and sort them into an organised and concise summary of key findings (Krippendorf 2013; Morgan 2013; Hsieh and Shannon 2005; Mayring 2000). Content analysis was used to analyse the meanings and relationships

of certain words. Content analysis enabled a more objective evaluation and assisted in removing subjectivity. As the study focused on 'perceptions' of workplace bullying, content analysis was appropriate to use. Participants frequently used some of the following words or concepts: bad culture; hierarchical structures; harassment; exclusion; entitled; power; insecure about position; culture of bullying in healthcare; pushing an agenda; and meeting targets. Raw data from the transcripts were then analysed and words with similar meanings and connotations were organised into categories and themes (Stan 2012). The researcher identified whether or not the categories could be linked and listed as themes or sub-themes. The researcher interpreted the responses literal content to include implied meaning and to draw realistic conclusions which could provide knowledge about individuals, groups and healthcare organisations.

Content analysis can also be used as a reflective process and in this study it allowed the researcher to draw on her own previous knowledge in the area of workplace bullying. The process of content analysis for this study was lengthy, a continuous process of coding and categorising and reflecting on the raw data (Morgan 2013; Stan 2012; Haggerty 1996). The process is not linear, requiring the researcher to revisit the data over periods of time to ensure she had thoroughly analysed the data. Krippendorf (2013) describes six key questions which researchers need to address when conducting content analysis of qualitative data: (1) Which data are analysed? (2) How are they defined? (3) What is the population from which they are drawn? (4) What is the context relative to which data are analysed? (5) What are the boundaries of the analysis? (6) What is the target of the inferences?

During the analysis, the researcher needed to be aware of her own prior knowledge and to not unconsciously shape the analysis into pre-determined findings. Prior to collecting any data, the researcher developed a draft of the study to ensure that during this phase of the research they were focused entirely on the data. Detailed notes were made immediately after the data were collected to minimise any errors into the data and all of the findings and preliminary data were incorporated, even if they did not seem relevant at the time. The researcher also acknowledges the limitations of this study that are discussed further in chapter 7.

### 3.7.2 Thematic analysis

Thematic analysis was used in the study to identify patterns or themes within the qualitative data sets. Furthermore, as thematic analysis is a method rather than a methodology, it provided a more flexible approach for the researcher (Vaismoradi, Turunan and Bondos 2013; Alhojailan 2012; Braun and Clarke 2006) to interpret various aspects of the research topic, particularly when exploring GHMTs' perceptions of workplace bullying. A thematic analysis also provided for rich thematic descriptions of the qualitative data sets (Nowell et al 2017; Clarke and Braun 2013; Alhojailan 2012) and was determined to be the most appropriate approach for this study to illustrate the diverse themes regarding workplace bullying via the researchers' interpretation (Clarke and Braun 2013; Alhojailan 2012). In addition, thematic analysis is among the most relevant and widely used approaches in health-related studies and provided clear links between themes. Thematic analysis focused on identifying and describing explicit and implicit ideas, themes, within the data rather than counting words. Codes were then assigned to represent the themes for further analysis (Nowell et al 2017; Morgan 2013; Vaismoradi, Turunan and Bondos 2013; Braun and Clarke 2006).). The researcher's aim was to identify a limited number of themes which reflected the textual data (Clarke and Braun 2013; Saldana, 2013). Braun and Clarke (2006) discuss a framework for conducting thematic analysis which the researcher used as a basis in the study. Figure 3.7 outlines this framework.

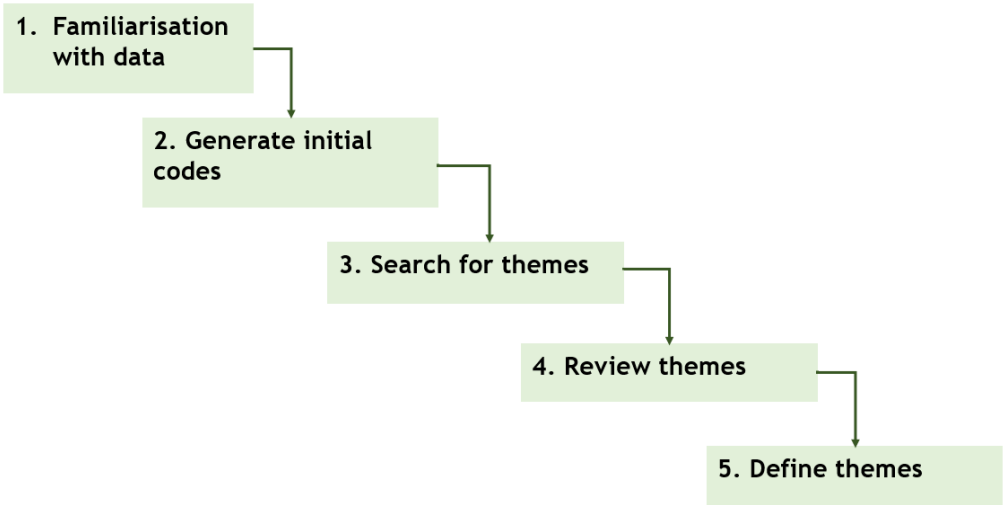


**Figure 3.7:** Framework for thematic analysis (Source: Braun and Clarke 2006).

Step 1 of this analysis involved the researcher listening to the recordings and reading through the transcripts to become familiar with the data corpus. Notes and early impressions of the data were made. In step 2, the researcher systematically organised the data into smaller chunks of meaning, codes. Each segment of data was coded that the researcher considered relevant or of interest to address the research questions. This coding was done line by line to enable an inductive analysis to be conducted. An inductive approach involves allowing the data to determine the themes. Preliminary ideas about codes emerged and this led to step 3, identifying themes in the data, characterised by what was significant or interesting about either the data and/or the research questions. Some codes fitted together into particular themes, others did not at this stage though were of significance. Step 4 of the analysis was to review the themes with a view to either modify or develop preliminary themes identified in step 3. The researcher analysed the themes according to if they were evident in the literature regarding workplace bullying or whether the data supported the theme. Themes need to be coherent and the researcher developed the themes within the context of the entire data set, removing overlapping themes and endeavouring not to have too many sub-themes. The final step in analysing the data was to "identify the essence of what each theme is about" (Braun and Clarke 2006, p.92). The researcher reviewed the themes and sub-themes to determine how they related to each other. This also assisted in defining the themes.

This process is not linear, and the researcher was able to move between stages of analysis numerous times, especially as the data being analysed were complex and provided a variety of themes. During the analysis, the researcher considered all data important regardless of whether their purpose or meaning were clear, as significance might become evident at later stages of interpretation and upon further exploration or reflection.

### 3.7.3 Coding the data

Coding of the data was completed over a three-month period between 1 July and 30 September 2014. Coding involved seeking distinct patterns in the data and then allocating a category or theme which described the data. Each focus group or interview was analysed separately, prior to all data being merged to identified commonalities and themes within the responses.

Identification of examples for each theme illustrated findings emerging from the analysis. A summary was developed to highlight how the discussions from the groups and/or

interviews agreed or differed from each other; points raised in more than more group and/or interview; whether experience or age impacted on responses; comments expressed by one person which seem relevant or worthy of consideration; and any unexpected issues raised.

Responses from the focus groups were first clustered by linking patterns and words which conveyed a similar meaning and which were important to the phenomenon in this study. Meaningful patterns and themes emerged among the coding of key words and phrases. The results from this analysis of the focus groups identified the key themes of intimidation (T2.2), organisational culture (T5.2) and power (T6.5).

Responses from the individual interviews were first clustered by linking patterns and words which conveyed a similar meaning, and which were important to the phenomenon in this study. Meaningful patterns and themes emerged among the coding of key words and phrases. The results from this analysis of the individual interviews indicated the key themes: intimidation (T2.2), talking about others (T2.6), organisational culture (T5.2), communication (T7.2) and responsibility (T8.1).

A key goal for analysing the data sets was to identify common themes which emerged from the focus groups and the individual interviews. However, the researcher also attached importance to exploring individuals' accounts relating to specific incidents of workplace bullying. The researcher sought to identify experiences and views of the individual participants as well as the most frequent views described by a range of participants. A total of nine main themes and several sub-themes were identified. The results from the analysis of the focus groups indicated the following key themes: intimidation (T2.2), organisational culture (T5.2) and power (T6.5).

## 3.8 Ethics

Any research involving human subjects needs to have stringent ethical considerations during the design, the data collection and the interpretation of the findings to minimise the potential risk of harm. Most ethics processes in tertiary institutions are sensitive to the needs of the researcher; however, they need to oversight the ethical conduct of all research being undertaken. Participants also have the right to know who has access to their data and what is being done with it.

This study involved ethics approvals across two tertiary institutions during the period 2013 to 2018 for phase one and phase two. Ethics approval was granted in February 2014 by the HREC at The University of New South Wales, Australia, reference number HC13347. Ethics approval was granted in March 2016 by the HREC at the University of Technology Sydney, Australia, reference number HREC ETH16-1055.

## 3.9 Reflection and reflexivity

The credibility of the research findings is dependent upon reliability, validity and if the study can be replicated. Reliability in this study implies consistency of the data collection methods and analysis to ensure the researcher's subjectivity. The researcher needed to reflect on the research questions so that they were precise and unambiguous. Validity in this study relates to how well the study can apply and translate to other healthcare settings, and to the world at large, through the generalisation of the findings. In this study it is envisaged that the outcomes will apply to practical situations for health managers across a range of organisations. The researcher was able to enhance the validity of this study by adopting inclusion and exclusion criteria for the population being interviewed and conducting the focus groups and individual interviews in a natural setting outside their work environments.

Qualitative research involves a continuous process of reflection by the researcher to ensure the impact of prejudices is limited (Somekh and Lewin 2006; Silverman 1998). With regard to this study, the researcher has significant depth of knowledge and familiarity with the phenomenon being explored and therefore reflexivity and, importantly, writing a reflexive journal, assisted in addressing any distortions or preconceptions the researcher may have subconsciously introduced (Attia and Edge 2017; Finlay 2002). Reflexivity is important as it is aimed at addressing the issue of accuracy, namely the social interaction component of the interviewer–interviewee (i.e. researcher–participant) relationship (Attia and Edge 2017; Morgan 2013; Finlay 2002). Reflexivity involved critically thinking about the researcher's own assumptions, preconceptions and experiences and determining how, or if, these affected the decisions in the research process, selection or interpretation of the findings (Somekh and Lewin 2006; Finlay 2002; Silverman 1998). Reflexivity allowed the researcher to be open to new or conflicting ideas and knowledge, and to challenge personal beliefs or experiences in interpreting meaning from the discussions (Attia and Edge 2017). For example, some of the incidents of workplace bullying provided by the

participants described thoughtless or unhelpful behaviour rather than workplace bullying. Their assertion that this type of behaviour was equally upsetting required the researcher to consider this when interpreting the meaning of the discussion. The research relationship is one which also benefits from reflection, examining the relationship with the participants and how, and if, the dynamic affects the responses to the questions (Somekh and Lewin 2006; Silverman 1998).

Researchers are not separate from the phenomena being studied and absolute neutrality and objectivity are, therefore, virtually impossible to achieve, with the values, attitudes and perceptions of both the participants and the researcher integral to the research process (Attia and Edge 2017; Finlay 2002). Furthermore, qualitative research assumes that meanings are not stable and fixed and, therefore, researchers are not seeking to find 'the' absolute truth by asking the right questions. Researchers using qualitative methods do not assume the participants' responses will be straightforward, nor that the questions themselves will be objective (Finlay 2002). The individual participants' values and interests are part of the research process as it involves understanding the socially constructed nature of the world. The researcher needs to consider their own position vis-à-vis the phenomena being studied and replication or duplication of an exact piece of research is, therefore, not always possible (Somekh and Lewin 2006; Finlay 2002).

For this reason, qualitative methodology cannot be precise. Though structure and rigour are essential for the research to be viewed as scientific – that is to say, as objective as possible – qualitative scholars argue that the social world is not systematic (Somekh and Lewin 2006; Silverman 1998). The need for the researcher to have well-structured and systematic questions and, at the same time, to be self-aware and ethical in conducting qualitative research is paramount (Attia and Edge 2017; Finlay 2002).

The candidate's research journal was also a means for the researcher to acknowledge her own values and beliefs on workplace bullying (Finlay 2002). The journal detailed the decisions which may influence the credibility of the study by providing an account of potential interviewer bias or preconceptions. These biases may negatively influence the interviews, or even the selection and interpretation of the findings (Attia and Edge 2017), and by detailing them and reviewing them during the process, the researcher was able to minimise the influence of her own beliefs and perceptions.

A reflexive journal was used to create transparency in the research process and was critical, particularly for phase one of the study. The journal provided a lens to draw on the researcher's personal experiences and knowledge of workplace bullying, to organise thoughts and feelings and to provide a 'voice' to the experience. The participants in the focus groups and individual interviews provided their 'voice' in the study by sharing their experiences and knowledge of workplace bullying as emerging managers within their various health contexts. The participants were able to broadly discuss the issue of workplace bullying and describe the impact on individuals, organisations and the wider society. The researcher reflected on the participants' ability to generate stories that illustrated personal experience and knowledge of incidents of workplace bullying. They were able to discuss their perceptions of this phenomenon as GHMTs.

This led the researcher to consider her own 'voice' in the study and key questions were posed to reflect on at each stage of the process, and to revisit potential biases throughout the research, particularly during the coding of the data. The researcher needed to consider her interactions with the participants and that this might be influenced by her own personal background, prior assumptions and experiences. The key questions the researcher reflected on were: how have my experiences of workplace bullying affected my interest in this topic and the interpretation of the data; what are my personal values; what areas do I know I am subjective about; how does my gender/ethnicity/culture/social class influence my position on this topic and my participants; where is the power held in relation to my research project; and where am I in the hierarchy? These reflections allowed the researcher to remain objective when interpreting the findings and were revisited with each review of the data.

During the coding stage of the study, the journal provided the researcher with a mechanism to organise her thoughts and interpretations and to ensure no one focus group or individual interviewee's view was privileged over another and that the analysis provided a fair comparison between accounts of all groups and/or participants, a notion of fair dealing. One question the researcher kept reviewing when analysing the data was whether the participants' knowledge of the researcher's professional background influenced their willingness to discuss the issue of workplace bullying openly, or how this implied knowledge may have impacted on what they shared. The process of reflexivity led to conducting the respondent validation interviews to further explore some of the

perceptions and concepts discussed by the participants and to provide for triangulation to further remove bias or perceived bias.

Further reflection on the findings from the focus groups and individual interviews and reaffirmed by the validation interviews was the need for a program and/or training which addressed and raised awareness of what constitutes workplace bullying, particularly in healthcare settings, which led to phase two of the study.

### 3.9.1 Assumptions

Self-evident truths are classified as assumptions in qualitative research (Creswell 2009). Self-evident truths are propositions known to be true by understanding their meaning, without further proof (Creswell 2009). This study made key assumptions regarding the participants in the focus group discussions in their role as GHMTs. As participants were over the age of 18 years and engaged in full-time employment in a management role in a health organisation, a key assumption was that they would base their responses on personal experiences or observations, and that they would respond to the best of their abilities. An additional assumption was they would be respectful of the nature of the discussions and each other.

The participants from the expert reference group were experienced professionals in the field of academia, research and teaching, workplace bullying or from a health context with close to 10 years' experience in their current roles. Key assumptions were that they would provide answers to the survey questions based on their expertise and provide valid information from a national and international perspective.

## 3.10 Detailed overview of the research plan

Table 3.7 provides a detailed overview of the research plan for this study. Each phase of the research is outlined with an overview of the specific research question/s the phase aimed to address. Aligned with this is the key component and aim or strategy used to answer the research questions. Participants and/or data sources and data analysis methods for each phase are provided. Finally, the key output from each phase has been identified.

**Table 3.7:** Detailed overview of the research plan

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output |
|---|---|---|---|---|---|---|
| **Scoping**<br><br>Context, setting and research tool development | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviour? | 1.1 Literature review (Chapter 2) | • To examine the academic literature on workplace bullying – both nationally and internationally<br>• To identify what is known about workplace bullying in a health context<br>• To identify what is known about perceptions of workplace bullying in a health context<br>• To identify gaps in the literature relating to health management trainees<br>• To establish the conceptual framework for the study<br>• To identify valid methods for data collection on workplace bullying | • Medical databases – peer-reviewed journals and/or book chapters<br>• Grey literature – reports and publications from government websites<br>• Snowball method – identified researchers in the field | Thematic analysis<br><br>Content analysis | • Development of research questions and research tools<br>• Positioning of proposed research study based on literature |
| | | 1.2 Informal discussions with HDR supervisors and independent health management consultants | • To understand healthcare settings from research colleagues with health service research expertise and experience (ie HDR supervisors and health management consultants) | • Discussions with key people who are either researchers or practitioners with expertise in health services management and/ or social sciences research at the University of New South Wales and the University of Technology Sydney | Content analysis | |

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output |
|---|---|---|---|---|---|---|
| **Phase one**<br><br>Data gathering and analysis<br><br>Formal validation of themes<br><br>Interpretation of emergent themes and findings | **RQ1:** How do graduate health management trainees define workplace bullying behaviours?<br>**RQ2a:** What types of behaviours do graduate health management trainees consider to be workplace bullying?<br>**RQ2b:** What types of bullying behaviours have graduate health management trainees observed in their role as a health manager?<br>**RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?<br>**RQ4:** How do health managers support staff to encourage reporting of workplace bullying?<br>**RQ5:** What approaches (if any) does their organisation have in place for dealing with workplace bullying? | 2.1<br>Focus group discussions and individual interviews | • To explore graduate health management trainees' perceptions of workplace bullying<br>• To investigate graduate health management trainees' understandings of workplace bullying<br>• To explore how graduate health management trainees, define, experience and respond to workplace bullying | • Graduate health management trainees in NSW healthcare settings | General inductive approach<br><br>Content analysis<br><br>Thematic analysis | • Identification of overarching domains, themes and sub-themes<br>• Validating study findings<br>• Theoretical interpretation of emergent findings |
| | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?<br>**RQ4**: How do health managers support to encourage reporting of workplace bullying?<br>**RQ5:** What approaches (if any) does their organisation have in place for dealing with workplace bullying?<br>**RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 2.2 Respondent validation interviews | • To validate/ check the findings from the focus groups and individual interviews<br>• To explore emergent themes | • Graduate health management trainees in NSW healthcare settings | Qualitative interviews<br><br>Content analysis<br><br>Thematic analysis<br><br>General inductive approach | • Interpreting study findings |
| | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours? | 2.3 Theoretical interpretation | • To interpret emergent findings | • Graduate health management trainees in NSW healthcare settings | Content analysis<br><br>Thematic analysis | • Theoretical interpretation of findings |

| Research phase | Key research question | Component | Aim/strategy | Participants/data sources | Data analysis method | Output |
|---|---|---|---|---|---|---|
| **Phase two**<br><br>Development of provisional anti-bullying learning framework | **RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 3.1<br>Draft provisional learning framework | • To develop a best-practice framework focused on workplace bullying in healthcare settings<br>• To test a proof of concept | • Expert reference group of national and international researchers/ academics/ experts in the field of workplace bullying and/or healthcare | Qualitative survey - online<br><br>Quantitative survey- online<br><br>Proof of concept | • Provisional anti-bullying learning framework |
| | **RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 3.2<br>Expert reference group | • To evaluate key principles and effective practices for learning and development frameworks focused on workplace bullying<br>• To test a proof of concept | • Expert reference group of national and international researchers/ academics/ experts in the field of work-place bullying and/or healthcare | Qualitative survey - online<br><br>Quantitative survey- online<br><br>Proof of concept | • Provisional anti-bullying learning framework |

## 3.11 Conclusion

This chapter has provided a detailed account of the research methodology, design and strategy used across the two phases of the study. Phase one used a qualitative research approach with focus groups, individual interviews and validation interviews. Phase two used qualitative and quantitative methods, with an expert reference group to provide feedback on the provisional anti-bullying learning framework developed specifically for this study and informed by the literature and findings. An outline of the provisional anti-bullying learning framework was presented (Appendix 3).

A detailed discussion was provided regarding qualitative methods used and the composition of each of the data sets. Discussion was provided regarding the methodology for analysing the data and results and the nine emergent themes, which will be explored in detail in Chapters 4 and 5. The process for ethics approval was outlined and the reflective process undertaken by the researcher during the study was discussed.

There were two overarching domains which emerged from the analysis of these findings: (1) perceptions of workplace bullying (Chapter 4); and (2) strategies for dealing with workplace bullying (Chapter 5). The next two chapters will comprehensively present the results from this analysis across the three qualitative data collection methods: (1) focus groups; (2) individual interviews; and (3) respondent validation interviews.

# Chapter 4: Results – Perceptions of Workplace Bullying

## 4.1 Introduction

The purpose of this study was to investigate GHMTs' perceptions of workplace bullying behaviours. Phase one involved three qualitative data collection methods: (1) focus groups; (2) individual interviews; and (3) respondent validation interviews, which were used to elicit a range of perceptions and experiences of workplace bullying. Two overarching domains emerged from the findings in phase one. These domains were: (1) perceptions of workplace bullying; and (2) strategies for dealing with workplace bullying. This chapter presents the findings on the first overarching domain, perceptions of workplace bullying. The following chapter, Chapter 5, will detail the results which focus on the second overarching domain, strategies for dealing with workplace bullying.

This chapter is presented in two sections. The first section reports the five themes which comprise the overarching domain of perceptions of workplace bullying. These themes emerged from thematic analysis (Nowell et al 2017; Morgan 2013; Vaismoradi, Turunan and Bondos 2013; Braun and Clarke 2006) of GHMTs' perceptions and experiences, identified from the focus groups and individual interviews. These five themes were: (1) level of awareness of workplace bullying; (2) behaviours which constitute workplace bullying; (3) causes of workplace bullying; (4) consequences of workplace bullying; and (5) the nature of workplace bullying. Findings from both the focus groups and the individual interviews are presented for each identified theme. Exemplar quotes are provided to illustrate each theme. Quotes are labelled, and participants numbered to indicate the participant or data set – focus group (FGP1) or individual interview (IP1) – to which the comment is attributed.

The second section presents the findings from respondent validation interviews. Exemplar quotes are provided to illustrate each theme. Quotes are labelled, and participants numbered (e.g. RVP2) to indicate which respondent the comment is attributed to. A summary is provided for further explanation.

As a result of these findings, the researcher posed five key questions for the validation interviews to further explore key themes. These key themes were:

Why workplace bullying is not reported (Theme 1: Level of awareness of workplace bullying and Theme 8: Reporting of workplace bullying)

The repeated nature of bullying behaviours (Theme 6: Nature of workplace bullying)

Importance of positional power (Theme 2: Behaviours which constitute workplace bullying and Theme 6: Nature of bullying behaviours)

Access to further support and strategies which may be effective to deal with workplace bullying (Theme 5: Dealing with workplace bullying and Theme 9: Training needs).

These key aspects, which emerged from the themes identified in the focus groups and the individual interviews, warranted further exploration.

### 4.1.1 Emergent themes

Similar themes and sub-themes emerged in the focus groups and the individual interviews. The results from the individual interviews indicated that the key sub-themes were intimidation (T2.2); talking about others (T2.6); organisational culture (T5.2); communication (T7.2); and responsibility (T8.1). The results from the focus groups and the individual interviews produced generally equivalent themes. Table 4.1 provides a summary of the coding indicating the themes and the sub-themes extracted from the focus groups and individual interview data. Each of the nine themes contained a number of interrelated concepts, which were identified during the thematic analysis. Descriptions of these sub-themes are provided in Appendix 9. Further detailed discussion and exploration of these themes will follow in Chapter 5.

Each of the themes also aligned with two overarching domains which emerged regarding this study: *perceptions* of workplace bullying and *strategies* for dealing with workplace bullying. The order of the themes evolved during the analysis of the data and was linked to the structure of the questions posed to the participants across the data sets. The researcher developed the interview schedule to follow a logical sequence and provide some order for the participants. The sequence of the questions went from the broadest to the narrowest questions, and from the least sensitive or least difficult questions, to the potentially more sensitive or most difficult questions regarding workplace bullying.

**Table 4.1** Identified themes and sub-themes

| Overarching domain | Theme | Sub-theme |
|---|---|---|
| Perceptions of workplace bullying | 1. Level of awareness of workplace bullying | 1.1 Effect on the co-worker<br>1.2 Victim's experience<br>1.3 Wrongdoing |
| Perceptions of workplace bullying | 2. Behaviours which constitute workplace bullying | 2.1 Abuse of authority<br>2.2 Intimidation<br>2.3 Isolating<br>2.4 Public humiliation<br>2.5 Racism<br>2.6 Talking about others |
| Perceptions of workplace bullying | 3. Causes of workplace bullying | 3.1 Demographics<br>3.2 Personal issues<br>3.3 Threat<br>3.4 Unintended |
| Perceptions of workplace bullying | 4. Consequences of workplace bullying | 4.1 For those engaging in bullying<br>4.2 For those being bullied |
| Strategies for dealing with workplace bullying | 5. Dealing with workplace bullying | 5.1 Manager to staff<br>5.2 Organisational culture<br>5.3 Staff to staff<br>5.4 Strategies for dealing with bullying in the workplace |
| Perceptions of workplace bullying | 6. Nature of workplace bullying | 6.1 Grievances<br>6.2 Organisational culture<br>6.3 Overt<br>6.4 Patterns<br>6.5 Power<br>6.6 Recognition |
| Strategies for dealing with workplace bullying | 7. Positive relationships | 7.1 Acknowledging positive actions<br>7.2 Communication<br>7.3 Other strategies<br>7.4 Understanding |
| Strategies for dealing with workplace bullying | 8. Reporting of workplace bullying | 8.1 Responsibility |
| Strategies for dealing with workplace bullying | 9. Training needs | 9.1 Existing training<br>9.2 Training needs |

The theme of organisational culture was strong across the focus groups and individual interviews and was evident in being described as both strategies for dealing with workplace bullying (Theme 5) and for the nature of workplace bullying (Theme 6). A finding from the participants was their discussion of what behaviours constitute workplace bullying and the range of examples they provided to illustrate abuse of authority (T2.1);

intimidation (T2.2); public humiliation (T2.4); and talking about others (T2.6), which in turn impact on the culture of an organisation.

Figure 4.1 provides a graphical representation of the themes and sub-themes identified in this study. The figure outlines the sub-themes which emerged from the participants description of their perceptions and experiences of workplace bullying. The interpretation and analysis of these sub-themes enabled the researcher to refine, relate and name the themes.

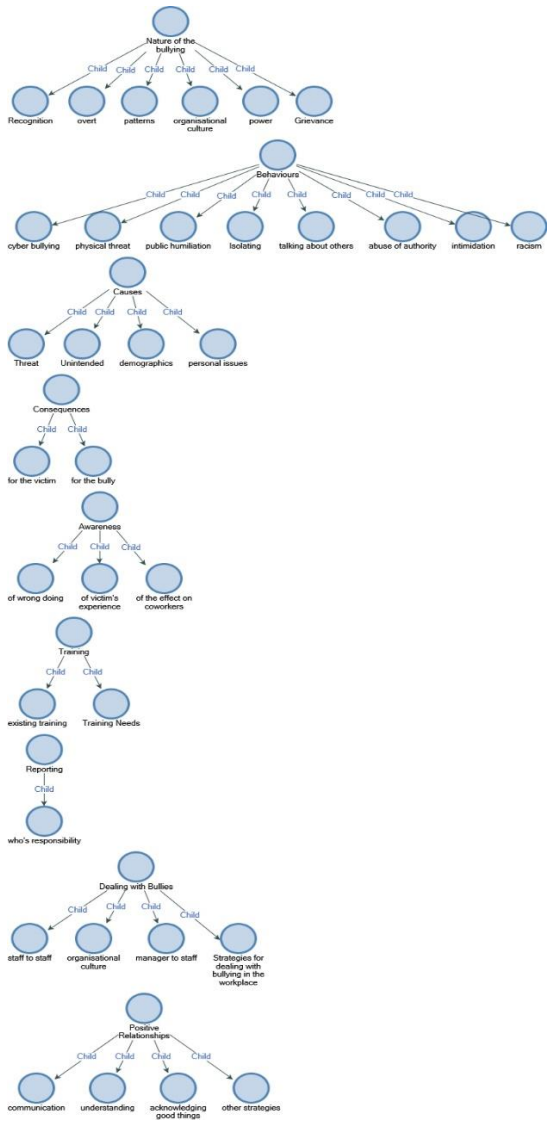


**Figure 4.1:** Graphical representation of the themes and sub-themes.

A comparison of the number of coding references for each of the nine identified themes and the sub-themes between the focus groups and the individual interviews is presented

in Figure 4.2. The results demonstrate that for both the focus groups and individual interviews there were a similar number of references in their responses for Theme 1 (level of awareness of workplace bullying); Theme 2 (behaviours which constitute workplace bullying) Theme 7 (positive relationships); Theme 8 (reporting of workplace bullying); and Theme 9 (training needs). However, the responses from the participants in the individual interviews provided greater discussion of Theme 3 (causes of workplace bullying); Theme 4 (consequences of workplace bullying); Theme 5 (dealing with workplace bullying); and, in particular, sub-theme 5.2 (organisational culture) and Theme 6 (nature of workplace bullying) than those in the focus groups.

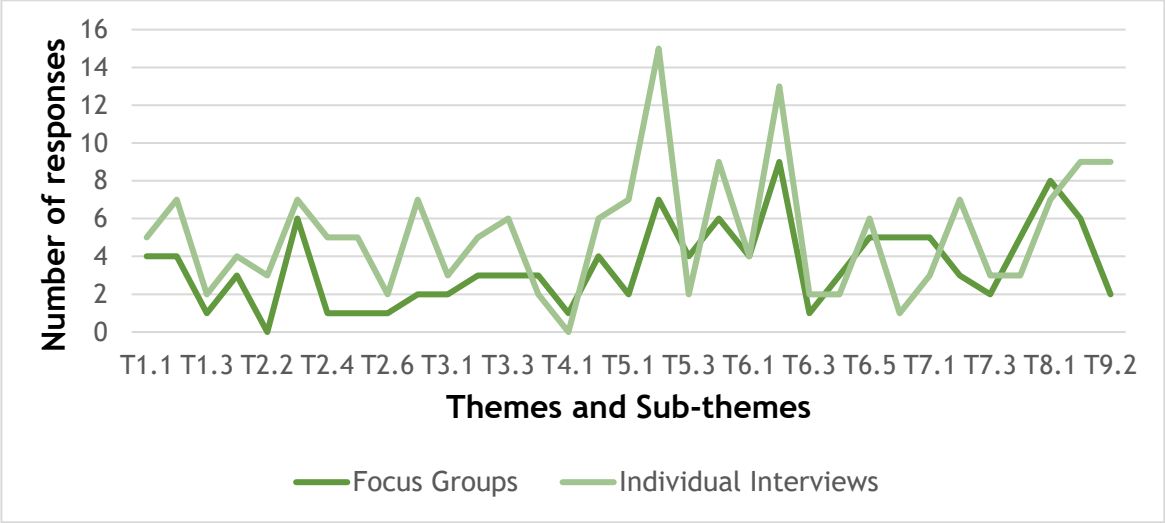


**Figure 4.2:** Response themes – focus groups compared to individual interviews.

Table 4.2 provides a combined summary of the nine themes and sub-themes for both the focus groups and the individual interviews based on the thematic analysis and coding conducted. The number of sources, coding references, words coded, and paragraphs coded for each theme and sub-theme have been collated and tabulated as the researcher coded each transcript separately and coded every segment of text which was relevant to specifically address the research question. The number for each is important as at this stage the researcher needed to code for as many potential codes and themes as possible in order to see emerging patterns. This allowed for patterns to emerge, and data identified by the same code were collated together into themes and sub-themes. The number of sources indicates the number of participants who described this sub-theme. A finding from the number of words coded indicates that the participants were able to describe their perceptions of workplace bullying in regard to the number of sub-themes, specifically,

effect on the co-worker (T1.1); abuse of authority (T2.1); personal issues (T3.2); consequences for those being bullied (T4.2); organisational culture (T5.2 and T6.2); other strategies (T7.3); responsibility (T8.1) and training needs (T9.2). Descriptions of these sub-themes are provided in Appendix 10.

**Table 4.2:** Summary of coding for **both** focus groups and individual interviews

| Themes<br>Sub-themes | Number of sources | Number of coding references | Number of words coded | Number of paragraphs coded |
|---|---|---|---|---|
| 1. Level of awareness of workplace bullying | | | | |
| Effect on the co-worker (T1.1) | 7 | 23 | 1125 | 36 |
| Victim's experience (T1.2) | 9 | 23 | 992 | 26 |
| Wrongdoing (T1.3) | 6 | 8 | 229 | 8 |
| 2.Behaviours which constitute workplace bullying | | | | |
| Abuse of authority (T2.1) | 7 | 26 | 1263 | 29 |
| Intimidation (T2.2) | 8 | 28 | 978 | 37 |
| Isolating (T2.3) | 7 | 13 | 325 | 13 |
| Public humiliation (T2.4) | 5 | 6 | 200 | 6 |
| Racism (T2.5) | 3 | 8 | 361 | 13 |
| Talking about others (T2.6) | 7 | 19 | 640 | 19 |
| 3. Causes of workplace bullying | | | | |
| Demographics (T3.1) | 8 | 23 | 1173 | 46 |
| Personal issues (T3.2) | 7 | 25 | 1566 | 56 |
| Threat (T3.3) | 8 | 27 | 1481 | 33 |
| Unintended (T3.4) | 7 | 17 | 621 | 24 |
| 4. Consequences of workplace bullying | | | | |
| For those engaging in bullying (T4.1) | 4 | 6 | 277 | 13 |
| For those being bullied (T4.2) | 10 | 27 | 1450 | 35 |
| 5.Dealing with workplace bullying | | | | |
| Manager to staff (T5.1) | 10 | 22 | 1451 | 26 |
| Organisational culture (T5.2) | 10 | 50 | 3500 | 59 |
| Staff to staff (T5.3) | 6 | 15 | 926 | 15 |
| Strategies for dealing with bullying in the workplace (T5.4) | 8 | 46 | 2894 | 117 |
| 6. Nature of workplace bullying | | | | |
| Grievances (T6.1) | 3 | 6 | 416 | 6 |
| Organisational culture (T6.2) | 8 | 48 | 3128 | 102 |
| Overt (T6.3) | 3 | 4 | 216 | 4 |
| Patterns (T6.4) | 4 | 12 | 844 | 24 |
| Power (T6.5) | 10 | 38 | 1859 | 58 |
| Recognition (T6.6) | 9 | 37 | 1983 | 52 |

| Themes<br>Sub-themes | Number of sources | Number of coding references | Number of words coded | Number of paragraphs coded |
|---|---|---|---|---|
| 7. Positive relationships | | | | |
| Acknowledging positive actions (T7.1) | 3 | 10 | 477 | 20 |
| Communication (T7.2) | 9 | 19 | 1112 | 21 |
| Other strategies (T7.3) | 8 | 31 | 2506 | 67 |
| Understanding (T7.4) | 4 | 5 | 285 | 9 |
| 8.Reporting of workplace bullying | | | | |
| Responsibility (T8.1) | 9 | 33 | 2247 | 58 |
| 9.Training needs | | | | |
| Existing training (T9.1) | 7 | 20 | 1310 | 50 |
| Training needs (T9.2) | 6 | 29 | 1883 | 47 |

## 4.2 Domain one – perceptions of workplace bullying

A total of five themes focused on GHMTs' perceptions of workplace bullying emerged from the three data sets (focus groups, individual interviews and validation interviews). These five themes were: (1) level of awareness of workplace bullying; (2) behaviours which constitute workplace bullying; (3) causes of workplace bullying; (4) consequences of workplace bullying; and (5) nature of workplace bullying (Figure 4.1).

### 4.2.1 Theme 1: Level of awareness of workplace bullying

Participants in both the focus groups and individual interviews described whether the person bullying was aware of their behaviour and the effects of this on co-workers/colleagues. Participants also reported their experiences of workplace bullying and how they felt about the behaviour either happening to them or when witnessing inappropriate behaviours. They also highlighted uncertainty as to whether some colleagues perceived their behaviour to be inappropriate. This indicated a level of awareness from participants regarding workplace bullying as they were able to recognise inappropriate behaviours and the impact of these behaviours on individuals. This was identified as a theme with three sub-themes: effect on the co-worker (T1.1), victim's experience (T1.2) and wrongdoing (T1.3).

***Examples of workplace bullying***

Participant discussions in both the focus groups and individual interviews provided specific examples of workplace bullying incidents either witnessed or known of – such as hearing

heated and demeaning conversations through a doorway ('everyone hears stories' [IP3]); a worker undermining a colleague who had overlapping roles and responsibilities; a worker making comments about another person's physical appearance; people being singled out over genuine medical conditions; publicly terminating someone's employment; unfair treatment; and being singled out and reprimanded publicly. IP1 sounded timid when providing their example, suggesting they may have been speaking from a lived experience rather than an observed incident.

> Put people down in front of other people or talk behind their backs about them. [IP1] (Theme 1.3: Wrongdoing)

Further examples of workplace bullying provided by participants included:

> Name calling, deliberately excluding people, trying to make people look bad in certain situations. [IP2] (Theme 1.3: Wrongdoing)

> [Bullying] can be portrayed in different ways for different people. [IP2] (Theme 1.1: Effect on the co-worker)

IP2's comment highlights the challenges of dealing effectively with workplace bullying, as each individual's perceptions and experiences will determine whether they view behaviour as workplace bullying and this, in turn, will affect colleagues due to the potential to under-report workplace bullying. Participants also provided some examples of what they perceived to be types of workplace bullying that were, in fact, incidents where colleagues' actions were thoughtless or unhelpful (i.e. not offering to buy coffee; not holding the lift doors; borrowing equipment without asking). This also reinforces the difficulties in identifying incidents of workplace bullying and adds to the limited awareness of workplace bullying by some management trainees. Participants did not agree on a consistent definition of workplace bullying.

> I think intimidation as well as breaching the boundaries of interpersonal space. [FGP4] (Theme 1.1: Effect on the co-worker)

IP4 commented that incidents of workplace bullying which occurred in front of others would be degrading to the person being bullied, regardless of whether they were a management trainee or a more experienced member of staff. IP4's response demonstrates they have a level of awareness of the impact of workplace bullying on those being bullied.

> Making smartarse comments [about someone] in public forums would have an impact on them. [IP4] (Theme 1.3: Wrongdoing)

### *Ability to perform tasks*

The key sub-themes emerging from the focus group data describe the effect on the co-worker and the victim's experience of workplace bullying (Themes 1.1 and 1.2). The most frequently reported experience amongst the management trainees was the impact of workplace bullying on their self-perceptions of their ability to perform the tasks of the role and the impact this had on their self-worth and wellbeing. The theme regarding the victim's experience (Theme 1.2) which emerged from the individual interviews was similar to that identified in the focus groups. The most frequently reported experiences as a result of workplace bullying amongst the management trainees were a feeling of inadequacy in completing the requirements of their role and that other staff highlighted their inexperience. The importance participants placed on having one's work valued is highlighted by participants who indicated that to not do so is a form of workplace bullying. To illustrate, FGP1's response demonstrates their perception that behaviour which does not value the work they are tasked with, as a management trainee, constitutes workplace bullying.

> Behaviours that do not give us value in work and which reduces our self-esteem. [FGP1] (Theme 1.1: Effect on the co-worker)

These experiences, in turn, impacted on management trainees' ability to respond to workplace bullying, as well as contributing to their feelings of self-worth. IP3's response indicates that they feel their self-worth is challenged when they are not provided support and sufficient time to complete tasks. This respondent also commented that, as a management trainee, they are in a learning environment and this is not always acknowledged by some of their colleagues. IP3 stated that they were working in units or portfolios within healthcare management in which they had no previous experience (e.g. finance).

> One of the key things is that [bullying] challenges a person's self-worth, that they feel challenged in that way. [IP3] (Theme 1.2: Victim's experience)

This is further evidenced by participants' reports that, given their inexperience and limited skills, they felt they were often provided with insufficient time to complete the work (Theme 1.2: Victim's experience). A consequence of not being able to complete the work was that they would then be tasked with what they described as 'easier' or meaningless projects. Participants perceived that the act of having their inexperience or limited skills brought to the attention of others is a form of workplace bullying.

Management trainees also commented that being excluded from meetings or specific projects due to their inexperience was a form of workplace bullying.

> I will also say there would be passive forms of bullying, not including people to come to meetings, or to be put on projects, especially for trainees. [IP8] (Theme 1.1: Effect on the co-worker)

> It's the repeated day in, day out actions that are deliberate in their intent to single people out. [IP4] (Theme 1.1: Effect on the co-worker)

***Lack of support from colleagues***

Further discussion in the focus group highlighted that some participants felt that if they were not supported by colleagues, especially when they were learning new tasks or processes, then this was a form of workplace bullying. Lack of support is not necessarily workplace bullying, however, and this again illustrates a limited awareness among some management trainees of what constitutes workplace bullying. FGP2's response highlights their perception that a supportive workplace environment encourages management trainees to contribute productively.

> If you support someone, they're more likely to be productive. [FGP2] (Theme 1.1: Effect on the co-worker)

***Personal impact of workplace bullying***

FGP6 and IP2's responses below describe the personal impact of workplace bullying and the feelings of avoidance, especially if they are not valued or supported. These focus group excerpts reflect the feelings of inadequacy among management trainees when other staff highlight their inexperience.

> When I was a trainee, I just felt like I was so exhausted, and I was actually crying. I was upset at work it's just devastating. I didn't want to go to work, didn't want to work in health anymore. [FGP6] (Themes 1.1: Effect on the co-worker and 1.2: Victim's experience and Theme 4.2: For those being bullied)

> That the sort of emotional bullying is probably the worst kind and has a greater personal impact. [IP2] (Theme 1.1: Effect on the co-worker)

A finding of the study was that, at times, more senior staff assumed management trainees were more capable than they actually were, and deliberately singled them out in meetings to humiliate them (Theme 1.1: Effect on the co-worker), thereby exposing their lack of knowledge.

### *Limited understanding of what constitutes workplace bullying*

Participants reported that individuals' perceptions of what behaviour is and is not acceptable varies depending on the individual and the situation. Participants also described the challenge of knowing when a behaviour constitutes workplace bullying, thereby demonstrating their limited awareness of workplace bullying (Theme 1.2: Victim's experience).

> People are going to have different places where they draw the line in terms of what's acceptable and what's not to them. [FGP 4] (Theme 1.2: Victim's experience)
>
> Whether it's perceived or not, like it's very individual in how you experience [bullying]. [FGP5] (Theme 1.2: Victim's experience)
>
> [The behaviour's] done in a manner that's unacceptable to the other person. [FGP1] (Theme 1.1: Effect on the co-worker)

### *Positional power*

IP6, for example, described feeling uncomfortable when a colleague spoke to them about another colleague in a negative way. They stated they were uncomfortable being exposed to, and included in, this type of workplace bullying, but did not think they were in a position to say anything to either the colleague or their manager. This demonstrates a limited understanding of procedures for reporting workplace bullying.

> She also used to put her down a lot to me, calling her dumb and stupid, and I felt uncomfortable. [IP6] (Theme 1.3: Wrongdoing)

A number of participants spoke about their perception of workplace bullying from the perspective of power and the role the individual has within an organisation rather than specific behaviours. The theme of power is explored in further detail in Theme 6: Nature of workplace bullying in relation to organisational culture and the hierarchical structures in healthcare organisations.

> In terms of what I perceived workplace bullying to be … I think it's more in terms of power and the role of someone. [IP1] (Theme 1.3: Wrongdoing)

The experiences described by several participants emphasise the impact being aware of workplace bullying has on the ability of management trainees to respond to workplace bullying. However, another respondent, IP7 commented they would say something to a colleague and ask them to stop speaking to them about other members of staff, adding 'I'm just that type of person who would speak out' [IP7]. This demonstrates that IP7 has

developed a range of skills and personal characteristics which would enable them to report workplace bullying.

***Summary***

Theme one focused on the level of awareness of workplace bullying which incorporates the negative impacts on colleagues witnessing workplace bullying as well as those individuals experiencing workplace bullying. Level of awareness also includes management trainees being able to recognise behaviours and actions as being inappropriate in the workplace though there was limited awareness and consistency of what constitutes workplace bullying as some examples provided by participants were not incidents of workplace bullying. This theme also highlighted the perception from management trainees of the lack of awareness the person engaging in bullying has and the effect of their behaviour on individuals and teams. As no participant admitted to displaying bullying behaviour themselves, they generally provided third-party observations.

### 4.2.2 Theme 2: Behaviours which constitute workplace bullying

Participants in both the focus groups and individual interviews described a range of workplace bullying incidents they had witnessed or been subjected to in their role as a GHMT. Participants spoke about the misuse of positional power and that this may include deliberate obstruction of career progression. Participants also spoke about incidents where there was direct personal harassment; repeated or unjustified criticism; and negative personal comments, either racial in nature or name-calling behind their back or in a public forum. This indicated that participants were able to describe behaviours which constitute workplace bullying and was identified as a theme with six sub-themes: abuse of authority (T2.1); intimidation (T2.2); isolating (T2.3); public humiliation (T2.4); racism (T2.5) and talking about others (T2.6).

***Intimidation and positional power***

A key theme which emerged from both the focus groups and the individual interviews was intimidation (Theme 2.2), which incorporates management trainees being afraid or cautious of the person enacting workplace bullying. The most frequently reported experience within the context of workplace bullying amongst the management trainees was feeling intimidated by others who were either more senior than them or had more

experience and/or greater knowledge (Theme 2.2: Intimidation) and therefore were perceived to have greater power. Participants described intimidation arising from the words and actions of colleagues including where people positioned themselves around a table in meetings or at their workstation to produce the same intimidatory effect (Theme 2.2). Participants commented that it was not always having power or authority that was intimidating but, rather, that it was the way people used their power which constituted workplace bullying.

> A certain type of people especially in power are expected to be very authoritative and direct but sometimes the way they use that power is still quite bullying. [FGP7] (Theme 2.1: Abuse of authority and Theme 6.5: Power)

Other key themes discussed by participants in the focus groups were abuse of authority (Theme 2.1) which involved staff in perceived positions of power using that power to engage in workplace bullying or to influence the behaviour of others. Talking about others (Theme 2.6) which included being spoken negatively about to colleagues; isolating (Theme 2.3), which incorporated feeling separated from colleagues in the team or wider work environment; and public humiliation (Theme 2.4), which included disgracing or deliberately embarrassing someone while others are watching, were also discussed frequently by participants in the individual interviews.

The most frequently reported experience among the management trainees was being spoken about behind their backs (Theme 2.6: Talking about others) or off-the-cuff backhanded comments (Theme 2.4: Public humiliation). This was further evidenced by some participants commenting they were specifically singled out (Theme 2.2: Intimidation) and felt uncomfortable among other colleagues. The following excerpts from IP1 and IP5 illustrate these themes.

> Manipulating my thoughts of a particular person or situation. [IP1] (Themes 2.4: Public humiliation and 2.6: Talking about others)

> Deliberately excluding people, trying to make people look bad in certain situations. [IP5] (Themes 2.2: Intimidation and 2.3: Isolating)

Several participants spoke about senior executives whose manner was often quite blunt to the point of telling staff what to do, or not accepting any explanation for not meeting a deadline. FGP3 recalled an incident where a senior executive stood over them at their workstation to chastise them about the errors in a report they had completed, which made them feel uncomfortable and physically intimidated. Participants spoke to different ways

in which intimidation was manifest: verbal, confronting and behind one's back; physical, standing over them as they were sitting; and proximal, standing up in their face in close proximity or physically blocking them from the group.

> Behaviour that continually makes someone feel uncomfortable or harassed. [FGP3] (Theme 2.2: Intimidation)

> Everyone's pushing their own agenda and I think that can be a contributing factor to inappropriate behaviour which results in bullies. [FGP2] (Theme 2.1: Abuse of authority)

Further discussion within this focus group explored the use of power as a form of workplace bullying. Participants commented on some middle managers who have career aspirations taking the opportunity to ensure they were seated next to the most senior executive at meetings. FGP4 commented that on several occasions they had been told to move to another position in the room in certain meetings. There was broad discussion amongst participants regarding how they perceived the use of power as a form of workplace bullying ranging from physical proximity to position or length of time in the organisation to age of the person. Participants did not agree on a consistent view of what constitutes power as a form of workplace bullying.

> To intimidate someone or do something with the intent of getting want you want. [FGP5] (Theme 2.2: Intimidation)

> Sometimes I feel so intimated by [where she sits], almost on top of me. [FGP1] (Theme 2.2: Intimidation)

A number of participants also spoke about behaviours such as 'purposely embarrassing someone' [FGP8] (Theme 2.4: Public humiliation) as a form of workplace bullying.

> You're spoken to negatively in the context of everyone else isn't. [FGP3] (Theme 2.4: Public humiliation)

> Outward things, name calling, deliberately excluding people, trying to make people look bad in certain situations. [IP4] (Theme 2.4: Public humiliation)

Participants reported being cautioned that 'certain staff would treat you differently depending on what you looked like' [FGP4] (Theme 2.5: Racism). Participants described behaviour with the intent to personally attack someone to discriminate against their race, culture or sexual preferences [IP4, IP7] (Theme 2.5: Racism). IP8, for example, described a series of incidents in which they were singled out due to their cultural and linguistic

background. As a result, IP8 was reluctant to contribute to meetings or share opinions, which impacted on their progress as a management trainee.

> A person made a comment to me about my culture on numerous occasions in a negative way. [IP8]. (Theme 2.5: Racism)

***Subtle behaviours***

Several participants also spoke about the fact that some inappropriate behaviours are quite subtle, making it difficult to identify them as incidents of workplace bullying, which was a barrier to reporting this behaviour: 'sometimes it is not clear' [FGP6] (Theme 2: Behaviours which constitute workplace bullying). Participants revealed that in addition to not understanding the existing processes for reporting workplace bullying, the uncertainty of recognising what constitutes workplace bullying often impeded their ability to report. Workplace bullying can be covert, and several participants spoke about passive forms of workplace bullying such as not providing opportunities for management trainees, either in regard to not being included in projects or not being receptive to any initiative they showed. Some participants also made a distinction between overt and covert types of bullying.

> One is obviously probably easier to … identify, than the other. [IP3] (Theme 2.2: Intimidation)

> Overt behaviours would be physical. [IP5] (Theme 2.2: Intimidation)

***Abuse of authority***

A number of participants spoke about the abuse of authority (Theme 2.1), which could involve taking advantage of staff in a less senior role or limiting the opportunities provided to management trainees. Participants spoke about what they perceived to be unfair treatment and favouritism in the workplace. Management trainees perceived unfair treatment to be that which singled them out as trainees with limited experience in the health sector.

> You're not capable of doing that ... you're only a trainee. [FGP6] (Theme 2.2: Intimidation)

Participants shared deeper insights for Theme 2.6 (Talking about others), by unpacking that talking about others could mean both talking about particular people or talking about other organisations. IP6 described negative and adverse impacts of this including creation

of silos that were both internal and external to one's work team ultimately leading to dysfunctional work teams, 'like the butterfly effect' [IP6].

> A manager may talk badly, in a negative way about another organisation and I think these perceptions flow down to the whole team and then you start to develop those negative perceptions of that organisation. [IP6] (Theme 2.6: Talking about others)

> Talking about people to others and undermining them in that way is like excluding. [FGP4] (Theme 2.6: Talking about others)

> Gossiping behind people's back. [IP7] (Themes 2.4: Public humiliation and 2.6: Talking about others)

Several participants spoke about being excluded from particular groups in the workplace. Strategies to do this were both subtle and overt, including having a door literally closed on them to signify they were not wanted in the room. Participants pondered whether they were imagining that this was the case (Theme 2.3: Isolating). Participants commented that this would have a negative impact on their productivity as they felt they were constantly on edge. The idea of a 'gang mentality' [FGP4] was also mentioned, with the comment regarding a group of people and one being a ringleader intentionally making certain people feel uncomfortable.

> Trying to make people feel isolated, powerless. [IP4] (Theme 2.3: Isolating)

***Summary***

Theme 2: Behaviours which constitute workplace bullying, encompassed a variety of behaviours, with the key sub-themes of 2.1 (abuse of authority) included deliberately impeding a person's career progress; giving staff inadequate time or resources or otherwise making it difficult to do their job; undermining proper process; favouritism in the workplace; using performance management as a way of slowly ousting a person from the team rather than a method of helping them improve; and refusal to give help when asked for it, telling management trainees they had better 'figure it out' [FGP2, FGP3, FGP6]. Theme 2.2 (intimidation) included colleagues warning management trainees remarks they made to them about others were in confidence, making them feel conflicted about making a complaint. Theme 2.3 (isolating) included inadequate supervision, not including people in meetings or projects and other related behaviour. Themes 2.4 (public humiliation) and 2.6 (talking about others) included running down other staff or teams, branches or organisations to a junior staff member or other inappropriate or unprofessional behaviour.

### 4.2.3 Theme 3: Causes of workplace bullying

Participants in both the focus groups and individual interviews were able to describe factors which contribute to people enacting workplace bullying. Participants spoke about certain types of people defined by age, experience or the number of years working in the organisation as contributing factors. Participants described a range of personal issues where the source of workplace bullying was problems in a colleague's personal life which manifested in acting out inappropriately as a way to release their frustration or anger. Participants also described cases where someone may personally dislike the victim for some reason or use the victim for 'social climbing' purposes – that is, to ingratiate themselves with others. Participants identified power as a cause of workplace bullying, either positional power or withholding information or resources. Participants also described incidents which were not intended as workplace bullying, as the person might not have been aware that their behaviour was negatively impacting on a colleague. This indicated that participants were able to describe causes of workplace bullying and was identified as a theme with four sub-themes: demographics (T3.1); personal issues (T3.2); threat (T3.3); and unintended (T3.4).

***Personal issues***

The key theme emerging from the focus group participants and individual interviews were personal issues (Theme 3.2), which involved factors in someone's private life impacting on their behaviour at work. Participants commented that people experiencing pressure in their personal lives that may allow workplace bullying to occur to them, may have feelings of guilt or inadequacy about their personal situation or fear that something could happen to their position if they were to speak out. Participants spoke about the increased pressure and stress for staff working in the healthcare sector regarding performance measures and budgets, which impacts on their personal lives as well (Theme 3.2: Personal issues).

> Sometimes people could be having – a series of events have happened where their temper is quite short, and they might blow. [IP8] (Theme 3.2: Personal issues)

> Other times it could be personal insecurities, people that are insecure and they bully that way. I mean it would be actual personal issues from home that people bring with them and they don't realise that it's affecting the workplace and their moods. [IP2] (Theme 3.2: Personal issues)

> Nobody, whether they're at work or in their real world, life, should be exposed to that sort of behaviour. [IP3] (Theme 3.4: Unintended)

*Increased stress on health managers*

Themes 3.3, threat – manifesting as a threat to inflict damage to someone's reputation – and unintended forms of workplace bullying (Theme 3.4), which incorporated unforeseen or unexpected consequences of workplace bullying, were also discussed by the focus group participants. The most frequently reported experience among the management trainees was the increased pressure and stress for staff working in the healthcare sector, which impacts on their personal lives (Theme 3.2) by, for example, leading to staff speaking inappropriately to their family and friends. The increased pressure experienced by healthcare managers regarding performance measures and budgets may lead to incidents of workplace bullying. This was further evidenced by some participants who had observed acute personal stress among their colleagues (Theme 3.2). Participants spoke of, for example, budgets or staffing requirements being frozen, which affected performance efficiency, and they had witnessed senior managers belittle colleagues due to this stress. The following quotation illustrates these themes.

> Movement of the organisation towards its goals … performance, efficiency, meeting targets. The whole organisation gets stressed and [bullying can] happen because of this. [FGP7] (Themes 3.2: Personal issues and 3.4: Unintended)

The participants in this focus group elucidated this theme further by discussing phases when workloads in their organisations were high. They spoke about times when budgets were being built; the prospect of restructures; and key staff leaving or moving to other positions, and the need to backfill key roles. FGP2 also made mention of issues when heading into government general elections, stating 'everything moves into caretaker mode and projects are frozen'. This discussion exemplified the link between the inability to cope with stress and the uncertainty of staff's position in this changing environment leading to workplace bullying (Themes 3.2: Personal issues). Theme 3.4, unintended forms of workplace bullying, was also highlighted during this discussion, as people were often unaware of the consequences on colleagues of their inappropriate behaviour during these periods of pressure. Participants also spoke to the potential of unintentional incidents of workplace bullying. They discussed how, due to the pressure, at work some people may inadvertently behave in an unacceptable way due to their frustrations or annoyance. However, some participants disagreed that workplace bullying could be unintentional and that unacceptable behaviour at work was unacceptable behaviour no matter what circumstances individuals may find themselves in.

> Makes them feel like they're pressured into doing something that they're not comfortable with. [FGP6] (Theme 3.3: Threat)

> I think it's human. Bullying happens everywhere, and you may not realise it. [FGP1] (Theme 3.4: Unintended)

> They're gaining pleasure from someone else's displeasure, discomfort. So, yeah, it's intentional, deliberate. [FGP3] (Theme 3.3: Threat)

***Job security***

The participants spoke about how other staff view management trainees as a potential threat. Some participants commented that as roles in healthcare become more uncertain and fluid, staff see management trainees as taking jobs away from them. The researcher observed some frustration from one participant when they were speaking about this issue, suggesting that they had experienced not being recognised for their knowledge. Insecurity amongst managers in a health context was also discussed by participants: insecurity about their positions, skills, competencies, knowledge and; about other people's position (Theme 3.3: Threat). Participants also discussed that this may be due to finite resources and multiple restructures over a career life cycle; with the constant challenge of having requests denied as a result, management trainees indicated that these staff may unintentionally engage in workplace bullying as they are increasingly disengaged from their job (Theme 3.4: Unintended).

> People see up and comers or they see people with a really good knowledge base … and that concerns them and patch protecting. I just think that insecurity generally. [FGP4] (Themes 3.2: Personal issues and 3.3: Threat and Theme 6.6: Recognition)

A number of participants also commented on the unique experience of working in the healthcare sector where they believe there is a high rate of burnout, particularly among middle managers, which they felt was a cause of workplace bullying.

> I think for middle managers it's probably burnout. [FGP2] (Theme 3.1: Demographics)

***Lack of innovation***

Theme 3.4, unintended forms of workplace bullying, was also highlighted, with participants commenting on the perceived lack of innovation by some in the workforce who have held the same position for several years. They indicated that as soon as someone, perhaps younger, has an idea or a different view, they may be subjected to workplace bullying. Another finding within the healthcare sector was the identification of a hierarchical structure (Theme 3.1: Demographics), in part created by an ageing

workforce, where some senior positions have been held by the same person for a considerable length of time or senior clinicians have been working for the same organisation for a number of years. Participants commented that older staff usually hold the more senior roles and there was discussion amongst participants regarding behaviour which could be viewed as 'rites of passage' [FGP3], especially within clinical settings. Participants reported that it is common knowledge in healthcare organisations that senior clinicians 'are not to be challenged' [FGP6] and that, due to their positions and ability to generate income for the hospital, there is a tacit acceptance of their behaviour. The following excerpts illustrate that the mere knowledge that rites of passage exist in healthcare organisations is enough to create the feeling of being threatened.

> We had to go through it [rites of passages] so we'll put you guys through it as well as you're coming up through the ranks. [FGP3] (Theme 3.3: Threat)

> I think if you're effective within health … like saving the organisation money … I think if you get results to a point then the behaviour is ignored. [FGP6] (Theme 3.3: Threat)

***Errors in work***

Several participants mentioned that in an environment where workplace bullying occurred the likelihood of errors being made increased. Management trainees felt that these errors could impact on patient care and safety. One participant commented they have been aware of errors being made as a result of workplace bullying as the staff member was stressed and anxious after a workplace bullying incident where they felt threatened.

> My perception is that [bullying] definitely still remains in both nursing and medical and I've seen [errors]. [FGP3] (Theme 3.3: Threat)

***Ageing healthcare workforce***

The participants in the individual interviews spoke about demographics (Theme 3.1), which includes categories of particular population groups. Participants commented on burnout among managers of a certain age (Theme 3.1: Demographics), especially those who have seen cycles of restructures with increasingly finite resources to implement change. The following quotations from participants illustrate these themes.

> I think [bullying] happens everywhere and at all levels. [IP3] (Theme 3.1: Demographics)

> It's more likely that it's going to be a new graduate or someone at the bottom of the organisation chart that's going to get bullied. They're more likely to be female and younger. [IP5] (Theme 3.1: Demographics)

> By not giving the right people, the right resources, access to people or people stopping what you're trying to do, which stops you from doing your job. [IP6] (Theme 3.2: Personal issues)

### *Acceptance of workplace bullying in times of high stress*

The participants spoke about workplace bullying being situational. At times behaviour which one person may view as bullying is perceived differently by another (Theme 3.4: Unintended). For example, a participant reflected on an incident where they observed a colleague on the receiving end of workplace bullying; however, that colleague felt the perpetrator was just 'blowing off steam' and they did not mind. The participant indicated they would have said something if they were in that situation. They also commented people may be quick to say they are being bullied but may not pause to consider whether it is actually workplace bullying. The concept of 'blowing off steam' and 'blowing up' was mentioned by several participants [FGP5, FGP7, IP2, IP5], as this was considered by management trainees to be acceptable behaviour in periods of stress and frustration.

### *Attached to projects*

Several participants spoke about increased accountability in the health context and, with that, greater responsibility that may contribute to people becoming too emotionally attached to and invested in their work. If the results and outcomes are less than expected, colleagues may vent their frustration and anger inappropriately (Theme 3.4: Unintended). Participants spoke about power as a cause of workplace bullying. They commented people may feel threatened by other's in positions of power, and, in an attempt to minimise this perceived threat, may 'drag other people down' [IP2, IP5] (Theme 3.3: Threat).

> Fear that something could happen to their job if they were to speak up about it. [IP3] (Theme 3.3: Threat)

> [Venting] is extremely inappropriate and it can be damaging for the recipient. [IP5] (Theme 3.4: Unintended)

> My perceptions are, particularly within management I think it's all about power and credibility. [IP1] (Theme 3.3: Threat)

Several comments were made about staff 'just not liking people' [IP1, IP4, IP6] they work with and the perception that this may lead to workplace bullying. Management trainees felt that if they were not liked by other staff, those staff might try to exclude them to gain a career advantage over them (Theme 3.4: Unintended). Comments were made that

these people were self-centred and would behave in a way with the sole purpose of advancing their career without considering other people.

***Summary***

Participants commented on the potential broader impact on patient care and safety in regard to workplace bullying. Senior clinicians and those in management positions were consistently identified as the primary source of workplace bullying in the healthcare sector; that is, staff in positions of authority. This was mentioned more frequently than any other demographic feature (Theme 3.1). Older staff were the next most common demographic likely to engage in workplace bullying. Many senior staff are also older staff, identifying them as the most likely to demonstrate workplace bullying.

### 4.2.4 Theme 4: Consequences of workplace bullying

Participants in both the focus groups and individual interviews were able to describe the impact of workplace bullying on the person being bullied. Few participants were able to describe impacts on the person engaging in the workplace bullying other than from a retributive and punitive point of view, questioning what happens to the person as a result of their inappropriate behaviour. This indicated that participants were able to describe the consequences of workplace bullying, which was identified as a theme with two sub-themes: consequences for those engaging in bullying (T4.1) and for those being bullied (T4.2).

***Exhaustion and lack of motivation***

The key themes emerging from the focus group participants and the individual interviews were about the consequences for those being bullied (Theme 4.2), including for their employment. The most frequently reported experience among the management trainees was feeling powerless to change the situation and being constantly exhausted by the pressure and the workload (Theme 4.2: For those being bullied). This was further evidenced by participants' comments that they were not motivated to complete tasks or that they did not want to come to work, and the potential for this to impact on the quality of care for patients. (Theme 4.2: For those being bullied). The following quotations illustrate this theme.

> I knew exactly what was happening, but I just watched because there's absolutely no incentive for me to say anything. [FGP6] (Theme 4.2: For those being bullied)

> You have to make a decision when you're going to report bullying because there are consequences and you need to think through the consequences. For trainees that's a bit of an issue because you then think, well what are my prospects of being employed. [FGP1] (Theme 4.2: For those being bullied and Theme 6.6: Recognition and Theme 8.1: Responsibility)

> When I was a trainee, I just felt like I was so exhausted, and I was actually crying. I was upset at work it's just devastating. I didn't want to go to work, didn't want to work in health anymore. [FGP4] (Themes 1.1: Effect on the co-worker and 1.2: Victim's experience and Theme 4.2: For those being bullied)

### *Tacit approval*

Several participants mentioned supervisors telling them 'that person's not a nice person' in an attempt to explain or excuse the workplace bullying and suggesting the management trainee limit their interactions with the person in question. Participants commented that numerous people know who is engaging in workplace bullying but there is almost a tacit approval and the notion that 'we put up with it'. This led to further discussion regarding organisational culture which identified a subsequent theme 5.2: Organisational culture and 6.2: Organisational culture. The following excerpts illustrate this theme.

> Bad culture, frustration, irritation, poor performance, wasted money. [FGP1] (Theme 4.2: For those being bullied)

They also commented on consequences for those who engage in workplace bullying in an attempt to explain their behaviour, in that pressure from senior executives may impact on their performance and their feelings of self-worth.

> Insecure about position, insecure about skill, insecure about other people's position and/or skill, particularly if that's a top-down issue, from my perspective. [IP2] (Theme 4.1: For those engaging in bullying)

> Making people feel really uncomfortable, I guess the end result is that they can't really perform, and they might have some issues. [IP1] (Theme 4.2: For those being bullied)

These quotes illustrate how the participants view potential consequences of workplace bullying for individuals and for healthcare organisations.

### *Cyclic nature*

The participants spoke at length to the fact that no one should be exposed or subjected to bullying in the workplace and highlighted a range of specific examples of the impact of workplace bullying (Theme 4.2: For those being bullied). Participants mentioned the cyclic

nature of the impacts of workplace bullying – it created stress, which could affect the individual's productivity at work, which had a flow on effect to colleagues and teams and resulted in the feeling of not wanting to come to work. The impact of stress also affected how well some management trainees were sleeping. Comments also included how exhausted management trainees felt and that they observed similar levels of exhaustion in their colleagues, which impacted on the ability of the team to complete projects effectively and on time.

> [Bullying] has a big impact on relationships and networks between people, organisations across the sector. [IP5] (Theme 4.2: For those being bullied)

> [Bullying] happens and it's not okay. People don't go to work to be put in a situation where they feel their self-worth is questioned, where they feel belittled. [IP7] (Theme 4.2: For those being bullied)

***Staff disengagement***

Comments were made regarding the potential for workplace bullying to create staff disengagement, which can result in a lack of innovation and ideas within the health sector. They also spoke of the waste of public money from recruiting staff to perform a function they are now not able to perform and from increased leave taken by individuals as a result of being bullied (Theme 4.2: For those being bullied).

> They'll probably leave. You spend a lot of time recruiting them. Those people given a choice would leave. People are disengaged. [IP3] (Theme 4.2: For those being bullied)

Management trainees also noted that some staff may need to seek professional support if workplace bullying was impacting on many areas of their lives, especially on their personal lives.

***Summary***

The consequences of workplace bullying for the victim were widely understood by management trainees to include impacts such as being detrimental to the individuals' workplace performance. They also commented on the time spent by managers in dealing with issues, time which would otherwise be spent in what they termed productive work. Management trainees believed incidents of workplace bullying would lead to inefficiencies and the inability of the team and/or organisation to meet targets. Participants also discussed impacts on the individuals' wellbeing such as personal unhappiness, discontent,

stress and anxiety. Management trainees were also able to describe the potential impact on patient care and safety and the detrimental effects on personal wellbeing, which contravene WHS and possibly OHS obligations to safeguard the wellbeing of employees and provide a safe work environment (Theme 4.2: For those being bullied).

### 4.2.5 Theme 6: Nature of workplace bullying

Participants in both the focus groups and individual interviews were able to describe how workplace bullying was enacted and also highlighted some differences in whether a behaviour is bullying or merely a disagreement between colleagues. Participants described in detail the culture of particular organisations, which they perceive as supporting workplace bullying. Participants in the individual interviews expressed the view that workplace bullying occurs between organisations. Participants were able to describe in detail examples of staff not having confidence that their concerns about workplace bullying would be taken seriously or that any action would be taken. Participants in the focus groups provided examples of people in positions of power frequently engaging in workplace bullying of other colleagues and GHMTs, highlighting that some staff engage in repeated acts of workplace bullying. Participants described both the overt and subtle forms of workplace bullying and spoke about the difficulties, at times, of identifying covert behaviours as they were not easily observed or were hidden. This indicated that participants were able to describe the nature of workplace bullying and were able to make the distinction between overt and covert forms of workplace bullying. This was identified as a theme with six sub-themes: grievances (T6.1); organisational culture (T6.2); overt (T6.3); patterns (T6.4); power (T6.5); and recognition (T6.6).

***Organisational culture***

The themes emerging from the focus groups and individual interviews included organisational culture (Theme 6.2), which incorporates those components which govern how people behave and interact in their work environment, and power (Theme 6.5), which manifests as the capacity to influence the behaviour of others. Participants reported that the culture of the organisation was a key determinant of the nature of workplace bullying (Theme 6.2: Organisational culture). This was further evidenced by participants commenting that there was a general acceptance among managers regarding inappropriate behaviours and that over time it becomes a pattern of behaviour (Theme 6.4: Patterns) and perhaps ‘the way of the world’ [IP3]. Participants felt that the culture

of the organisation creates an environment in which workplace bullying is allowed to flourish (Theme 6.2: Organisational culture). This was further evidenced by participants commenting that within days of reporting an incident of workplace bullying, several people were aware they had filed a report (Theme 6.2: Organisational culture). The following quotations illustrate these themes.

> Once you get into a position of power you become used to entitlements or you get used to certain behaviours or acting in a certain way to get what you want … breeds a personality of aggression. [FGP5] (Themes 6.2: Organisational culture and 6.5: Power)

> If you're ignoring people and you're not saying good morning to them and you're walking past them in the corridor and not acknowledging them, (1) it's bullying but (2) it just breeds this really negative revolting attitude within the team. [FGP3] (Theme 6.2: Organisational culture)

> Even in the workplace surveys [poor culture] comes up and that it's really glossed over. [IP8] (Theme 6.2: Organisational culture)

> They may see this as – they might start to feel like okay this is the way that we behave around here. [IP2] (Theme 6.2: Organisational culture)

***Repeated patterns***

The participants were able to identify the link between the nature of workplace bullying and the causes or consequences. They noted that having an executive leadership team committed to the vision and mission of the organisation is something that is critical to a positive culture but that is not common in their experience (Theme 6.2: Organisational culture). Participants mentioned that while organisations have a vision and mission statement they don't always adhere to it – 'they are just words on a sheet of paper' [FGP5] (Theme 6.2: Organisational culture) – and simply provide lip service to these values rather than them being embedded into the culture of the organisation. Participants spoke about this resulting in fostering an organisational culture where workplace bullying is given tacit approval and allowed to flourish and go unchecked by senior management. Participants also commented on the repeated pattern of behaviours due to the workload and stress and identified that some people will revert to workplace bullying when they are stressed (Theme 6.4: Patterns). The following excerpts illustrate how participants experience the culture of some healthcare organisations in their ability to raise incidents of workplace bullying.

> You have to make a decision when you're going to report bullying because there are consequences and you need to think through the consequences. For trainees that's a bit of an issue because you then think, well what are my prospects of being employed. [FGP4] (Theme 4.2: For those being bullied and Theme 6.6: Recognition and Theme 8.1: Responsibility)

> Most people put their heads down and do their own work and not have to think about this stuff. If its' clear that your senior management don't care, then there's no hope. So, they're part of the problem as well. [IP6] (Theme 6.2: Organisational culture)

***Favouritism based on hierarchy***

The discussions then explored management trainees' perceptions of the hierarchical structures within healthcare organisations and how they feel this leads to workplace bullying. A few commented that they perceived an element of favouritism in appointing staff to temporary positions based on these hierarchical structures. Some also mentioned that people may be promoted to positions simply because they have been with the organisation for a period of time and it is 'their time' [FGP7]. Others disagreed, stating that the recruitment processes of their individual organisation would ensure transparency of appointments to senior roles and, in fact, some roles had been filled outside of the organisation. FGP7 spoke at length about the perception that she had been passed over for a role because of her gender.

> [The] hierarchical structure of healthcare breeds the bullying, that breeds a bullying culture. Hierarchical structures do tend to breed a bit of a bullying culture. [FGP2] (Themes 6.2: Organisational culture and 6.5: Power)

> It comes down … to power and what's acceptable and what's not. It does happen in healthcare. [FGP4] (Theme 6.5: Power)

> Bullying is rife, even at senior levels, even at executive levels, between executives, upwards and downwards. [FGP6] (Theme 6.5: Power)

***Silos in healthcare***

Comments were made by the participants about the healthcare sector not being a traditional business but rather made up of myriad specialised knowledge areas (e.g. medicine, nursing, allied health) but also areas such as information technology, data management and business intelligence. Participants spoke of the fact that no one person in the healthcare sector knows everything due to these specialised areas, and this specialised knowledge perhaps breeds the characteristics of power (Theme 6.5: Power). Participants relayed their experiences as management trainees when other staff withheld information from them which was of a specialised nature (e.g. ABF coding), which often

led them to feel isolated. Some participants indicated they did not know who they could then ask to intervene and assist. Participants felt this was an exercise of power and a form of workplace bullying. Others commented that older staff may feel threatened by management trainees and withhold information due to a fear of job security. This also was evident in the discussions for Theme 3.3 (threat).

> People see up and comers or they see people with a really good knowledge base … and that concerns them and patch protecting. I just think that insecurity generally. [FGP1] (Themes 3.2: Personal issues and 3.3: Threat and Theme 6.6: Recognition)

> If a manager looks at performance management as a method to up-skill their team. [FGP7] (Theme 6.6: Recognition)

> A certain type of people especially in power are expected to be very authoritative and direct but sometimes the way they use that power is still quite bullying. [FGP7]. (Theme 2.1: Abuse of authority and Theme 6.5: Power)

***Recognition and acknowledgement***

The participants in the focus groups also discussed recognition (Theme 6.6), which includes acknowledging someone for their achievements and contributions. Staff retention was discussed in the guise of recognition of not only achievements but contributions (Theme 6.6: Recognition) to the performance of the team. Participants felt that good managers were more likely to acknowledge the work of management trainees and modelled positive behaviour they would adopt in future as their career progressed. Management trainees spoke of being acknowledged in a senior meeting for a piece of work they produced at the end of a three-month project.

***Overt and covert forms of workplace bullying***

Several participants were able to comment about the overt and covert nature of workplace bullying by providing specific examples of overt behaviour, e.g. putting people down in front of others, talking behind colleagues' backs (Theme 6.3: Overt). In addition, they were able to discuss the notion of power and credibility, particularly within management, by 'bringing people down' and wanting control over people and the situation (Theme 6.5: Power).

***Inexperienced health managers***

A number of participants spoke of senior managers who 'were out of their depth' [IP5], while others commented on senior managers who felt their own positions were tenuous if

their organisation was being externally reviewed by NSW Health and, therefore, were 'demanding of accurate information and reports' [IP5]. Of those in senior management positions, there was a perception that staff were less likely to speak up about their behaviour (Theme 6.5: Power) due to fear of reprisal, which can be challenging in dealing with workplace bullying.

### *Power differentials*

The participants spoke of tension when they were dependent on other staff to perform their job properly (including managing staff and delivering safe, high-quality care) when they were experiencing workplace bullying. Management trainees suggested that this impacted on their being able to speak up and report workplace bullying, particularly as they were dependent on that person to do their job. The implications of this are significant, as these actions contribute to the creation of power differentials, sustain the already perceived poor organisational culture and allow practices to continue that are unacceptable.

> I would be less likely to do my role or want to work with a person who is bullying me. But that person might be integral for me to doing a particular role. [IP5] (Theme 6.5: Power)

> Just thinking about the particular profession that isn't used to having their opinions questioned. So that is very much positional power. It can be abused by some. [IP7] (Theme 5.2: Organisational culture and Theme 6.5: Power)

> There is an acceptance that this is okay behaviour where we work. So, therefore [bullying's] part of the culture of the organisation. [IP3] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

The perception that the culture within the management structures of their organisation contributed to workplace bullying by creating an environment where unacceptable behaviour is allowed to occur was also mentioned by participants.

> It's character, it's the environment, particularly in management. The culture is a big thing. [IP4] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

### *Use of technology*

Some participants spoke about power in the use of technology and ways of communicating across the organisation. IP4 mentioned a time when, as a management trainee, they had been copied into a lengthy email thread about a project which had nothing to do with

them, other than that they had attended a few meetings with that particular team. They commented that there were approximately 10 other staff who were copied into the email thread, which was circulated with the intent to single out one person on the team who had made an error in a report.

> Bullying occurs a lot in emails, maybe cc-ing everyone, making someone look bad. [IP4] (Theme 6.5: Power)

***Pathways for escalation***

Raising areas of concern with managers, and who management trainees might approach if they had an issue with their direct manager, was also discussed. Participants spoke about the need to respect the existing grievance processes (Theme 6.1: Grievances) but to also be able to source impartial advice from others they trust. One respondent, IP1, described a situation in which they were experiencing difficulties with their direct manager and did not feel they had an appropriate pathway to raise the issue due to the senior position of their manager.

> I don't feel as a trainee in that situation that I had the ability, knowing the [position] of the person and the pull they had in the organisation, to put a stop to [bullying]. [IP1] (Theme 5.2: Organisational culture and Themes 6.2: Organisational culture and 6.5: Power)

Several participants indicated that they would report workplace bullying; however, the question was, to whom should they report. Reporting to the human resources department was mentioned as a 'probably' [IP3, IP5, IP8] (Theme 6.1: Grievances), although concern was expressed regarding the perceived level of confidentiality and impartiality of an internal department.

***Summary***

Theme 6, the nature of workplace bullying, highlights the complexities of the issue of workplace bullying. Key findings which emerged were those of power, insecurity and credibility. The discussions with the participants explored how these themes interact to allow workplace bullying to flourish. The hierarchical nature of the healthcare sector and the prevailing poor culture lead to an environment in which workplace bullying was the norm. In healthcare settings there is often an interdependence on other staff within the unit or work stream for individuals to be able to perform their job effectively and this dependence impacts, and is impacted by, this environment. Interdependence and

insecurity among some staff created an environment that allowed workplace bullying to occur.

Workplace bullying was generally thought to be situational by many participants – that is, occurring during times of acute stress rather than as an ongoing pattern of behaviour. A key situation which stimulated grievances with colleagues and which could lead to workplace bullying was management not getting what it needed from staff, causing things to go wrong and budgets to be unmet, which resulted in acute stress for managers who have full accountability for the performance of their department (Theme 6.1: Grievances).

There was much confusion amongst participants about how to manage emotions such as anger and successfully address a grievance with a manager or fellow staff member without inviting accusations of workplace bullying (i.e. how to be assertive). Also, staff, including management trainees, observed that no outcome or change had occurred after bringing grievances to management's attention and felt this to be detrimental to organisational culture.

## 4.3 Respondent validation interviews

Respondent validation interviews were conducted to further explore the five key themes regarding perceptions of workplace bullying and the discussions which evolved from the focus groups and individual interviews data: (1) level of awareness of workplace bullying; (2) behaviours which constitute workplace bullying; (3) causes of workplace bullying; (4) consequences of workplace bullying; and (5) nature of workplace bullying. The following outlines the findings from the respondent validation interviews which provided further information about workplace bullying in a health context.

### 4.3.1 Theme 1: Level of awareness of workplace bullying

Participants in the focus groups and individual interviews reported that they have heard stories about workplace bullying in their organisations but probably would not say anything [FGP3, FGP8, IP2] and that in their role as a management trainee they often did not know the appropriate processes for reporting workplace bullying. Participants in the validation interviews were able to validate the challenges of reporting workplace bullying not only as a management trainee but also within the healthcare sector.

> As a trainee it might be difficult to report because of the position we are in. Also, I think there is fear attached to what if you report something that isn't bullying and it's hard to recover from that. [RVP3] (Theme 1.1: Effect on the co-worker and Theme 8.1: Responsibility)

There was a repeated theme in the focus groups and the individual interviews of workplace bullying occurring due to competition for resources and desire for career advancement, which necessitated being seen to get results at any cost (Theme 3.3: Threat). The following quotations illustrate that the participants in the validation interviews felt that the desire for career advancement can lead to public confrontation as a form of workplace bullying.

> I'm not sure. If it's harassment it happens a lot but sometimes there may be an incident, like a verbal argument in a corridor, which would be upsetting. And humiliating. [RVP3] (Theme 1.2: Victim's experience and Theme 2.6: Talking about others)

> I have overheard things whilst in my office and that's not good either. I guess it needs to have happened before for it to be bullying or at least for it to be taken seriously as bullying. [RVP1] (Theme 1.2: Victim's experience and Theme 2.6: Talking about others)

That workplace bullying appeared to be ignored where the perpetrator was getting good results – for example, saving the hospital money or achieving good patient outcomes – was mentioned more than once. RVP5 described incidents where a senior executive who was meeting a range of key performance indicators was also engaging in workplace bullying. RVP5 suggested that this behaviour would impact on the team over time, as the perception was this senior executive was able to 'get away with bullying others' [RVP5]. RVP2 commented that inappropriate behaviour may go unnoticed if it was occurring on rare occasions but stated that if it was taking place frequently, then it would likely have an impact on the team witnessing the workplace bullying.

> You may not notice it's bullying if it happens once but over a few times, yeah, it would get to you. [RVP5] (Theme 1.1: Effect on the co-worker)

> If someone was rude to you as a one-off it might not get to you but if they were rude to you a lot, it would be harder to walk away. [RVP2] (Theme 1.1: Effect on the co-worker)

Personal insecurity in general was identified as a major cause of workplace bullying. Participants suggested that personal development in the areas of building rapport and the interpersonal skills to deal with workplace bullying may be a means to combat this issue.

> I think building rapport with people is really, really important. Being able to connect with people on all different levels of their life. I think that's – that is relationship building, and helpful in the workplace. [RVP2] (Theme 1.1: Effect on the co-worker)

Some participants also made a link between repeated workplace bullying and the impact on patient care and safety. For example, one participant described an incident in which a staff member was spoken to about an issue in front of patients and other staff. They witnessed this person being quite upset and felt this incident would impact on their work for a period of time. This supports the findings that patient care and safety may be impacted when workplace bullying occurs. RVP4 commented that this form of public humiliation would not only be unsettling for the staff member but could impact on their work as they would be distracted.

> I know of a time when someone was [intentionally] walked into [a public] corridor to be spoken to but there were patients and family and other nurses around. Not good. [RVP4] (Theme 1.2: Victim's experience and Theme 2.4: Public humiliation)

### 4.3.2 Theme 2: Behaviours which constitute workplace bullying

Anxiety around job security for management trainees leads to feeling easily threatened by others, which can also lead to colleagues engaging in workplace bullying against anyone seen as competition for a position or looking for promotion to the position they temporarily occupy. Participants in the validation interviews discussed occasions when they have observed colleagues being singled out for unfair treatment, which leads to increasing anxiety and reinforces feeling threatened. RVP3 reported that at times this has led to the staff member resigning after extended periods of sick leave.

> Over my career I have known of a few instances where individuals have been singled out and constantly harassed or made to feel incompetent, especially amongst clinicians. [RVP5] (Themes 2.1: Abuse of authority and 2.3: Isolating and Theme 4.2: For those being bullied)

> At times this has led to the individual resigning after extended periods of sick leave. [RVP3] (Themes 2.1: Abuse of authority and 2.3: Isolating and Theme 4.2: For those being bullied)

This issue of misuse of hierarchical power also caused some junior staff to be reluctant to report observed or experienced workplace bullying for fear of repercussions from people with power over their career. For example, if an individual's direct manager engages in workplace bullying and the management trainee reports them, and they become aware of it – as they must if the situation is to change – and if the management trainee has to

continue to work under them, there is clearly a valid concern the behaviour may only get worse, or their career path may be impacted. Several participants spoke about the fact that as management trainees in a learning role they had no authority or position in an organisation. RVP3 illustrated this finding that management trainees who are junior to other staff had no power or authority to make requests of colleagues.

> We don't have any. You can ask others for things because you're sitting in the CE's office, but they probably wouldn't [provide the information] if they knew it was just something I needed. [RVP3] (Theme 2.1: Abuse of authority and Theme 6.5: Power)

RVP3 spoke about the use of power in work relationships and the withholding of documents which were essential to them being able to perform their job. The subtle nature of this behaviour makes it difficult for people to recognise this as a form of workplace bullying. This supports the finding that this is a common practice in healthcare organisations, with several participants reporting they had observed this behaviour directed towards management trainees and describing it as a form of covert workplace bullying.

> People have kept documents from me that I need or not been helpful when I didn't know where to find things. It's also interesting in meetings with managers and how they treat people. Sometimes they can be demanding and abrupt. [RVP3] (Theme 2.1: Abuse of authority and Theme 6.5: Power)

There was a general sense of older staff in senior positions coming from a time when such behaviour was accepted, and not adjusting to newer expectations of more collaborative and team-based workplace behaviour, and perhaps not being open to new ideas or suggestions from more junior staff members. Senior clinicians were mentioned repeatedly by numerous participants as a source of workplace bullying.

> I have seen that, not with me personally, but I have heard of trainees who have been singled out in meetings [by senior staff] for not knowing something or not being prepared. And because you might only be in that rotation for a few months it's hard to speak up. I would chat to my supervisor about it if it happened to me. [RVP5] (Theme 2.4: Public humiliation and Theme 4.2: For those being bullied)

Participants spoke to positional power creating a sense of entitlement, with the authoritative and direct approach required to achieve results and performance manage staff being misinterpreted or taken too far, or an individual finding themselves elevated to a position of power without the personal skills they need to deal with power appropriately (e.g. less scrutiny and accountability encouraging misuse of power).

> When I was involved in the [GHMP] Program, it was very much a case of you were in a supernumerary position, so you clearly felt that you didn't have positional power. Those in positions of power in some organisations can certainly intimidate others simply because of the position or title they hold. [RVP4] (Theme 2.3: Isolating and Theme 6.5: Power)

> Trainees may feel that they are unable to approach those with more perceived power. I've also worked with some who are in a position though they are not overly competent and at times their [inappropriate] behaviour could be a result of this. [RVP1]. (Theme 2.3: Isolating and Theme 6.5: Power)

### 4.3.3 Theme 4: Consequences of workplace bullying

Participants described some confusion over priorities and loyalties. For example, if a person with positional power warns a junior staff member they are telling them something in confidence, and proceeds to demean other staff, participants questioned whether this was misuse of power or whether it was workplace bullying. They also spoke to an inability to appropriately use positional power where a staff member's personal skill set determined whether or not workplace bullying occurred.

> As a trainee you know you're not in a position where you can call people on their behaviour if they are far more senior. But I would definitely talk to someone else, like my supervisor or even another trainee if it was bothering me. [RVP2] (Theme 4.2: For those being bullied)

Several participants expressed confusion about where the line is drawn between performance management; behaviour considered tough and forceful in order to achieve results was the same type of behaviour that was considered to be workplace bullying. It should also be noted a small number of participants felt workplace bullying was less likely to occur at senior management levels due to higher standards of professionalism. This was in part due to the era of promotion based on merit and detailed selection criteria within healthcare organisations. Participants also commented that some senior appointments were made from outside the employing organisation.

The participants reported that a common strategy currently used (both by victims and by workplaces) for dealing with workplace bullying was avoidance; staff tend to prefer to leave the organisation rather than report or address the behaviour, and organisations tended to simply move perpetrators to other areas. Participants described the types of support they would seek either internal or external to their organisations. The following quotations illustrate some examples.

> Friends or a counsellor if [the bullying] was really bad. There's support at work, well there's HR and I suppose they would give you other advice if you needed it. [RVP2] (Theme 4.2: For those being bullied)

> A confidential counselling agency. However, the impact would also be noticeable at home, so perhaps talking with family would provide the perspective an individual might need. [RVP5] (Theme 4.2: For those being bullied)

Several participants noted that in severe cases of workplace bullying staff had access to sick leave, workers' compensation and were able to seek professional psychological support outside the workplace. RVP4 described key support mechanisms that they would find useful if they were experiencing workplace bullying.

> Lifeline. Or there's even some websites for workers to log on to. I'd probably say family though as you'd just want someone to listen first. [RVP4] (Theme 4.2: For those being bullied)

### 4.3.4 Theme 6: Nature of workplace bullying

Participants stated that management trainees are usually employed on temporary contracts for the two-year program and, therefore, do not want to jeopardise future employment opportunities by being seen to 'rock the boat' [RVP5]. They may therefore be reluctant to report workplace bullying, especially as they are in a junior position. Participants also reported that as management trainees are new to the organisation and rotate through a range of departments every few months, they may not have been provided with detailed information regarding processes to report workplace bullying.

> Perhaps the processes are not clear in the organisation, you know there's HR but sometimes you're not sure if what's going on needs to be escalated to that point. Also, I guess as a trainee you don't want to be seen as complaining when you're new to the organisation. [RVP5] (Theme 6.5: Power and Theme 8.1: Responsibility)

The participants proposed that a management trainee taking a complaint to the union or the human resources department was equally met with ambivalence; there were some suggestions workplaces took a dim view of reporting workplace bullying and employees were actively discouraged from taking this route. Many incidents of workplace bullying may go unreported as management trainees are not sure if the behaviour is, in fact, workplace bullying.

> Uncertainty would be one of them especially if they are only employed on a temporary or part-time basis or even contractors. I also think that in some organisations there are inadequate human resources department procedures, or ill-defined procedures

> some of which may not be widely known. [RVP4] (Theme 6.5: Power and Theme 8.1: Responsibility)

> Power would also be a contributing factor, the perception of not being in a position of power and therefore there may be reluctance to report. Overarching would also be not recognising the behaviour as bullying and thereby not viewing it as reportable. [RVP2] (Theme 6.5: Power and Theme 8.1: Responsibility)

At the same time, there was a suggestion among participants that making a formal complaint was a very complicated and intimidating process, with an uncertain outcome, and therefore viewed as a last resort. RVP1 discussed the possibility of unrealistic expectations those reporting may have regarding the outcome. RVP1 mentioned that their experience had been those reporting wanted 'quick, swift and public action' [RVP1] and this was not always the case. The complexities of healthcare organisations and the reporting of workplace bullying require careful investigation, and this can be time consuming and involve multiple parties. Another participant described a widely held view among management trainees that the human resources department is not always the best avenue to seek when reporting workplace bullying.

> They reported bullying before and they didn't get the result they expected. Like the person being moved to another unit or some other form of disciplinary action. [RVP1] (Theme 6.5: Power and Theme 8.1: Responsibility)

> The human resources department isn't always seen as being impartial, if you know what I mean, and that might prevent staff reporting. The person is in a senior position and it wouldn't be good for your career to report them. [RVP4] (Theme 6.5: Power and Theme 8.1: Responsibility)

## 4.4 Conclusion

The current chapter has provided a comprehensive examination of GHMTs' perceptions of workplace bullying as they emerged from the exploration of phase one: six research questions, interpreting the emergent themes and the three key data sets; focus groups; individual interviews; and respondent validation. This chapter also provided a detailed discussion regarding the five themes which demonstrated the perceptions of workplace bullying emerging from the focus groups and the individual interviews and respondent validation interviews, namely: Theme 1: Level of awareness of workplace bullying; Theme 2: Behaviours which constitute workplace bullying; Theme 3: Causes of workplace bullying; Theme 4: Consequences of workplace bullying; and Theme 6: Nature of workplace bullying. There is also discussion on the sub-themes which emerged from the

data. The qualitative data is rich in all three data sets and illustrations for each theme have been included.

The results from the focus groups and the individual interviews produced generally equivalent themes. Discussion of particular themes in the individual interviews was comparatively more in-depth than in the focus groups. This was reflective of the sensitive nature of the topic and the fact that, perhaps because of their direct experience with workplace bullying, some participants preferred to participate in the one-on-one phone interview with the researcher. Respondent validation interviews were conducted to further explore key themes and discussions which evolved from the focus groups and individual interviews. The next chapter will focus on the key findings for strategies for dealing with workplace bullying.

# Chapter 5: Results – Strategies for Dealing with Workplace Bullying

## 5.1 Introduction

This chapter presents the findings on strategies for dealing with workplace bullying, from GHMTs' perspectives. There are four themes for strategies for dealing with workplace bullying: (1) dealing with workplace bullying; (2) positive relationships; (3) reporting of workplace bullying; and (4) training needs. Findings from both the focus groups and the individual interviews are presented for each of the identified themes. Exemplar quotes are provided to illustrate each theme. Quotes are labelled, and participants numbered to indicate the respondent or data set to which the comment is attributed (e.g. focus group – FGP2 – or individual interview – IP5).

Section 5.3 presents the findings from respondent validation interviews. The inclusion of exemplar quotes are provided to illustrate each theme. Quotes are labelled, and participants numbered to indicate which respondent the comment is attributed to (e.g. RVP2). A summary is provided for further explanation. Section 5.4 presents a review of the overall results for strategies for dealing with workplace bullying and the four identified themes.

## 5.2 Domain two – strategies for dealing with workplace bullying

Four themes which focused on GHMTs' responses for strategies for dealing with workplace bullying emerged from the qualitative data. These four themes were: (1) dealing with workplace bullying; (2) positive relationships; (3) reporting of workplace bullying; and (4) training needs. Within these themes, some of the strategies described by participants for dealing with workplace bullying were proactive and focused on positive behaviours (e.g. recognition of achievements, staff wellbeing programs) and others less helpful and punitive (e.g. demoting or firing the individual, suspending them for a period of time). Participants also suggested ways of dealing with workplace bullying which were more direct (e.g. counselling, skills development, assertiveness training/coaching, referral to outside agencies) and others spoke about strategies which were more indirect (e.g. awareness raising, staff briefings, social skills training, anger management training).

### 5.2.1 Theme 5: Dealing with workplace bullying

***Role of managers and staff***

Participants in both the focus groups and individual interviews described their perceptions of the role of managers and staff in dealing with incidents of workplace bullying. Participants in the focus groups reported that incidents of workplace bullying need to be raised at the management level in order for the situation to be resolved. Participants in the individual interviews had a contrary view, describing a lack of confidence in the ability of management – and particularly the human resources department – to maintain confidentiality when a workplace bullying incident has been raised. Participants spoke at length about the culture of the organisations they have worked in and how this needs to be respectful and positive to empower individuals to deal with the issues of workplace bullying. Participants in the individual interviews described the need for mechanisms and training to support staff to be able to address workplace bullying before escalating it through to management and/or the human resources department. This indicated that participants were able to describe ways of dealing with workplace bullying and was identified as a theme with four sub-themes: manager to staff (T5.1); organisational culture (T5.2); staff to staff (T5.3); and strategies for dealing with bullying in the workplace (T5.4).

***Organisational culture***

The findings emerging from the focus groups and individual interviews were the role of organisational culture in (Theme 5.2), and strategies for dealing with (Theme 5.4), bullying in the workplace. The most frequently reported experience among the management trainees was the culture of the organisation enabling an environment in which workplace bullying was allowed to flourish (Theme 5.2: Organisational culture). Participants also reported that the hierarchical nature of the health sector contributed to a workplace bullying culture (Theme 5.2: Organisational culture). This was further evidenced by some participants noting that inadequate engagement with staff created a culture of frustration and poor performance, which could lead to poor patient care and quality (Theme 5.2: Organisational culture). Participants revealed that there was a tacit acceptance of certain types of behaviour among sections of the workforce (e.g. clinicians) and their experience as management trainees of not feeling confident speaking up about workplace bullying to senior clinicians. This highlights how implementing strategies that

impact on the culture of an organisation can address workplace bullying. The following quotations illustrate these themes.

> Just thinking about the particular profession [clinicians] that isn't used to having their opinions questioned. So that is very much positional power and it can be abused by some. [IP1] (Theme 5.2: Organisational culture and Theme 6.5: Power)

> The challenge that no one has managed to achieve, to get [a positive] culture across the entire organisation. [FGP3] (Theme 5.2: Organisational culture)

Similarly, participants described how they could feel tension and negativity in a work environment and the impact that this had on their fulfilment at work and how they experienced workplace bullying.

> You can feel the culture. You can walk into a ward or an environment where you know it feels good and supportive and fun. [FGP4] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

Discussion focused on the fact that in some organisations they have out-of-hours social events as a strategy to foster positive staff wellbeing and thereby improve the culture of the team. Participants spoke about ten-pin bowling nights, trivia nights and even Friday drinks. One respondent, FGP2, described occasions when they felt undue pressure to attend these events and were even singled out publicly for not attending.

> Sometimes I don't like the people who I work with and I don't want to socialise with them at all. Isn't that bullying? Making you come to something you don't want to come to. [FGP2] (Theme 5.2: Organisational culture)

***Respect***

Further discussion in the focus group also involved comments about not liking the people one works with: 'it's not like they are top of my Christmas card list' [FGP2] and 'we don't always have to like the people we work with' [FGP4]. Participants spoke about the importance of being professional and respectful in their interactions with colleagues regardless of whether they liked that person and the need to 'respect their position/title' [FGP1], as an indirect strategy for dealing with workplace bullying. The need to effectively and appropriately manage poor-performing staff was viewed by several management trainees as a way for management to remove someone they did not like from the team. Participants reported that they felt that performance management was used by some managers to make vexatious claims against a member of staff they wanted moved to

another team or work area and was viewed as an ineffective strategy for dealing with workplace bullying – and, in fact, as a potential form of workplace bullying in and of itself.

***Awareness***

Participants mentioned a tri-annual survey undertaken by NSW Health, known as the 'Your Say Survey', and commented that the results should be known to the entire organisation, as currently this is not common practice in some organisations. (Theme 5.3: Staff to staff). Management trainees felt it would be useful to know if workplace bullying is happening – 'feed back to your team about what's going on in the organisation' [FGP3]. Others spoke about behaviours that contributed to a positive culture, such as being nice to people or common courtesy – saying good morning, asking about their weekend, letting people know when you're leaving at the end of the day (Theme 5.3: Staff to staff). FGP7 mentioned the idea that during annual performance reviews staff could be asked directly about workplace bullying, especially if the results from the survey indicated the organisation had a proportion of reported incidents of workplace bullying. They stated that in a one-on-one situation, management trainees may be more comfortable discussing issues with their manager when prompted.

> Like performance reviews. You should ask do you have any problems in the workplace and any bullying behaviours sort of thing. [FGP7] (Theme 5.4: Strategies for dealing with bullying in the workplace)

***Responsibility***

Participants also discussed who they believe is responsible for dealing with workplace bullying, with a consensus among the focus group participants that it is every individual employee's responsibility. Participants spoke about having the courage to speak out about workplace bullying as a key strategy, although also conveying that, as management trainees, they were not confident in speaking out. The researcher explored this further, with participants suggesting that a lack of assertiveness skills leads to a lack of confidence in speaking out about workplace bullying.

> Everyone is responsible for dealing with bullying but it's scary – a lot of people don't have the courage. [FGP5] (Theme 5.4: Strategies for dealing with bullying in the workplace)

One respondent suggested a strategy for dealing with workplace bullying would be to call out the behaviour to the person.

> Instead of escalating something straight away to the manager, actually calling the person out and saying I don't appreciate that. [IP7] (Theme 5.4: Strategies for dealing with bullying in the workplace)

Participants spoke about fostering trust and respect for the people they work with, and some commented that the behaviour of the manager should be consistent. They felt managers should state clearly what is acceptable behaviour and what will not be tolerated (Theme 5.1: Manager to staff) in that department, and that managers should explore opportunities to reiterate this when workplace bullying occurs.

> [Behaviour] should be led by the manager of the ward, unit or wherever it is, and [communication] should be consistent across the organisation. [FGP1] (Theme 5.4: Strategies for dealing with bullying in the workplace)

> I felt I was not there to stop [bullying]. I was there not to buy into [the behaviour]. I made [the behaviour] aware to my manager and I felt that it's the manager's responsibility to stop [bullying], not mine. [IP2] (Themes 5.2: Organisational culture and 5.4: Strategies for dealing with bullying in the workplace)

***Policies***

Several participants commented that policies within organisations should be realistic and based on input from a range of staff across the organisation, from the most junior member to the most senior member of staff. Some participants spoke about zero tolerance as a stated aim for NSW Health, although questioned its practicality and urged their organisation to develop other strategies.

> I think policy is [important]. Zero tolerance is in the code of conduct. [But] what can we as an organisation do? Instead of going zero – that's unrealistic. [FGP6] (Theme 5.4: Strategies for dealing with bullying in the workplace and Theme 9.1: Existing training)

***Authority***

A number of participants indicated that workplace bullying comes down to the staff in positions of authority (i.e. managers) to create an environment (Theme 5.1: Manager to staff) in which workplace bullying it not acceptable and therefore does not occur.

> I think also for us as graduate trainees, or for managers, in terms of [knowing what] behaviours [are acceptable] or strategies that help. [FGP7] (Theme 5.4: Strategies for dealing with bullying in the workplace)

### *Workplace advisors*

Workplace advisors or Culture advisors are employed in some NSW health entities (Theme 5.4: Strategies for dealing with bullying in the workplace) to provide training and act as mediators. These advisors also have responsibility for developing, implementing and evaluating programs that build positive workplaces and provide support for all employees in an environment of organisational and cultural improvement. Participants noted that they had seen evidence of this work in their organisations.

> I've seen a bit of mediation/arbitration. [FGP5] (Theme 5.2: Organisational culture)

### *Physical environment*

Further comments were made about the impact a lack of available private space to engage in a conversation with someone about issues they might be having. The emergence of open-plan offices, hot desks and agile workspaces has resulted in limited private space to have these conversations. The need to book meeting rooms well in advance was noted as creating an environment in which conversations often happened ad hoc, in corridors or public spaces, and often in the 'heat of the moment' [FGP4]. Focus group participants were concerned about witnessing these heated, public discussions.

> Open communication. If someone's got a gripe, letting them have their gripe in the space of a private office, not in front of the person they're worried about and being able to work through [the issue] with them in an office. [FGP3] (Theme 5.4: Strategies for dealing with bullying in the workplace and Theme 7.1: Acknowledging positive actions)

### *Culture*

Participants found it difficult to recognise that workplace bullying also impacts on the person engaging in the bullying. They described workplace environments with hierarchical structures, and therefore power imbalances, as being more likely to increase the pressure for expected performance outcomes, which may lead to more tolerance of workplace bullying (Theme 5.1: Manager to staff). Management trainees believed that this, in turn, impacted on the culture of the team, which was reported as being an important strategy for dealing with workplace bullying.

> I don't feel as a trainee in that situation that I had the ability, knowing the personalities of the people and the pull they had in the organisation, to put a stop to [the bullying]. [IP8] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

> There is an acceptance that this is okay behaviour where we work. So therefore, it's part of the culture of the organisation. [IP5] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

> It's character, it's the environment, particularly in management. The culture is a big thing. [IP3] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)

***Hierarchy***

Participants suggested that the higher the position (e.g. executive or director level), the more support they received as a management trainee and the less workplace bullying they witnessed (Theme 5.2: Organisational culture); however, they indicated that at the middle manager or a similar level, some had experienced workplace bullying (Theme 5.3: Staff to staff). One respondent commented that if you were younger and female, you were more likely to experience workplace bullying (Theme 5.2: Organisational culture) and were often singled out amongst peers in meetings. Given the proportion of young females who have undertaken the GHMP, and the percentage of women in healthcare management, this was a notable comment.

> They're more likely to be female and younger. [IP5] (Theme 5.4: Strategies for dealing with bullying in the workplace)

***Organisational culture***

Other participants commented on their experience and observation of the impact of workplace bullying on their organisation's culture.

> It basically comes down to improving culture and trying to [remove] those negative perceptions of other organisations and people. [IP6] (Theme 5.4: Strategies for dealing with bullying in the workplace)

> [Bullying] is very detrimental to the ethos of the workforce, the feeling that no one can stand up, no one can solve this problem. [IP4] (Theme 5.4: Strategies for dealing with bullying in the workplace)

***Positive approaches***

Several participants indicated that if they were a manager they would encourage their staff to speak with them if they were uncomfortable and would be available and supportive, with some highlighting this is not something they saw with their own managers (Theme 5.1: Manager to staff). One respondent mentioned they knew of a manager who instigated a round-table muffin meeting once a week where the team would join in for 20

minutes for a coffee and a catch up as a means of team-building and cohesion. One respondent, IP2, spoke about a range of strategies that could create a positive culture in their organisations and stated that being able to challenge people when they were engaging in unacceptable behaviour would be preferable.

> Being respectful to say that we do challenge each other's behaviour here, and creating a culture where people feel comfortable to speak up. [IP2] (Theme 5.4: Strategies for dealing with bullying in the workplace)

Participants discussed approaches different organisations used to deal with workplace bullying. These approaches varied from those organisations that had a policy in place to address workplace bullying, but that had no other mechanism to support the enactment of the policy, to organisations whose values are embedded in all processes and procedures.

> You read the policy, it says report [bullying], but apart from that, there's nothing else. [IP3] (Theme 5.4: Strategies for dealing with bullying in the workplace and Theme 8.1: Responsibility)

> I've worked in an organisation where the core values of that organisation basically in a sense addressed bullying. [IP4] (Themes 5.2: Organisational culture and 5.4: Strategies for dealing with bullying in the workplace)

> My organisation has a lot of mission statements and strategies and things like that. So, I think the culture is there that bullying doesn't necessarily occur. [IP7] (Themes 5.2: Organisational culture and 5.4: Strategies for dealing with bullying in the workplace)

The need to define the range of behaviours which constitute workplace bullying was highlighted; participants were often unaware of when workplace bullying was occurring as they did not view certain behaviour as workplace bullying (Theme 5.4: Strategies for dealing with bullying in the workplace). This highlighted management trainees' limited awareness of workplace bullying.

***Summary***

Section 5.2.1 has presented the importance of a positive organisational culture on reducing workplace bullying and improving employee satisfaction as a key strategy for dealing with workplace bullying. As noted previously in this study, organisational culture can also have a negative effect, encouraging and spreading workplace bullying, particularly when senior staff and management are observed indulging in this behaviour with impunity. This can result in difficulty in staff retention; reduced productivity; higher

rates of sick leave being taken; the organisation losing time and money; and, potentially, patient care and safety being negatively impacted down the line.

### 5.2.2 Theme 7: Positive relationships

Participants in both the focus groups and individual interviews were able to describe their desire as a future health manager to build positive relationships within their units and/or teams as a key strategy to overcome workplace bullying and improve organisational culture. Participants in the individual interviews described how they felt as GHMTs when they were acknowledged for their work and contribution, and that this encouraged them to develop deeper understandings of the healthcare sector. Several participants described in detail how effective communication across the organisation and between organisations can led to greater understanding, build networking opportunities, improve relationships and achieve better outcomes for the health service and patient care. The participants in the individual interviews described the need to accept differences and understand the needs of others. Participants described specific examples of strategies they have observed in their organisation which have contributed to developing a collaborative team dynamic. This indicated that they were able to describe the importance of developing positive relationships in workplaces as a means of preventing workplace bullying and was identified as a theme with four sub-themes: acknowledging positive actions (T7.1); communication (T7.2); other strategies (T7.3); and understanding (T7.4).

***Focus groups***

The themes emerging from the focus group participants were acknowledging positive actions (Theme 7.1) and understanding (Theme 7.4). The most frequently reported experience among the management trainees was lack of acknowledgement of their contributions to the projects they are involved in, and a lack of consideration for the value of their ideas (Theme 7.1: Acknowledging positive actions). This was further evidenced by some participants commenting that they were either not acknowledged by their colleagues or, when they were, that it was not sincere. Participants stated that they often thank their colleagues for providing support and advice (Theme 7.1: Acknowledging positive actions) to them in their role as management trainee. The following quotations illustrate these themes.

> Feedback, both ways, fosters trust and it fosters some respect for people. [FGP1] (Theme 7.1: Acknowledging positive actions)

> I say thank you to people when they help me out and I generally say thank you anyway. [FGP4] (Theme 7.1: Acknowledging positive actions)

***Mentoring***

Several participants identified the importance of having a designated person to support them, with some mentioning having access to a mentor would provide not only a sounding board but someone to whom they could speak to confidentially (Theme 7.2: Communication). They suggested this would been seen by others as a mechanism for creating positive relationships within, and across, teams or work streams. Management trainees reported that observing positive behaviours and people being professional and friendly contributed to a positive workplace culture.

> People recognise good acts when they see them, when they happen, [these] breed a better culture within the team. [FGP2] (Theme 7.1: Acknowledging positive actions)

***Managers with integrity***

One respondent, FGP3, spoke about the need for managers to have integrity, to do the right thing because it is right. This elicited further discussion amongst the focus groups highlighting the positive impact they had experienced when working with managers who were fair but firm in dealing with unacceptable behaviour. In contrast, some participants described times when they have worked with managers who they felt did not act with integrity, noting that this had a negative effect on the team as management trainees were singled out and spoken about behind their backs due to their limited experience.

> Having integrity as a manager. [FGP3] (Theme 7.4: Understanding)

***Social activities***

Other participants spoke to activities (e.g. bowling, trivia nights, casual dinners) to support employees and make them feel more like a team (Theme 7.3: Other strategies), as they believed their organisation currently did not provide enough opportunity for team bonding outside the work environment. However, as previously noted (Section 5.2.1), some participants felt they had been singled out for not attending such events.

***Constructive feedback***

The desire for constructive feedback from managers to the team and individuals, especially as a way of modelling appropriate behaviours and sound leadership, was evident in the data. Discussion evolved regarding the manner in which people are spoken to; at

times, even when the message is a valid one, the way staff are addressed and how public this communication is were viewed as inappropriate and could in, and of, itself be workplace bullying (Theme 7.2: Communication).

***Reflecting on chosen profession***

A comment of note from one respondent, FGP7, centred on reflecting on why individuals entered the healthcare profession. Participants reported that the healthcare profession is traditionally known for being a caring profession, especially amongst clinicians (Theme 7.4: Understanding), and being able to connect and remind colleagues of the reasons or drivers for their desire to work in the healthcare sector might contribute to staff being more engaged with their work and their colleagues, which might mean 'all this bullying stuff wouldn't exist' [FGP4] (Theme 7.4: Understanding). This prompted discussion among focus group participants regarding having empathy for colleagues and supporting them when experiencing challenges at work as a form of staff wellbeing.

> If you truly care about the people you work with and people you care for, there's no place for bullying in that type of culture. [FGP5] (Theme 7.1: Acknowledging positive actions)

***Managing underperforming staff***

Several participants discussed managing staff who are underperforming as a means of holding people to account for their actions, behaviours, and their performance measures (e.g. key performance indicators). They stated that performance-managing staff effectively would lead to positive relationships and respect amongst the team (Theme 7.1: Acknowledging positive actions).

Comments were made by some participants regarding the siloed nature of the healthcare sector, noting that the unique position they have as management trainees enables them to see the whole organisation and observe behaviours others may not be aware of (Theme 7.4: Understanding). These comments provide an insight into the contribution management trainees can make to the culture of an organisation and the influence they may have in future in a management role.

> We are in a unique position as a trainee to see the [whole] organisation. [FGP7] (Theme 7.4: Understanding)

### *Individual interviews*

The key theme which emerged from the individual interviews was that of communication (Theme 7.2). The most frequently reported experience among the management trainees was how other people communicate with them to guide and support them to become effective managers (Theme 7.2: Communication) in a constructive and positive way. This was further evidenced by some participants commenting at times the feedback is negative, punitive and public (Theme 7.4: Understanding) and that this makes them feel inadequate and uncomfortable. Some participants also mentioned that as they are often new to the organisation, they do not know the protocols or procedures for dealing with workplace bullying and are unsure who they should speak to about unacceptable behaviours. This demonstrates a limited understanding of existing procedures for reporting workplace bullying. This was corroborated by other participants commenting that in their role as a management trainee they were often tasked with projects across more than one team and were not always sure who was their direct line manager.

> There's the openness between either the manager and their staff would be extremely helpful to know that you could go to a particular person if something is happening. [IP1] (Theme 7.2: Communication)

> It's about educating people of firstly what is bullying behaviour in the workplace and secondly, what the lines of escalation, of how you report [bullying]. [IP6] (Theme 7.2: Communication and Theme 8.1: Responsibility)

### *Modelling appropriate behaviour*

The participants spoke about modelling appropriate behaviours as a key to enhancing positive relationships in the workplace as a manager (Theme 7.3: Other strategies) and felt that managers modelling behaviours expected from the team would, in turn, be reflected in the teams' actions. Participants suggested that modelling leadership by acting appropriately to deal with workplace bullying when it occurred demonstrated being an effective manager. The alternative view was also discussed. Participants reported that if they were aware of a senior manager engaging in workplace bullying of a junior manager, they would speak up. Their declared motivation to speak up was based on a belief that workplace bullying was not acceptable and that they had a duty to promote a positive culture and relationships (Theme 7.3: Other strategies).

> There needs to be more transparency between branches, organisations, teams so there's that communication that everyone is aware of what needs to be done [to enhance positive relationships]. [IP5] (Theme 7.2: Communication)

### *Building rapport*

Building rapport and positive relationships with people and being able to connect with them on different levels (Theme 7.4: Understanding) was identified by participants as a strategy that enhances trust and positive relationships. This was reported as a link to recognising when staff are performing well (Theme 6.6: Recognition) or have gone above and beyond and acknowledging them. Some participants commented on the training and professional development opportunities they had been provided as part of the GHMP and how key skills developed have assisted them in building positive relationships at work.

> Some of the best things I did were during my graduate training program, the conflict resolution, mediation and assertiveness training. [IP6] (Theme 7.2: Communication)

### *Understanding work motivation*

Understanding what motivates staff in their work was suggested by participants to develop positive relationships (Theme 7.4: Understanding) and the ability for managers to recognise the need to be flexible, as motivations will vary among individual team members. One respondent, IP3, commented that as a management trainee this was an important aspect of learning to become an effective manager and lead teams in future.

> Listening is essential to understand how people work and understand what their needs are. Once you have an understanding of why other people come to work and how they feel most comfortable contributing, you can build a positive relationship. [IP3] (Theme 7.2: Communication)

### *Core values of the organisation*

The core values of the organisation were mentioned by some as a way of fostering positive relationships and performance management of individuals (Theme 7.3: Other strategies). Participants suggested that if staff did not consistently demonstrate the core organisational values, they may be deemed as not a good fit for the organisation. They clarified that they were not aware of the process or outcomes if an individual did not abide by the values of the organisation.

### *Contributing to the culture of the organisation*

Several participants spoke about how they can contribute to the culture of the organisation by fostering positive relationships across teams. Some examples they provided were being friendly to everyone, making an effort to go out for lunch or coffee when they start with a new team, managing their own stress and taking the time to

maintain relationships with colleagues (Theme 7.3: Other strategies). They stated that one could contribute to a positive culture just by focusing on one's job and performing well.

> I try to give everyone the time of day, no matter if they're an administrative person, straight up to the CEO. I feel that everyone in the organisation has something to teach me. [IP4] (Theme 7.2: Communication)

The Employee Assistance Program (EAP) was mentioned as a strategy to build positive relationships as individuals are provided with access to someone external to their work situation, or even their personal situation, not only to discuss their concerns but also to provide insights and strategies they could implement (Theme 7.3: Other strategies).

***Summary***

A strategy repeatedly mentioned by participants in this study was modelling of appropriate behaviour by management and mentoring by more senior staff (Theme 7.3: Other strategies). This gives staff a clear indication of what positive relationships look like, and a confidential way to test ideas and understandings with a more experienced person.

Personal training in emotional intelligence or professionalism was also mentioned as a way of improving positive workplace relationships, implying positive relationships are partly dependent on self-awareness and individual development levels. Other strategies mentioned included encouragement to be generally friendly and polite, and guidelines on exactly what that looks like; asking people to reflect on the reasons they chose a career in the healthcare sector; reconnecting with the reason they chose to work in a predominantly caring profession and reflecting on how they are expressing that caring aspect of themselves in their work life; and teaching stress management strategies.

### 5.2.3 Theme 8: Reporting of workplace bullying

Participants in both the focus groups and individual interviews described their perception that staff need to be supported and encouraged to report workplace bullying. Participants in the focus groups spoke at length about responsibility in reporting incidents of workplace bullying, from lower-level staff to managers and senior executives. Participants in the individual interviews also described responsibility for reporting workplace bullying from the viewpoint of the bystanders or witnesses. This indicated that participants were able

to describe the importance of reporting workplace bullying, and this was identified as a theme with one sub-theme, responsibility (T8.1).

### *Responsibility*

The key finding emerging from the focus groups and individual interviews was responsibility (Theme 8.1). The most frequently reported experience amongst the management trainees was the need for everyone in the organisation to take responsibility for reporting workplace bullying (Theme 8.1). This was further evidenced by some participants commenting that all staff need to contribute to a culture in which workplace bullying is not accepted or condoned. (Theme 8.1: Responsibility). Participants were able to provide examples of when their organisations had not addressed the issue of workplace bullying effectively or had provided inadequate information about organisational procedures. The following quotations illustrate this theme.

> Somebody's responsible for preventing this bullying behaviour. We had a HR manager here and he's really famous for his bullying behaviour. [FGP5] (Theme 8.1: Responsibility)

> People went over to HR and within three days pretty much everyone knew about [the complaint]. There was no confidentiality which means no one's ever going to talk up about [bullying]. [FGP1] (Theme 8.1: Responsibility)

> There's a no-tolerance policy. That's documented steps to take on how to address bullying. I'm not sure. I haven't read it. [FGP7] (Theme 8.1: Responsibility)

> Promoting a culture of not accepting the bullying. Having workplace bullying policies and procedures and the whole idea of whistleblowers and things like that would obviously help. [IP7] (Theme 8.1: Responsibility)

### *Raising issues*

The participants indicated they were not always comfortable raising an issue as workplace bullying in case this course was disproportionate or they had misinterpreted the behaviour, and noted that this may in turn impact on their future employment prospects (Theme 8.1: Responsibility). Others commented that as management trainees they had observed many incidents of workplace bullying but did not feel empowered to report the behaviour or know how to progress reporting through their organisation.

> This is the person you report a grievance to but that's the person I have the grievance with. [FGP6] (Theme 8.1: Responsibility)

### *Unclear processes*

Participants commented on the perceptions of workplace bullying and the challenge in either speaking to the individual about their behaviour (when they may not even recognise they are engaging in bullying) or reporting the behaviour when the process is not always clear (Theme 8.1: Responsibility). Discussion included the dilemma of trying to report workplace bullying when the staff charged with dealing with it appear to not want to hear the grievance. The consensus among the participants was that the human resources department represents the organisation, and there was consequently a feeling of mistrust in reporting workplace bullying to the human resources department, even if this was the documented process.

> We have a grievance policy. Raising it through HR, but I think HR would probably view themselves as representing the organisation. [IP4] (Theme 8.1: Responsibility)

> I brought an issue to my manager's attention. I asked her about it later and she said I've addressed that. I don't know what happened. I'm not sure what she did. I didn't ask because I didn't think it was appropriate. [IP3] (Theme 8.1: Responsibility)

They stated as management trainees they did not want to be viewed as someone who made complaints about workplace bullying and commented that they would like to see a program where they were provided with strategies on how to deal with people or situations they believed related to workplace bullying.

> You set a program in place to manage that discontent and check in at regular intervals and provide them with services like Employee Assistance Program. [FGP3] (Theme 8.1: Responsibility)

### *Understanding existing processes and procedures*

Several participants spoke about the importance of reminding staff that workplace bullying is not okay and that if they feel uncomfortable with certain behaviours, they should be able to discuss this with their managers. The challenge is both in understanding the existing procedures the organisation has for reporting and in having confidence that it has effective processes and procedures in place to deal with workplace bullying. Participants spoke about having openness between managers and their staff and the benefits of knowing that one could seek one's manager out to discuss any concerns. Many felt this was not the case in their organisations.

> I haven't really noticed any process or come across any manager giving advice on what to do in a bullying situation. [IP5] (Theme 8.1: Responsibility)

> I don't think I've really had much on bullying in the workplace. I think it's one of those unknown zones still. [IP5] (Theme 8.1: Responsibility)

The participants frequently outlined effective strategies by describing ineffective policy in organisations they have worked in. Several participants commented that while their organisation did in fact have a policy in relation to workplace bullying, most offer limited guidance regarding reporting, i.e. what to report, how to report and to whom to report. Many stated that as management trainees they were simply provided with a link to the policy and asked to read it, without clearly understanding the procedures.

> Trying to report [bullying] to the right person who doesn't necessarily want to hear it. [IP2] (Theme 8.1: Responsibility)

> We have a very limited policy and that's probably it. [IP5] (Theme 8.1: Responsibility)

***Summary***

Universally, participants commented that reporting workplace bullying came with consequences (Theme 8.1: Responsibility) such as limiting career progression and future employment prospects. Other consequences included being labelled a troublemaker; having no clear outcome and the workplace situation worsening due to retaliation or because of perceived impunity; doubts about confidentiality; and damaging one's social standing with colleagues. Due to this, participants expressed a great reluctance to report workplace bullying.

### 5.2.4 Theme 9: Training needs

Participants in both the focus groups and individual interviews described a range of workplace bullying-related training that was available in their organisations and that they have participated in. Participants also described at length the deficits of the available training and how they perceived this as contributing to gaps in their understanding of how to deal with workplace bullying as GHMTs. This indicated that participants were able to describe existing training for workplace bullying in their organisations and was identified as a theme with two sub-themes: existing training (T9.1) and training needs (9.2).

***Existing anti-bullying training in healthcare***

Focus group participants and interviewees had varying opinions about existing anti-bullying training (Theme 9.1). The most frequently reported experience amongst the management trainees focused on existing training and the ineffectiveness of that which

was offered (Theme 9.1: Existing training). They spoke about the inconsistencies in anti-bullying training offered in their organisations and suggested areas where training or information could be improved (Theme 9.2: Training needs). Participants elaborated that policies are useful as a guide but have limited impact on changing the culture of the organisation (Theme 9.1: Existing training). In addition to effective policy, participants noted the essentiality of interpersonal skills (e.g. communication, emotional intelligence, resilience, empathy) to being an effective manager. The following quotations from participants illustrate this theme.

> I think policy is [important]. Zero tolerance is in the code of conduct. [But] what can we as an organisation do? Instead of going zero – that's unrealistic. [FGP4] (Theme 5.4: Strategies for dealing with bullying in the workplace and Theme 9.1: Existing training)

> Policy is great for guiding you around process but it's not great guiding you around relationships and the way that you do that. [FGP2] (Theme 9.1: Existing training)

A number of participants commented on the skills and knowledge they would find useful as a management trainee and the particular types of workshops they would value (Theme 9.2: Training needs). This highlights management trainees' need for further anti-bullying training or workshops to be offered.

> The training that sometimes is given, the person thinks this doesn't apply to me, [because] I'm the manager. [IP2] (Theme 9.1: Existing training)

> It's mandatory that every staff member attend a bullying workshop session. What we are told in that session is of new regulations which are that if you see [bullying] you must report it. [IP3] (Theme 9.1: Existing training)

> The bullying survey came up and then someone on the Board noticed that people thought they were bullied. Then they said show this bullying video. Not in recent years have I had any training. [IP7] (Theme 9.2: Training needs)

***Skill development for responding to workplace bullying***

Several participants spoke about the development and modelling of key leadership skills such as communication, emotional intelligence, empathy, teamwork and collaboration for management trainees. They also commented on the need to develop certain skills (e.g. resilience) for those who are being bullied so that they are able to deal with workplace bullying more effectively, and stated they would appreciate more opportunities to participate in this type of training.

> How do we give people the skills and it's maybe people don't have the skills to deal with [bullying]? [FGP5] (Theme 9.2: Training needs)

> That's probably why programs like the one that we've been on or are going through [GHMP] are important because they give you that guidance and they give you that support and they teach you the right behaviours. [FGP1] (Theme 9.1: Existing training)

A number of participants stated that the concept of emotional intelligence should have greater emphasis for management trainees and middle managers (Theme 9.2: Training needs), as should information regarding the values of the organisation, including clearly stating what behaviours are acceptable and appropriate (Theme 9.2: Training needs). This demonstrates that management trainees would like to be exposed to further training and workshops.

> I haven't really noticed any process or come across any manager giving advice on what to do in a bullying situation. So, I think that's a space to be better looked into and maybe strengthened. [IP1] (Themes 9.1: Existing training and 9.2: Training needs)

According to participants it is important that management trainees participate in a program to develop knowledge of what workplace bullying is and what behaviours are acceptable, and the skills to deal with workplace bullying (Theme 9.2: Training needs). There was discussion about the best ways to achieve this: 'how do you give people the skills' [FGP5]. Participants noted that current approaches, including the voluntary nature of participation in workplace bullying prevention classes, were less than ideal.

> There was a brief 15- or 20-minute presentation and a group activity around [the presentation] about how to deal with workplace bullying. [FGP3] (Theme 9.1: Existing training)

> We have some bullying prevention classes but it's not mandatory. [The classes] happen monthly, I think it's one or two hours. [FGP1] (Theme 9.2: Training needs)

### *Effective programs*

A program introduced by NSW Health called Essentials of Care (EOC) (NSW Health 2016) was mentioned by several participants. This learning and development program is designed to engage healthcare teams to activate local action plans to improve practice in delivering healthcare and to contribute to the development of a culture of critical inquiry. Some participants reported that in organisations they worked in which had introduced the EOC program (NSW Health 2016) they have observed a positive change in the culture of the organisation.

> They introduced Essentials of Care and there was a massive shift in culture. [FGP5] (Theme 9.1: Existing training)

Others spoke about the perceived ineffectiveness of the wide-scale workplace culture survey rolled out across NSW Health.

> We did the Yes Survey, but I don't think anything came of that. [FGP7] (Theme 9.1: Existing training)

***Organisational and individual responsibility***

The participants spoke about open and transparent communication embedded into the core values of the organisation as part of the existing training mechanisms to enhance positive relationships (Theme 9.1: Existing training). Accountability was also mentioned; everyone in the organisation has a responsibility for dealing with workplace bullying by reporting, attending anti-bullying training and behaving in an appropriate manner in the workplace. Some suggested an accountability measure should be introduced in the public health sector in NSW, with a hard line taken for those engaging in workplace bullying, similar to a three-strikes-and-out system; however, they described this as unrealistic and difficult to monitor (Theme 9.2: Training needs). Participants reported this would be easier in the private health sector; some had experience working in that sector and had observed occasions when staff had been placed on formal improvement plans due to their inappropriate behaviour. Some participants also stated that the private sector is an attractive option for people and these organisations would have no difficulty in recruiting if staff were to leave.

Participants described the disproportionate number of staff allocated to their organisation to support the mandatory training requirements in the public health sector.

> They've started a positive culture consultant, workplace culture consultant. But one person in a district the size of a district is … [FGP6] (Theme 9.1: Existing training)

***Orientation for new staff***

The participants spoke to their specific organisations' orientation processes for new staff and discussed how these were limited regarding the outlining of acceptable behaviours or documentation of reporting processes (Theme 9.1: Existing training). Participants also noted that they had not been made aware of specific processes or even provided with advice from their managers on how to deal with a workplace bullying incident, and, in fact, the entire area was very unknown. Several participants spoke about their experience

of being directed to posters hung throughout the corridors and to mandatory training, questioning the efficacy of this strategy in dealing with workplace bullying over time.

> They bombard us with posters and in-services here, there and everywhere. I don't know how effective that is. [IP8] (Theme 9.1: Existing training)

A number of participants reported that the culture in some healthcare organisations was a barrier to reporting workplace bullying and suggested that a package whereby skills are developed for staff to empower them to report workplace bullying would be of assistance to them as management trainees (Theme 9.2: Training needs).

***Summary***

While it was clear that the types of training varied from workplace to workplace, participants reported that the available training covered a number of important areas (Theme 9.1: Existing training). Management trainees suggested further training and workshops could be developed with a focus on how to appropriately use power; how to behave in a professional manner; communication skills; how to discuss with another staff member when their behaviour is unacceptable; how to work better as a team; knowing the correct escalation pathways; how to reflect on one's behaviour in the workplace to identify areas for improvement; mandatory reporting regulations; having a duty of care to each other; what workplace bullying is; and how to manage a one-off incident (Theme 9.2: Training needs).

There were a range of responses in relation to existing practices for raising awareness of the issue of workplace bullying in their organisations. These practices included a 15–20-minute presentation; a class of 1–2 hours; being shown a video after a workplace bullying incident in the organisation came to light; and on-the-job training. Most felt the information was not getting to the staff who they believed needed it, as the classes were optional, and those staff simply did not attend. There were repeated suggestions that making the classes mandatory would be helpful in changing culture. Those participants working in organisations with mandatory classes reported an improvement in workplace culture.

## 5.3 Respondent validation interviews

Respondent validation interviews were conducted to further explore and confirm the findings from the four key themes regarding strategies for dealing with workplace bullying

and the discussions which evolved from the focus groups and individual interviews data: (1) dealing with workplace bullying; (2) positive relationships; (3) reporting of workplace bullying; and (4) training needs. Most participants agreed with the findings and provided further information. The following outlines the responses from the respondent validation interviews, which provided further information about workplace bullying in a health context.

### 5.3.1 Theme 5: Dealing with workplace bullying

Participants agreed with the examples from the findings of useful strategies for dealing with bullying in the workplace (Theme 5.4), such as improving communication skills and improving organisational culture.

> Knowing what [workplace bullying] is and where to go for help. Like an organisational chart – if this happens do this. But I guess it would be different for every workplace. [RVP2] (Theme 5.4: Strategies for dealing with bullying in the workplace)

Other suggestions from participants that provided further exploration of the findings included ensuring staff hear back and are kept informed of progress after they have made a complaint, rather than it disappearing into the system and the person never hearing back about it or never knowing the outcome.

> To understand the impacts bullying has on people. People can get sick from it, mental health stuff. Its important people know what [bullying is] but more importantly to know who to report to in your organisation and that something's actually going to get done. Simple strategies not ones that will take months to implement. [RVP1] (Theme 5.4: Strategies for dealing with bullying in the workplace)

### 5.3.2 Theme 7: Positive relationships

Participants agreed with the findings and spoke about investigating and legitimising all complaints so staff know vexatious complaints and petty grievances will be weeded out. A further exploration of the findings resulted in participants describing that a dim view should be taken of petty grievances in organisations. Some participants commented that the consequences for workplace bullying need to be clear and act as a deterrent across the entire organisation.

> I'm a proponent of the need for effective training and education in all areas of health, this would be no different. Managing those difficult conversations with your team or individuals is always a challenge. At times there may be misunderstandings which

> could lead to unacceptable behaviours or outbursts. [RVP3] (Theme 7.2: Communication)

> There are either ill-defined HR procedures or they are not clearly outlined so that would be a strategy to investigate, how to ensure the procedures are effective and well-communicated to all. [RVP2] (Theme 7.2: Communication)

One respondent, RVP4, spoke about the need to include the patient's perspective in developing effective strategies for healthcare organisations.

> Not forgetting about patients in this process either. [RVP4] (Theme 7.2: Communication)

Several participants commented that as management trainees they could contribute to building positive relationships in their organisations by valuing the opportunity they have been provided on the GHMP.

> To build positive relationships by what I can give back to the organisation. I think that's why people may value me as a management trainee, because I do try to give back to the organisation from what they give to me. [RVP1] (Theme 7.1: Acknowledging positive actions).

### 5.3.3 Theme 8: Reporting of workplace bullying

Participants in the focus groups and individual interviews noted that, as management trainees, they are not aware of the processes for escalating issues or complaints nor of to whom they need to report workplace bullying. Participants corroborated these discussions by commenting that the challenges of reporting workplace bullying include not being aware of what behaviours constitute workplace bullying and, therefore, being uncertain about whether the incident should be escalated and reported.

> That's the thing, you don't really. I suppose it has more to do with what other people think is not ok and you sort of go with that. [RVP2] (Theme 8.1: Responsibility)

### 5.3.4 Theme 9: Training needs

Participants reported that there are a variety of training courses offered in healthcare but that they do not focus on dealing with workplace bullying. Participants agreed with the findings, noting that what training is offered is not always effective or sustained. Some participants suggested there is a need to include workplace bullying and its impact on healthcare organisations as a subject in their university courses, particularly in the health management degrees.

> Education. There's lots of training in health, with online modules now but not a lot on bullying or how to deal with it. There's a poster I've seen but other than that not much. [RVP3] (Theme 9.1: Existing training)

> It certainly wouldn't hurt and there's not much available which specifically focuses on bullying. [RVP3] (Theme 9.2: Training needs)

> Some health organisations have a range of online modules though the people management doesn't address bullying specifically. [RVP4] (Theme 9.2: Training needs)

> There's not even a focus in some of the University subjects for health managers. [RVP5] (Theme 9.2: Training needs)

## 5.4 Conclusion

The current chapter presented the findings relating to strategies for dealing with workplace bullying which emerged from the exploration of phase one: six research questions, interpreting the emergent themes and the three key data sets: focus groups; individual interviews; and respondent validation interviews. This chapter also provided a detailed discussion regarding the four identified themes, namely: Theme 5: Dealing with workplace bullying; Theme 7: Positive relationships; Theme 8: Reporting of workplace bullying; and Theme 9: Training needs which influence strategies for dealing with workplace bullying. There was also discussion on the sub-themes which emerged as a result of the coding. The qualitative data from all three data sets are rich and specific comments and findings for each data set and each theme have been included.

There were three broad themes that were consistently mentioned across all three data sets. Themes 1 (power), 2 (culture) and 3 (reporting) emerged consistently throughout the focus group discussions, individual interviews and respondent validation interviews. These broad themes will be discussed in further detail in Chapter 7.

The next chapter will focus on phase two of the study, which involved establishing an international expert reference group to provide feedback by way of proof of concept and expert comment on the provisional anti-bullying learning framework developed specifically for this study.

# Chapter 6: Phase 2: Results of Expert Reference Group

## 6.1 Introduction

The previous two chapters discussed the results from phase one of the study, with findings from the three data sets: focus groups, individual interviews and respondent validation interviews. This chapter presents the results from phase two of the study, the expert reference group and the quantitative and qualitative surveys, as outlined by Figure 6.1 below. Data were collected from this group during the period 1 August–30 September 2016.

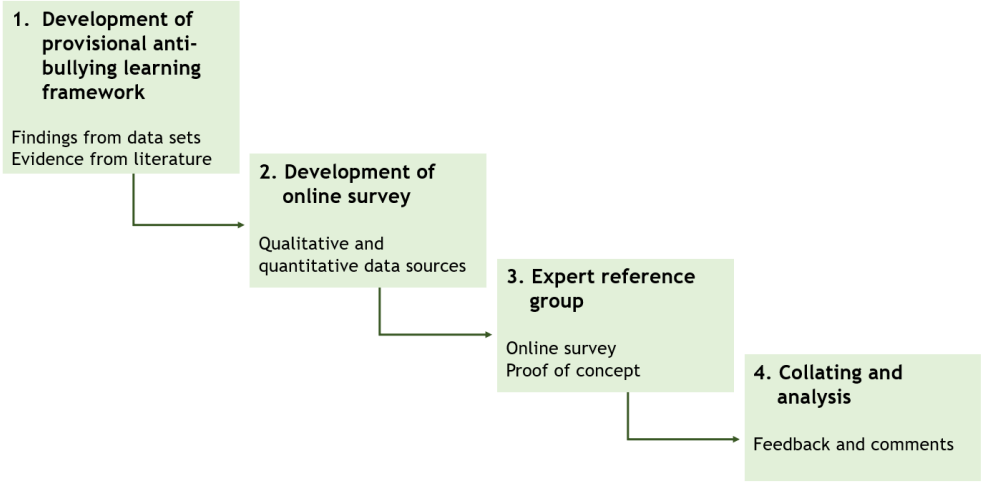


**Figure 6.1:** Research approach – phase two.

The purpose of this study was to investigate GHMTs' perceptions of workplace bullying. As a result of phase one – in particular, the consistent findings regarding limited awareness of what constitutes workplace bullying, limited understanding of existing procedures for reporting and the need for further training or workshops – a provisional anti-bullying learning framework was developed. Phase two of this study involved establishing an international expert reference group to provide feedback by way of proof of concept (Kendig 2016) and for their expert comment on the provisional framework for healthcare settings.

Education and awareness-raising are needed as a prevention strategy to address bullying in the workplace (Cowan 2012; Einarsen 2011; Johnson 2011; Bryant et al 2009; Knox Haly

2008). Assisting organisations to change attitudes towards workplace bullying is vital if we are to deal effectively with the increase in, and the impact of, workplace bullying in Australia (Balducci et al 2011; Bellot 2011; Cleary 2009). A provisional anti-bullying learning framework was developed to address RQ6: What are the essential elements of a learning framework designed specifically for emerging health managers? Evidence demonstrated that targeted training in the form of awareness-raising could address the issue of organisational cultures that may encourage conformity and acceptance of workplace bullying (Balducci et al 2011; Bellot 2011; Cleary 2009). The aim of the provisional framework is to provide guiding principles and a range of effective strategies for healthcare organisations to consider when developing training modules to understand and address workplace bullying.

## 6.2 Provisional anti-bullying learning framework

Figure 6.2 below provides a graphical representation of the five guiding principles and a brief description of the provisional anti-bullying learning framework developed specifically for this study.

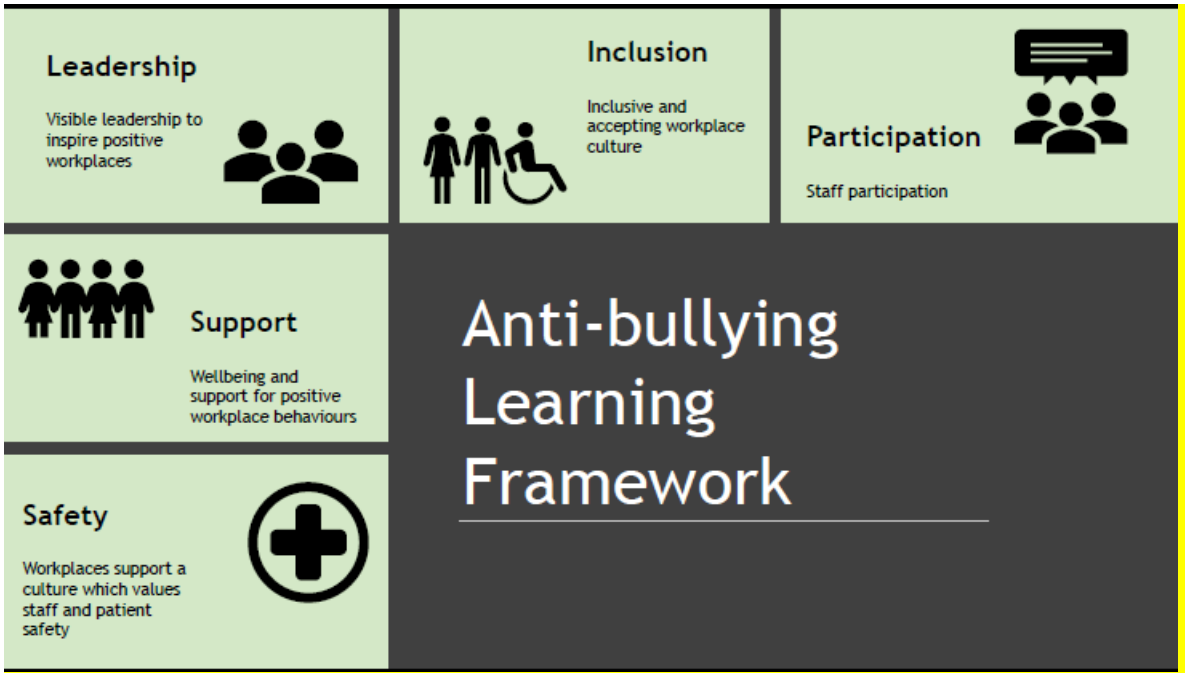


**Figure 6.2**: Guiding principles – provisional anti-bullying learning framework.

The guiding principles informed the development of effective practices and aims for workplace bullying programs in healthcare settings based on the researcher's expertise and the findings from the three data sets. Table 6.1 below outlines these components, which underpin the provisional anti-bullying learning framework.

**Table 6.1:** Provisional anti-bullying learning framework aims

| | |
|---|---|
| Aims | • To provide information and develop understandings about workplace bullying in healthcare organisations<br>• To implement an anti-bullying policy in individual workplaces |
| Target participants | Emerging and middle managers and team leaders in Australian health services |
| Learning outcomes | • Define workplace bullying<br>• Describe workplace bullying<br>• Define key issues to change workplace bullying<br>• Describe whole-of-organisation strategies to address workplace bullying<br>• Identify positive initiatives which help address workplace bullying<br>• Define essential features of an anti-bullying policy<br>• Describe recent Australian research findings about workplace bullying |

The provisional anti-bullying learning framework encompasses key guiding principles and effective practices for workplace learning and development, specifically in healthcare settings. Table 6.2 below describes the guiding principles for anti-bullying training in the provisional framework in detail.

**Table 6.2:** Guiding principles for anti-bullying training

| Guiding Principles | | Effective Practices |
|---|---|---|
| **Leadership**<br><br>Visible leadership to inspire positive workplaces | Chief Executives and senior executives play an active role in building a positive workplace environment where the whole organisation feels included, connected, safe and respected. | • Learning and development programs are supported by health service leadership.<br>• Communications align with the messages delivered within the training and inform employees about: how to access training; the requirement to undertake training; and how the training applies within the workplace.<br>• Managers and leaders are trained in additional areas such as understanding their legal obligations and the skills required to identify psychological hazards and ensure appropriate control measures are in place.<br>• Combined learning and development sessions are conducted with managers and staff, which support understanding of different roles, common understanding of acceptable workplace behaviours and collaboration across disciplines.<br>• Health service leaders are committed to building the capability of their workforce by modelling best practice, encouraging staff participation in learning and development opportunities and providing programs that contribute to the creation of a positive workplace culture. |
| **Inclusion**<br><br>Inclusive and accepting workplace culture | All staff in the organisation are active participants in building a culture which values diversity, and fosters positive, respectful relationships. | • Learning and development programs match the values of the health service and help build a positive work-place culture.<br>• Learning and development programs reinforce acceptable and respectful workplace behaviour in a positive way, also recognising the need for improvements in culture across the healthcare sector.<br>• Learning and development needs of different types of employees are assessed regularly.<br>• Learning and development programs are accessible and appropriate for building knowledge and skills.<br>• Learning and development programs emphasise the collective responsibility of management and staff to promote a safe and respectful workplace culture and improve capabilities such as leadership, performance management, communication and values-driven practice. |
| **Participation**<br><br>Staff participation | Individuals are active participants in their own learning and wellbeing, feel connected and use their social and emotional skills to be respectful, resilient and safe. | • Learning and development programs support the identification, development and promotion of acceptable workplace behaviours, including the importance of speaking out about inappropriate and negative workplace behaviours.<br>• Learning and development provides opportunities for staff to reflect, embrace key messages and acquire new skills.<br>• Learning and development programs are offered in different modes to support different learning styles.<br>• Delivery of training and development is appropriate for the audience and purpose of the training.<br>• Learning and development maximises engagement, self-reflection, shared learnings, acquisition of knowledge and skill development.<br>• Learning and development programs are based on best-practice evidence.<br>• Learning and development programs are composed of discrete modules which support the efficient delivery of relevant information and skills development. |

| Guiding Principles | | Effective Practices |
|---|---|---|
| **Support**<br><br>Wellbeing and support for positive workplace behaviours<br><br> | All staff share and encourage an understanding of wellbeing and support for positive workplace behaviour. | • Learning and development programs should be based on the definitions of workplace bullying, harassment and discrimination. (acknowledging these terms can be defined in different ways by different organisations and groups).<br>• Staff members receive induction training that, at a minimum, includes information on:<br>— the standards of behaviour expected in the workplace including the use of social media, if relevant<br>— how workplace bullying, harassment and discrimination should be reported and how such reports are managed<br>— where to go internally and externally for more information.<br>• Learning and development programs include information on:<br>— how individuals can respond to inappropriate behaviour including workplace bullying, harassment and discrimination and support others to respond<br>— how to report workplace bullying , harassment and discrimination<br>— the various processes, interventions and time frames for responding to workplace bullying, harassment and discrimination. |
| **Safety**<br><br>Workplaces support a culture which values staff and patient safety<br><br> | All staff are committed to enhancing a culture, within a system, that supports safety, continuous improvement and quality outcomes. | • Mechanisms exist to incorporate findings from analysis of measures such as training outcomes, indicators and incidents into actions across organisational culture, quality and safety domains. |

### 6.2.1 Quantitative survey – proof of concept for the provisional anti-bullying learning framework

This section outlines the results of the quantitative survey questions provided to the international expert reference group to explore the proof of concept for the provisional framework. The purpose of seeking feedback was to inform future practice for the development and implementation of learning frameworks that address workplace bullying in healthcare settings. This feedback could also provide scope for further development in subsequent studies. A range of questions were developed to elicit responses regarding the relevance of the guiding principles in the provisional framework. These guiding principles help inform effective practices for future development and implementation of learning and development programs in healthcare settings to address the issue of workplace bullying. The experts were asked to provide feedback on the effective practices in the provisional framework. Table 6.3 below highlights the responses from the expert refence group to the specific principles in relation to the effective practices in the provisional framework, which may lead to the development of a learning and development program.

**Table 6.3:** Expert reference group responses – provisional anti-bullying learning framework

| | STRONGLY DISAGREE | DISAGREE | NEUTRAL | AGREE | STRONGLY AGREE | TOTAL |
|---|---|---|---|---|---|---|
| a. Aims and learning outcomes clearly stated | 0 | 0 | 0 | 4 | 0 | 4 |
| b. Duration of each session is adequate | 0 | 0 | 1 | 3 | 0 | 4 |
| c. Language used is appropriate, sensitive and free of jargon | 0 | 1 | 1 | 1 | 1 | 4 |
| d. Blend of engaging learning experiences | 0 | 1 | 1 | 1 | 1 | 4 |
| e. Opportunities for participants to contribute to discussion | 0 | 0 | 0 | 3 | 1 | 4 |
| f. Teaching methods used are appropriate and will enhance learning | 0 | 1 | 1 | 2 | 0 | 4 |
| g. Evidence of peer interaction in sessions | 0 | 0 | 0 | 4 | 0 | 4 |
| h. Opportunities for collaborative learning | 0 | 0 | 0 | 4 | 0 | 4 |
| i. Facilitator's notes provide sufficient direction | 0 | 0 | 0 | 3 | 1 | 4 |
| j. Activities are sequential and build on knowledge and concepts | 0 | 0 | 0 | 4 | 0 | 4 |

There was strong support from the respondents to principles (a) aims and learning outcomes were clearly stated; (g) evidence of peer interaction in sessions; (h) opportunities for collaborative learning; and (j) activities are sequential and build on knowledge and concepts, with four respondents indicating they agreed with these statements. These principles were also considered to be strengths of the provisional anti-bullying learning framework.

A total of three respondents also indicated they agreed and, one respondent said that they strongly agreed, with principles (e) opportunities for participants to contribute to discussion, and (i) facilitator's notes provide sufficient direction. Some respondents commented that facilitators would need a strong background in the material and provided suggestions, which are highlighted in the following discussion regarding the content.

In terms of principle (b) duration of each session is adequate, one respondent indicated they were neutral although three respondents agree with the statement. Further comments were made by the respondents providing recommendations for the duration of the sessions; it was suggested that session three could be broken down into three shorter sessions of 60-minute duration. This is highlighted in the following discussion regarding the content.

The variations across some of the responses for principles (c) language used is appropriate, sensitive and free of jargon; (d) blend of engaging learning experiences; and (f) teaching methods used are appropriate and will enhance learning, may be attributed to the countries of residence of the experts participating in this study. The same respondent indicated 'disagree' to these three principles; this was the respondent from the United Kingdom, whose background is in human resources and management. The nuances in describing workplace bullying in different countries is evidenced in the literature, which notes that no universal definition exists (Branch, Ramsay and Barker 2013; Cowan 2012; Piotrowski 2012; Samnani and Singh 2012; Rutherford 2004). The provisional anti-bullying learning framework was developed specifically with an Australian audience in mind and, therefore, the terminology is appropriate to this need and incorporates language which is widely accepted.

Responses also varied for principle (f) teaching methods used are appropriate and will enhance learning, with one respondent disagreeing, one respondent neutral and two

respondents agreeing with this statement. Respondents provided suggestions in regard to the use of video- or internet-based activities to enhance the learning; this is highlighted in the following discussion.

Experts were asked to comment on the guiding principles outlined in the provisional framework. They all acknowledged that workplace bullying is very complex, and that any organisation can have occurrences of workplace bullying. The key is how organisations respond to workplace bullying and this includes developing a positive work environment based on positive behaviours addressing a range of issues embedded into procedures and policies. The experts agreed the guiding principles in the provisional anti-bullying learning framework were comprehensive. One respondent, ERGP4, questioned whether there should also be some consideration of legal components (criminal or civil) covering how Australian laws deter workplace bullying; it should be noted this respondent was from the USA, where civil litigation is more common. Overall, the respondents indicated the guiding principles for the provisional anti-bullying learning framework were strong and they provided some suggestions and recommendations for future development and refinement.

### 6.2.2 Qualitative survey – workplace bullying in global healthcare settings

This section will outline the results from the qualitative survey in which the expert reference group was asked to provide comments on broader issues of workplace bullying in healthcare settings. These questions were posed to take advantage of the respondents' expertise and experience on a global scale and to explore approaches that might inform the development and implementation of effective practices for future anti-bullying learning frameworks in healthcare settings in Australia.

A section was included in the survey to elicit broader discussion regarding workplace bullying in the healthcare setting and to draw on the experiences of these international experts. Understanding workplace bullying in different healthcare settings may provide an awareness of other practices management trainees may encounter in their future roles as healthcare leaders. Six key questions were posed to the expert reference group for comment and discussion based on their knowledge and experience in the field of workplace bullying and health management issues. The primary aim was to explore how other countries deal with workplace bullying, either in a healthcare setting or in general workplaces, and to identify strategies or approaches that may be similar and/or different

to healthcare settings in Australia. Table 6.4 outlines the questions posed for this section of the survey.

**Table 6.4:** Expert reference group responses – broader issues

| | |
|---|---|
| 1. | What is unique about workplace bullying in healthcare? |
| 2. | Describe any 'cutting edge' approaches to dealing with workplace bullying in your country. |
| 3. | Describe approaches to dealing with workplace bullying in a healthcare context in your country. |
| 4. | What other workplace bullying programs have you been involved with? |
| 5. | How do these compare with other programs you may be aware of? |
| 6. | Describe 'best practice' implementation for workplace bullying programs. |

The following discussion outlines the specific responses to these broader questions. The researcher wanted to explore whether there were aspects of workplace bullying unique to a healthcare setting that may not be evident in other contexts. Respondents commented that workplace bullying generally occurs in very intense, high-stress situations where emotions are already heightened. This is supported by findings from the focus groups and the individual interviews, with comments embedded in Theme 1 (level of awareness of workplace bullying) and Theme 3 (causes of workplace bullying), which reinforce that healthcare environments are intense and create high stress among workers, particularly GHMTs. Other experts (ERGP1 and ERGP2) commented that they did not necessarily see anything unique about workplace bullying in healthcare but, rather, more that there are likely similar behaviours, similar contributing factors and similar outcomes across many sectors and industries, although they did not elaborate on what these were. Others (ERGP 4) commented that the expectations around interactions between the different professional services make the behaviour unique to a healthcare setting. The contribution of the hierarchical nature of health systems – and specifically the interactions between doctors and nurses – to workplace bullying was mentioned by three out of four respondents, and this in fact may be a unique aspect within healthcare that is not evidenced in other workplace environments.

Three out of four respondents (ERGP2, ERGP3 and ERGP4) spoke to specific skills training as an approach to dealing with workplace bullying and commented that, in their

experience, effective workplace bullying programs focused on skill development to ensure long-term behavioural and cultural change rather than off-the-shelf or one-off programs. ERGP3 and ERGP4 suggested programs with approaches to developing empathy have proven to be successful, although they did not mention any specific programs but, rather, general in-principle approaches. Findings from the focus groups and individual interviews also support this view that the development of empathy would be beneficial, as evidenced in Theme 5 (dealing with workplace bullying) and Theme 7 (positive relationships). Other approaches that received frequent mention were programs which develop skills in emotional intelligence, conflict resolution and anger management. These skills have been identified in the literature (Jenkins 2013; Hutchinson et al 2010; Bryant et al 2009) as those which can effectively deal with workplace bullying and should be taught within an organisational framework. The research also indicates that a move towards restorative practices will have longer-term impacts on reducing workplace bullying. These approaches are also supported in the findings from the focus groups and the individual interviews, such as Theme 5 (dealing with workplace bullying) and Theme 7 (positive relationships).

ERGP1 and ERGP2 commented that successful programs that they have been involved in generally focus on positive behaviour and cultural development rather than specifically focusing on workplace bullying. At the core of these programs is skills development such as interpersonal skills training and training in emotional intelligence. One respondent, ERGP4, mentioned 'character education', a term loosely used to describe developing the skills of good manners such as moral, civic and socially acceptable behaviours. This term can now encapsulate social and emotional learning, critical thinking, conflict resolution and mediation. These skills and concepts are well supported by the literature (Good et al 2018; Branch, Ramsay and Barker 2013; Dutton et al 2013; Caponecchia and Wyatt 2011; Einarsen et al 2009) contained within this study, in addition to findings from the focus groups and individual interviews in Theme 5 (dealing with workplace bullying), Theme 7 (positive relationships) and Theme 9 (training needs). The findings from the experts indicated that there are no significantly different approaches adopted internationally for dealing with workplace bullying.

Respondents did not identify anything different to what they deemed the standard approaches to dealing with workplace bullying across all sectors and industries – that is, raising awareness of the issue and nature of workplace bullying, reviewing or developing

policies and procedures, developing a reporting process, and mechanisms for data collection. The research supports a whole-of-organisation and sector-wide approach to address these aspects and provide for cultural change, regardless of whether or not it is in a healthcare setting (Askew et al 2012; Broome and Williams-Evans 2010; Cleary et al 2009). The provisional anti-bullying learning framework incorporates these practices and was commended by the experts.

The researcher posed the question of how these approaches and programs might compare with others the experts were aware of. Three out of four respondents commented that in a healthcare setting there would be a need for close partnerships between management and unions to implement any program or change. ERGP3 and ERGP4 stated that the clinical workforce is highly unionised in Australia and many other countries and this needs to be navigated deftly by managers to ensure a whole-of-organisation approach (Australian Public Service Commission 2006). Other respondents (ERGP2 and ERGP3) commented that some programs that purport to address workplace bullying are of only a few hours' duration with no follow-up or evaluation process to evaluate efficacy. This was reinforced by findings from the focus groups and individual interviews in Theme 1 (level of awareness of workplace bullying), Theme 5 (dealing with workplace bullying) and Theme 9 (training needs). ERGP2 and ERGP3 stated that a key strength of the provisional framework is the fact that a learning and development program could be developed with a number of sessions of varying length which can be revisited and reviewed on an ongoing basis.

The experts suggested that prioritising and committing to the time necessary to develop the different practices contained within the provisional framework would be critical, and challenging for organisations if they were serious about dealing with workplace bullying. They indicated that a session focusing on policy development could take significant time if all members of the organisation are to be engaged and involved.

ERGP2 and ERGP4 reflected that the success of any program in workplaces is in large part due to effective implementation of programs, policies and procedures. They commended the provisional framework as a first step to raising awareness of workplace bullying and suggested it could then be used in conjunction with other programs and initiatives. The findings from the focus groups and the individual interviews also reinforced that the length of training sessions available and the mandatory nature of some of these short sessions are not as effective as they should be, as highlighted by comments in Theme 1 (level of

awareness of workplace bullying), Theme 5 (dealing with workplace bullying) and Theme 9 (training needs).

The experts were asked to describe best-practice models for implementation of workplace bullying programs based on their experience. Most respondents commented that the issue of workplace bullying is complex. They suggested that the overarching premise for best practice of workplace bullying programs is that it involves good change management and implementation principles. One respondent, ERGP3, discussed 10 key change management and implementation principles in detail: (1) Address the human side systematically; (2) Start at the top; (3) Involve every layer; (4) Make the formal case; (5) Create ownership; (6) Communicate the message; (7) Assess the cultural landscape; (8) Address culture explicitly; (9) Prepare for the unexpected; and (10) Speak to the individual.

There was consensus amongst the experts that another best-practice model involves engaging all members of the organisation in addressing the issue of workplace bullying in a positive way, although they also conceded this would be challenging across large and complex organisations such as those in the health sector. Respondents noted that research identifies that workplace bullying occurs when workers are stressed and have no margin in their lives; individuals may then act out in harmful ways and cope negatively with their situation. This is also supported by the findings from the focus groups and individual interviews in Theme 3 (causes of workplace bullying), Theme 4 (consequences of workplace bullying) and Theme 6 (nature of workplace bullying). The experts discussed the impacts of this behaviour on colleagues and co-workers, including on the quality of life, quality of work environment, quality of interpersonal relationships, quality of patient care and provision of support and/or self-care.

## 6.3 Conclusion

The current chapter has examined the results from the expert reference group, which was phase two of the study. The expert reference group was established to provide feedback and comment on the guiding principles of the provisional anti-bullying learning framework specifically designed for this study. The results from the expert reference group support the findings from phase one and aligned with the key themes, specifically: Theme 1 (level of awareness of workplace bullying); Theme 3 (causes of workplace bullying); Theme 4 (consequences of workplace bullying); Theme 5 (dealing with workplace bullying);

Theme 6 (nature of workplace bullying); Theme 7 (positive relationships); and Theme 9 (training needs).

Overall, the respondents indicated the guiding principles for the provisional anti-bullying learning framework were strong and they provided some suggestions and recommendations for future development and refinement. Further development of the provisional framework could be undertaken in future research studies to incorporate the suggestions and recommendations from the expert reference group. This could lead to a pilot being conducted with further re-development to provide for use in a variety of workplace settings worldwide. This will be discussed further in Chapter 8.

The researcher also explored broader issues relating to workplace bullying in a range of health contexts internationally. The expert reference group commended the provisional anti-bullying learning framework and suggested it be used in conjunction with other learning and development programs and initiatives. This research supports a whole-of-organisation and sector-wide approach that addresses these aspects and provides for cultural change regardless of whether or not it is in a healthcare setting. The provisional framework incorporates these approaches and was commended by the experts. The implications of the results from the two phases of this study will be discussed in detail in the following chapters.

# Chapter 7: Discussion

## 7.1 Introduction

### 7.1.1 Overview of the study

This thesis commenced with an overview of the purpose of this study, which was to develop a comprehensive understanding of GHMTs' perceptions of workplace bullying. An outline of the literature review undertaken as part of this study was then provided. The literature review identified a gap in the knowledge of GHMTs' perceptions of workplace bullying. The literature review also highlighted the need to develop definitions, policies, procedures and frameworks which could prevent, or at least, address workplace bullying. The reviewed studies illuminated a range of strategies, which, when implemented effectively, were thought to be able to reduce the frequency of workplace bullying.

Workplace bullying in the health sector affects the individuals involved, the organisations and the patients they serve (Livne and Goussinsky 2018; Branch, Ramsay and Barker 2013; Broome and Williams-Evans 2010; Felblinger 2009). The prevalence of workplace bullying throughout the medical workforce in Australia and elsewhere has received minimal research focus (Amrein 2012). Many factors impact on prevalence rates, including how workplace bullying is defined, population size, measurement and reporting systems, and cultural practices around workplace bullying. The evidence base needs to be improved, as there are challenges in gathering statistics based on lack of a common definition; self-reporting, which can result in both under- and over-reporting; lack of consistency in research and data; and myriad regulators and commissions who require reports, resulting in unnecessary duplication (Safe Work Australia 2016; Askew et al 2012; Cleary et al 2009; Einarsen et al 2009; Hauge et al 2009).

The research methodology, design and strategy used in this study were then outlined. A discussion of the methodological foundations was followed by an overview of the key research paradigms adopted in this study. Details were provided about the key data sets and composition of each of the data sets. Results from phase one were outlined in detail. This phase involved three qualitative data sets: focus groups, individual interviews and respondent validation interviews, each of which was used to elicit a range of perceptions, experiences and understandings about workplace bullying. Details regarding ethical and

research approvals were outlined, as was the reflexive processes undertaken by the researcher.

As a result of phase one and the consistent findings regarding limited awareness of what constitutes workplace bullying, limited understanding of existing procedures for reporting and the need for further anti-bullying training or workshops, a provisional anti-bullying learning framework was developed specifically for this study. As the paucity of research in this field using qualitative methods is evident in the literature, the purpose of this study was to elicit and describe perceptions from GHMTs towards workplace bullying. Results for phase two of this study involved the establishment of an expert reference group to provide feedback by way of proof of concept (Kendig 2016) as well as expert comment on the provisional anti-bullying learning framework.

This chapter will focus on a detailed and comprehensive discussion of the common themes from the findings across the data sets and will highlight the significance of these results. There were also unexpected results from the study, which will be discussed. Links to the literature and the findings described in Chapter 2 will be identified to outline the implications for healthcare management and emerging managers. The aim of this chapter is to contribute to a deeper understanding of the potential impacts of workplace bullying to patient quality and safety in healthcare based on the perceptions of GHMTs. This discussion may have broader implications for leadership practices in healthcare and providing a safe and positive working environment for all staff – in other words, essentially what gives us joy, meaning and purpose at work.

## 7.2 Summary of research findings

This section will summarise the findings of the study. Two overarching domains emerged from phase one of the study: (1) perceptions of workplace bullying and (2) strategies for dealing with workplace bullying. These themes and the findings from this study will be discussed and a summary of each research question will be presented. Table 7.1 below provides an overview of the research plan including the key research questions and the key findings for the two phases of this study.

**Table 7.1:** Detailed overview of research plan with key findings

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output | Key findings |
|---|---|---|---|---|---|---|---|
| **Scoping**<br><br>Context, setting and research tool development | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviour? | 1.1 Literature review (Chapter 2) | • To examine the academic literature on workplace bullying – both nationally and internationally<br>• To identify what is known about workplace bullying in a health context<br>• To identify what is known about perceptions of workplace bullying in a health context<br>• To identify gaps in the literature relating to health management trainees<br>To establish the conceptual framework for the study<br>• To identify valid methods for data collection on workplace bullying | • Medical databases – peer reviewed journals and/or book chapters<br>• Grey literature – reports and publications from government websites<br>• Snow-balling – identified researchers in the field | Thematic analysis<br><br>Content analysis | • Development of research questions and research tools<br>• Positioning of proposed research study based on literature | • Gap in literature – health management trainees 'perspective<br>• Gap in literature – healthcare settings in Australia |
| | | 1.2 Informal discussions with HDR supervisors and independent health management consultants | • To understand healthcare settings from research colleagues with health service research expertise and experience (ie HDR supervisors and health management consultants) | • Discussions with key people who are either researchers or practitioners with expertise in health services management and /or social sciences research at the University of New South Wales and the University of Technology Sydney | Content analysis | | |

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output | Key findings |
|---|---|---|---|---|---|---|---|
| **Phase one**<br><br>Data gathering and analysis<br><br>Formal validation of themes<br><br>Interpretation of emergent themes and findings | **RQ1:** How do graduate health management trainees define workplace bullying behaviours?<br>**RQ2a:** What types of behaviours do graduate health management trainees consider to be workplace bullying?<br>**RQ2b:**What types of bullying behaviours have graduate management trainees observed in their role as a health manager?<br>**RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?<br>**RQ4:** How do health managers support staff to encourage reporting of workplace bullying?<br>**RQ5:** What approaches (if any) does their organisation have in place for dealing with workplace bullying? | 2.1<br>Focus group discussions and individual interviews | • To explore graduate health management trainees' perceptions of workplace bullying<br>• To investigate graduate health management trainees' understandings of workplace bullying<br>• To explore how graduate health management trainees, define, experience and respond to workplace bullying | • Graduate health management trainees in NSW healthcare settings | General inductive approach<br><br>Content analysis<br><br>Thematic analysis | • Identification of themes and sub-themes<br>• Validating study findings<br>• Theoretical interpretation of emergent findings | Two overarching domains, key themes and sub-themes<br>1. perceptions of workplace bullying<br>• level of awareness<br>• behaviours<br>• causes<br>• consequences<br>• nature of bullying behaviours<br>2. Strategies to deal with workplace bullying<br>• dealing with bullying behaviours<br>• positive relationships<br>• reporting<br>• training needs |

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output | Key findings |
|---|---|---|---|---|---|---|---|
| **Phase one (cont'd)** | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?<br>**RQ4:** How do health managers support to encourage reporting of workplace bullying?<br>**RQ5:** What approaches (if any) does their organisation have in place for dealing with workplace bullying?<br>**RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 2.2 Respondent validation interviews | • To validate/check the findings from the focus groups and individual interviews<br>• To explore emergent themes | • Graduate health management trainees in NSW healthcare settings | Qualitative interviews<br><br>Content analysis<br><br>Thematic analysis<br><br>General inductive approach | • Interpreting study findings | • Reinforced key themes and sub-themes<br>• Further explored concept of training and professional development |
| | **RQ3:** What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours? | 2.3 Theoretical interpretation | • To interpret emergent findings using existing theory | | Content analysis<br><br>Thematic analysis | • Theoretical interpretation of findings | • Reinforced key themes and sub-themes<br>• Further explored concept of training and professional development |

| Research phase | Key research question | Component | Aim/strategy | Participants/ data sources | Data analysis method | Output | Key findings |
|---|---|---|---|---|---|---|---|
| **Phase two**<br><br>Development of provisional anti-bullying learning framework | **RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 3.1<br>Draft provisional anti-bullying learning framework | • To develop a best-practice framework focused on workplace bullying in healthcare settings<br>• To test a proof of concept | • Expert reference group of national and international researchers/ academics/experts in the field of workplace bullying and/or healthcare | Qualitative survey - online<br><br>Quantitative survey- online<br><br>Proof of concept | • Provisional anti-bullying learning framework | • Five Guiding Principles for healthcare settings developed<br>1. Leadership<br>2. Inclusion<br>3. Participation<br>4. Support<br>5. Safety<br>• Effective practices for healthcare settings developed |
| | **RQ6:** What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers? | 3.2<br>Expert reference group | • To evaluate key principles and effective practices for learning and development frameworks focused on workplace bullying<br>• To test a proof of concept | • Expert reference group of national and international researchers/ academics/experts in the field of workplace bullying and/or healthcare | Qualitative survey - online<br><br>Quantitative survey - online<br><br>Proof of concept | • Provisional anti-bullying learning framework | • Experts agreed Guiding Principles were strong<br>• Suggestions and recommendations for future development and refinement |

### 7.2.1 Overarching domain – perceptions of workplace bullying

The findings from phase one of the study identified key themes from GHMTs which were classified as elements that describe a person's perception of workplace bullying. These themes included: the level of awareness of workplace bullying; behaviours which constitute workplace bullying; causes of workplace bullying; consequences of workplace bullying; and the nature of workplace bullying. The literature describes elements that influence perceptions of workplace bullying (Wilson 2016; Rodwell and Demir 2012; MacIntosh et al 2010; Escartin et al 2009; Cornero and Martinez 2005; International Council of Nurses 2005) and which were similar to the themes which emerged from the GHMTs. Figure 7.1 below outlines the themes and the findings identified by GHMTs in this study, which were grouped as perceptions of workplace bullying.

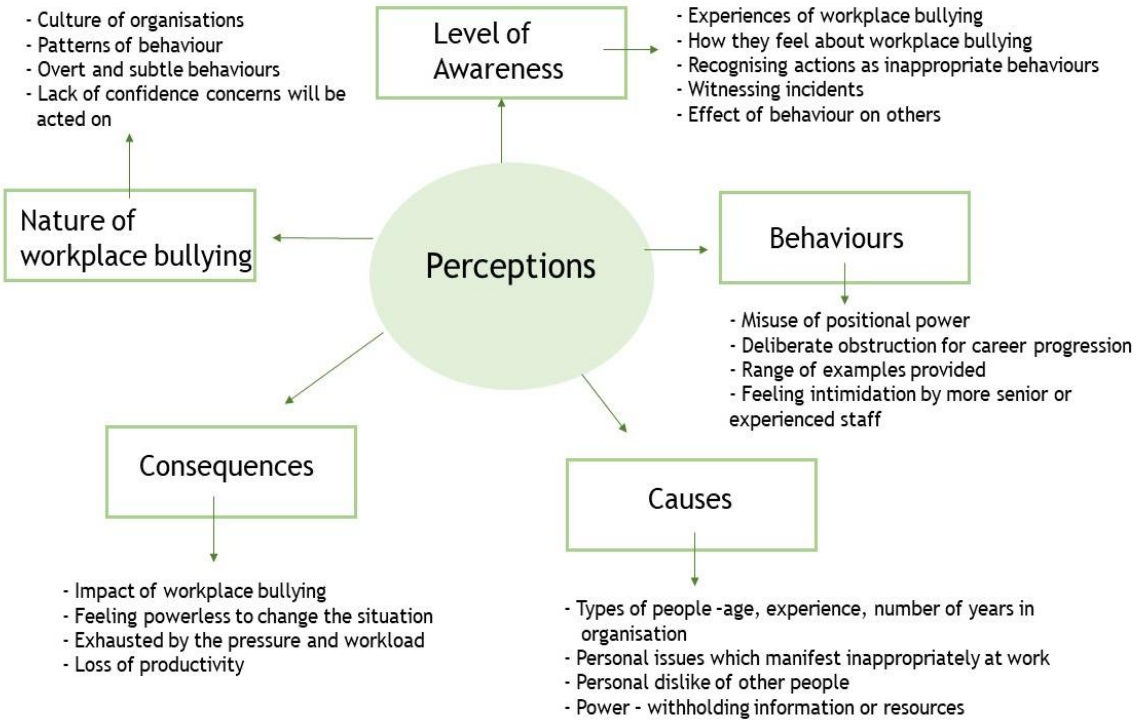


**Figure 7.1:** Trainees' perceptions of workplace bullying.

GHMTs described their perceptions of workplace bullying by providing comments about their experiences of workplace bullying in their healthcare organisations and the impact of organisational culture on their confidence in taking appropriate action. Health management trainees spoke about how they felt when witnessing workplace bullying and

their observations of the effects on other people of inappropriate behaviours. They were able to recognise behaviours that constitute workplace bullying, such as the misuse of positional power, and some described this as a deliberate obstruction to career progression or using power to withhold information or resources, which prevented them from completing tasks. They also provided a range of examples of workplace bullying incidents they had witnessed, and some commented that these incidents had contributed to them feeling intimidated by senior or experienced staff. Participants described the causes of workplace bullying in their experience, such as the age or experience of individual staff members or the length of time they have been employed in the organisation. GHMTs commented on personal issues affecting individuals which may impact on their behaviour at work and the increasing pressure and workload, which is exhausting. They were also able to describe consequences of workplace bullying for the organisation, such as loss of productivity, as illustrated by the following quotations.

> If you support someone, they're more likely to be productive. [FGP2] (Theme 1: Level of awareness of workplace bullying)

> By not giving the right people, the right resources, access to people or people stopping what you're trying to do, which stops you from doing your job. [IP6]. (Theme 3: Causes of workplace bullying)

> They'll probably leave. You spend a lot of time recruiting them. Those people given a choice would leave. People are disengaged. [IP3] (Theme 4: Consequences of workplace bullying)

### 7.2.2 Overarching domain – strategies for dealing with workplace bullying

The findings from phase one of the study identified key themes from GHMTs were classified by the researcher as elements that describe strategies for dealing with workplace bullying. These themes included: dealing with workplace bullying; positive relationships; reporting of workplace bullying; and training needs. The literature describes key strategies for dealing with workplace bullying (Einarsen and Nielsen 2018; Berry et al 2016; NSW Public Service Commission 2014; Cleary 2009) and these were similar to the themes which emerged from the GHMTs. Figure 7.2 below outlines the themes and the findings identified by GHMTs in this study, which were grouped as strategies for dealing with workplace bullying.

**Figure 7.2:** Strategies for dealing with workplace bullying.

GHMTs described strategies their organisations use to address workplace bullying and commented on the deficits of the currently available training, which contribute to the gaps in their knowledge and understanding of workplace bullying. Participants spoke about the need for mechanisms not only for reporting workplace bullying but also for clear procedures communicated across the organisation to encourage and support staff to report incidents. They discussed that, as future health leaders, they would encourage positive relationships and building trust, respect and acceptance of each other's needs, which would impact on the culture of the organisation, and commented that polices alone were limited in changing the culture of an organisation. They expressed the view that for managers to be effective in dealing with workplace bullying, they need good interpersonal skills.

### 7.2.3 Research question one

RQ1: How do graduate health management trainees define workplace bullying behaviours?

Research question one was posed to the focus groups and individual interview participants during phase one of the study. The literature review identified that a common, universally accepted definition of workplace bullying does not exist and is instead based on the

individual's perception of what constitutes workplace bullying. The findings for this research question were varied, as expected; however, the common definition across the data involved behaviours which are harmful to others, repeated and have an impact on the target's feeling of self-worth. The similarities across the data collected defined workplace bullying as behaviours that make people feel continually uncomfortable. Other elements characterising workplace bullying as identified by GHMTs included unwanted behaviour; singling people out; deliberately ignoring people; and being disrespectful of others. Healthcare organisations will need to determine and adopt a clear definition of workplace bullying in their specific context in order to deal appropriately with workplace bullying.

### 7.2.4 Research question two

RQ2a: What types of behaviours do graduate health management trainees consider to be workplace bullying?

RQ2b: What types of behaviours have graduate health management trainees observed in their role as a health manager?

Findings from these research questions across the data collected highlighted a range of examples of incidents of workplace bullying in healthcare organisations. The most common behaviour from the findings was backhanded or demeaning comments and gossiping about GHMTs, often in a public space in the workplace. This was further highlighted by similarities in the findings regarding being excluded from meetings or projects. Findings also included verbal abuse to undermine and intentionally put down the GHMT. A finding which emerged from the data was the potential to use technology to enact workplace bullying such as via emails or text messages. While not a common finding, it is of interest given that workplaces are becoming more agile as organisations cater for staff who work remotely.

In response to question 2b, specific behaviours observed by GHMTs included those where there was an imbalance of power, perceived unfair treatment or favouritism. The data also indicate that talking negatively about other healthcare organisations was common. In addition, behaviours that deliberately isolated people was a key finding. Similar findings across the data were behaviours that impacted on trainees being able to perform the tasks of their job, such as being denied access to resources, information or people. A finding

from the data which provided a difference was the observation of workplace bullying more frequently in hospital settings than in healthcare agencies.

### 7.2.5 Research question three

RQ3: What are graduate health management trainees' perceptions of, and attitudes to, workplace bullying behaviours?

The most significant finding for the perceptions of GHMTs regarding workplace bullying from the data was the use of power and the culture of the organisation. Similarities across the data found that the healthcare sector is hierarchical and can lead to a culture in which workplace bullying is accepted. The findings also indicated trainees perceive the ageing workforce and burn-out among middle managers as contributors to workplace bullying. Similarities in findings from the data pointed towards the perception that other staff are insecure about their positions when trainees are working in their team. In addition, the increased workloads, pressure to perform and stress of staff – both from work and from their personal lives – emerged from the data as a finding regarding how trainees perceive workplace bullying. The findings also described some different attitudes regarding innovation and new ideas and the data highlighted that GHMTs experience workplace bullying as they are perceived to be a threat to staff who have been in the same role for many years.

Findings showed that clinicians or senior long-serving staff who are 'getting results' for the organisation often have their inappropriate behaviour ignored and this goes to the use of power and the culture within an organisation. Findings from the data demonstrated that GHMTs overwhelmingly agreed that workplace bullying is not acceptable in healthcare organisations.

### 7.2.6 Research question four

RQ4: How do health managers support staff to encourage reporting of workplace bullying?

A finding from the data was that health management trainees did not feel supported in reporting incidents of workplace bullying, as they believe that reporting procedures for workplace bullying within their healthcare organisations were ineffective. The findings also highlighted that trainees knew that reported incidents were not dealt with

appropriately or in a timely manner. This finding was similar across the data, with numerous references to the human resources department being ineffective.

Common findings regarding how to encourage staff to report workplace bullying were that trainees were reminded by their health managers that if they were uncomfortable, they could speak with them. Health managers also provided support for trainees to address the issue of workplace bullying themselves before making a formal report. In addition, findings from the data highlighted that health managers could reinforce the values and behaviours of the organisation which could support trainees in reporting workplace bullying. The data also indicated that many of these practices had varying success rates as some GHMTs did not feel supported in reporting workplace bullying (particularly if it was against their manager) or felt that the mandatory training was not effective.

Another finding was that mentoring was used in some healthcare organisations. In these cases, trainees are able to have confidential conversations with someone they trust – who may be outside their organisation – to encourage reporting of workplace bullying. A similarity across the data was the finding that health managers support trainees in attending mandatory training and workshops where the procedure for reporting workplace bullying is outlined. Trainees believe some of these workshops were ineffective and did not provide strategies to deal with workplace bullying.

### 7.2.7 Research question five

RQ5: What approaches (if any) does their organisation have in place for dealing with workplace bullying?

A key finding from the data was that health management trainees are not clear on the approaches and strategies for dealing with workplace bullying within their healthcare organisations. Similarities across the data were that health management trainees were not confident that the ani-bullying training offered was well attended or followed up in their organisations. The findings from the data included the use of posters and workshops as approaches which trainees believe were ineffective. A common finding across the data was the existence of a policy dealing with workplace bullying in their organisation, although these contained limited information on strategies for addressing workplace bullying, focusing instead on the process for reporting or escalating incidents.

The use of mediation or arbitration in organisations through workplace culture consultants was viewed by trainees as having a positive influence on the culture of the organisation. Another similarity across the data was that in healthcare organisations the key approach is commonly to report workplace bullying to the human resources department.

### 7.2.8 Research question six

RQ6: What are the essential elements of a learning framework to deal with workplace bullying designed specifically for emerging health managers?

A finding that emerged from the data was the health management trainees desire to have access to effective education and training on workplace bullying and ongoing learning and development opportunities. Common findings across the data regarding essential elements included: the need for a clear definition of workplace bullying; standards of acceptable behaviour; procedures for reporting workplace bullying; support when experiencing workplace bullying; and interventions to deal with workplace bullying. Another similarity across the data was that the senior leadership in the organisation had a key role in actively addressing workplace bullying by implementing effective strategies. Findings from the data in relation to essential elements also included that all staff, not just health managers, need to participate in learning and development programs to promote safe and respectful working environments. In addition, elements which included the development and enhancement of a range of skills were evident in the data. Key skills included communication, resilience and emotional intelligence. The findings also pointed to the need for mechanisms to incorporate analysis of any workplace surveys, training or metrics regarding incidents of workplace bullying.

## 7.3 Discussion of common themes

The following discussion focuses on the common themes which emerged across all the data sets and provides a greater understanding of workplace bullying from a GHMTs perspective. The sample size from which the data was gathered was representative and adds to the knowledge of the specific group studied, namely management trainees. The results provide meaningful findings and insights which could be significant in adding to the knowledge of workplace bullying in healthcare. Comparatively more discussion of particular themes was evident in the individual interviews than in the focus group

participants, which provided for the richness in the findings. This was to be expected, as several of the participants nominated to participate in the individual interviews rather than the focus groups due to the sensitive nature of the topic and, perhaps, their direct experiences with workplace bullying.

Three broad themes cut across all the data sets. These themes focused on (1) power, (2) culture and (3) reporting. Table 7.2 provides a summary of the constant themes across the three data sets and the sub-themes to which they are aligned. An example quote from the participants from the data set is included to further highlight the themes and to also illustrate how they are interrelated.

### 7.3.1 Power

The theme of misuse of positional power (Hutchinson et al 2010; Agervold 2009; Balducci et al 2009; Turney 2003) was universally of great concern to GHMTs because of its perceived prevalence; its potential effect on career progression; the potential for more junior staff to follow the behavioural lead of senior staff, leading to a worsening of the situation for the victim; and the inescapable nature of positional power, with the view that one can hardly avoid one's manager indefinitely. GHMTs are employed in supernumerary positions and therefore feel they have no positional power in their organisations. These concerns are supported by the literature, which also describes informal positions of power in healthcare (Gordon et al 2015; Gabel 2012; Isosaari 2011; Milton 2010). Gabel (2012, p. 1159) states that 'power and leadership are linked … leadership in healthcare involves … power'.

There was some reporting from GHMTs of people in positions of power being aware that their victim was also being bullied by others and taking no action. There were other comments from the GHMTs that staff notorious for workplace bullying, such as senior clinicians, would openly dismiss junior staff's complaints about this unacceptable behaviour with an almost 'too bad, I don't care if it upset you' attitude. These findings are supported by Gabel (2012), who discusses positional power used by clinicians, in particular doctors, to influence medical staff, patients and students. Pierro et al (2011) and Raven (2008) also discuss the use of coercive power by people in supervisory roles and the threat of demotion, undesirable work arrangements or projects. GHMTs frequently commented on their experiences of the use of coercive power.

**Table 7.2** Summary of cross-cutting themes

| Constant broad theme | Themes and Sub-themes | Example quote |
|---|---|---|
| Power | Theme 2.1; 2.2; 2.3; 2.4<br>Theme 3.3<br>Theme 5.1; 5.2; 5.4<br>Theme 6.4; 6.5 | Just thinking about the particular profession that isn't used to having their opinions questioned. So that is very much positional power. It can be abused by some. [IP7] (Theme 5.2: Organisational culture and Theme 6.5: Power)<br>I have seen that, not with me personally, but I have heard of trainees who have been singled out in meetings for not knowing something or not being prepared. And because you might only be in that rotation for a few months it's hard to speak up. I would chat to my supervisor about it if it happened to me. [RVP5] (Theme 2.4: Public humiliation and Theme 5.4: Strategies for dealing with bullying in the workplace) |
| Culture | Theme 2.3; 2.4; 2.6<br>Theme 5.1; 5.2; 5.3; 5.4<br>Theme 6.2; 6.4<br>Theme 7.1 | You can feel the culture. You can walk into a ward or an environment where you know it feels good and supportive and fun. [FGP4] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)<br>There is an acceptance that this is okay behaviour where we work. So therefore, it's part of the culture of the organisation. [IP5] (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture)<br>As a trainee you know you're not in a position where you can call people on their behaviour if they are far more senior. But I would definitely talk to someone else, like my Supervisor or even another Trainee if it was bothering me. [RVP2] (Theme 5.4: Strategies for dealing with bullying in the workplace) |
| Reporting | Theme 1.1; 1.2<br>Theme 8.1<br>Theme 9.1 | This is the person you report a grievance to but that's the person I have the grievance with. [FGP6] (Theme 8.1: Responsibility)<br>Promoting a culture of not accepting the bullying. Having workplace bullying policies and procedures and the whole idea of whistle-blowers and things like that would obviously help. [IP7] (Theme 8.1: Responsibility)<br>As a trainee it might be difficult to report because of the position we are in. Also, I think there is fear attached to what if you report something that isn't bullying and it's hard to recover from that. [RVP3] (Theme 1.1: Effect on the co-worker and Theme 8.1: Responsibility) |

GHMTs also commented on their observations that there was a tendency for workplace bullying to spread through a workplace or team. Observing the situation go unchecked created a greater likelihood others' would also begin to display such behaviour; this view is supported by Allen (2015) and Quine (2001). GHMTs took the view that poor performance anywhere in the organisation had the potential to negatively impact patient safety and care. Johnson (2009) and Rutherford and Rissel (2005) discuss patient safety from a nursing perspective, highlighting that due to workplace bullying, nurses were less tolerant of their patients. Rowe and Sherlock (2005) and Griffin (2004) argue that less experienced clinicians are more likely to make mistakes as a result of workplace bullying. The impact on patient safety due to workplace bullying will be explored further in section 7.5.5.

Positional power was the most commonly identified factor by GHMTs in workplace bullying, with individuals seen as inheriting power due to their status in the organisation. Studies by Einarsen and Nielsen (2018), Gabel (2012) and Turney (2003) support this finding, linking positional power with status in the organisation. Another common theme repeatedly referred to by GHMTs was a lack of the personal skills needed to deal with power – that is, the ability to be assertive rather than aggressive (and knowing the difference); having a clear barometer of what does and does not constitute professional behaviour of the standard expected in the workplace and the standard expected of management; and recognising the line between direct and authoritative performance management and workplace bullying. This is well supported by the literature referenced in this study (Glaso and Notelaers 2012; Gumbus 2011; Lovell and Lee 2011; Broome and Williams-Evans 2010, Saunders et al 2007).

GHMTs described in detail Theme 2.2, intimidation, which covered all forms of direct person-to-person workplace bullying. Some of the behaviours mentioned included harassment; behaviour which is repeated towards a recipient; causing others to feel demeaned, whether verbally or non-verbally (e.g. rolling of the eyes); pressuring people into doing things they are uncomfortable with; attempting to assert dominance (with or without positional power); ignoring personal space or personal boundaries; coercion; being singled out for repeated or unjustified criticism; being victimised or picked on; discrimination based on personal characteristics such as appearance or race; exclusion; being treated with disrespect; negative feedback on work performance without constructive suggestions for improvement; dehumanising people and treating them like a

commodity; managers displaying inappropriate behaviour and then warning junior staff who have witnessed it to respect the manager's confidence; singling a person out for undue pressure; refusing to accept limitations created by genuine medical conditions; and threatening a person's employment.

Senior clinicians were identified repeatedly by GHMTs as a source of workplace bullying. Some GHMTs viewed the behaviour of senior clinicians as aggressively targeting any perceived threats to patient care and they were therefore conflicted about whether this behaviour might be condoned by staff. Senior staff in general were felt to be threatened by up-and-coming junior staff, resulting in resistance to new ideas or ways of working, which could be interpreted as workplace bullying by the junior staff member (Theme 3.3: Threat). It was also felt that senior staff who did not receive the same standard of training may feel threatened by the more highly educated junior staff. There was also recognition some workplace bullying incidents are career-related, in that people may display very different behaviours at work to outside of it, perhaps in an effort to advance their careers, and therefore the term 'bullying behaviours' was more accurate than to label a person 'a bully' in general.

Theme 6.5, power, was mentioned in many ways by GHMTs, who felt power was associated with workplace bullying – from misuse of positional power, to bullying in order to *feel* personally powerful, at any level of the organisation; a definition of workplace bullying that included making another feel powerless was often mentioned. Maintaining and increasing power was commonly observed by GHMTs to be a major reason for workplace bullying, in such ways as undermining those perceived as a threat to one's career; limiting access to the resources necessary to achieve the results needed to progress one's career; and maintaining one's status and, therefore, both power within the organisation and self-esteem.

The hierarchical nature of the healthcare sector was discussed by GHMTs as contributing to workplace bullying. This view is evident in the literature, which highlights that static and hierarchical leadership relationships remain the norm in healthcare (Gordon et al 2015; Yukl 2013), as does having older staff in senior positions, who perhaps came up in the ranks when behavioural expectations were different. The point was made by GHMTs that workplace bullying from a junior or lower-ranked member of staff towards a more senior member was almost unheard of; the majority of observed and experienced

workplace bullying occurred between peers or was directed from higher positions towards lower (Theme 6.5: Power). GHMTs commented that this might be due to a workplace culture in which managers have observed other managers behaving this way, or have experienced managers behaving in this way towards them when they were more junior and noted this behaviour went unchecked.

Findings from the focus groups and the individual interviews also reinforced this view in Theme 5 (dealing with workplace bullying) and Theme 6 (nature of workplace bullying). The hierarchical nature of healthcare and the high-stress environment is also well supported by the literature, which notes that workplace bullying is evident in organisations where hierarchical systems and structures are the norm (Johnson 2015; Biggio and Cortese 2013; Drabek and Merecz 2013; Cowan 2012; Samnani and Singh 2012; Balducci et al 2011; Bellot 2011; Casida and Parker 2011; Einarsen et al 2011; Cleary et al 2009, Saunders et al 2007).

A distinction can be made between overt positional power, feeling personally powerful due the ability to affect someone else, and knowledge as power. The healthcare sector contains many different areas of specialised knowledge, with no one person knowing everything about how the system works, and this creates opportunity for conflict as workers push different agendas based on their understanding of the needs of their own area. Pushing an agenda outside of one's governance process or undermining people, whether above or below the perpetrator in position, was said to be workplace bullying. Indeed, any act which interfered with a person's ability to do their job and/or progress on their career path was viewed as a form of workplace bullying. The literature supports this view among GHMTs, as studies demonstrate that workplace bullying can include deliberately excluding someone from workplace activities (Safe Work Australia 2013; Cleary et al 2009; Rutherford 2004) or withholding information that is vital for effective work performance (Live and Goussinsky 2018; Safe Work Australia 2013; Askew et al 2012; Cleary et al 2009).

While GHMTs acknowledged the increased stress that comes with a management position, there was also a perception that workplace bullying directed toward lower level staff to achieve improved results was largely about wanting to progress one's own career. A key question here is, what are acceptable ways to use positional power, and what are not? In general, this was very unclear to GHMTs in this study.

The provisional anti-bullying learning framework will address the issue of power in healthcare organisations by understanding different roles and common understanding of acceptable behaviours and collaboration across disciplines. The framework also emphasises the collective responsibility of management and staff to improve capabilities such as leadership, performance management, communication and values-driven practice.

### 7.3.2 Culture

Many GHMTs expressed a strong desire for management to have the ability to model appropriate workplace behaviour in order to create a positive workplace culture and improve their ability to contribute productively. The literature supports this view, as workplace bullying may be about leadership and organisational issues as well as interpersonal relationships within organisations (Fontes et al 2019; Johnson et al 2015; Van Rooyan and McCormack 2013; Becher and Visovsky 2012; Spence Laschinger et al 2012; Gumbus 2011). Isolating or excluding a person was seen by GHMTs to be a form of workplace bullying (Theme 2.3: Isolating) and may be either direct, by a particular person, or indirect, by attempting to influence the perception of the group regarding the victim, which may lead to their exclusion by the group. Excluding a person was felt to be humiliating or intimidating ('If you are observing it, it's really uncomfortable' [IP6]); damaging to self-esteem ('It can lead to depression for some people who are really upset' [IP3]); and affecting the ability to work as a team ('It can make you not want to come into work, lower staff morale especially and bullying can lead to a low performing team' [IP7]). Isolating behaviours contributed to poor workplace culture, which could lead to the staff member seeking employment elsewhere, as well as negative emotional consequences on a personal level for the victim. GHMTs commented that some behaviours were difficult to recognise and name as workplace bullying, with people inclined to feel they may be being too sensitive and perhaps imagining it. This view is supported by the literature, in particular House of Representatives Standing Committee on Education and Employment (2012), Rocker (2012), Casida and Parker (2011) and Felblinger (2009). GHMTs cited particular behaviours – such as closing the door before people walk into a room to indicate they are not wanted; talking about people behind their back; not responding to or ignoring people; and being consistently unfriendly to a particular staff member – to illustrate the difficulties in recognising the more subtle behaviours and to highlight workplace culture.

GHMTs identified a clear trickle-down effect of observing workplace bullying by senior staff members going unchecked, creating a culture of bullying all the way down the line to the detriment of workplace culture and employee productivity. GHMTs stated that if even one person, at any level, was seen to get away with it, it was not possible to credibly rein in the behaviour when coming from anyone else, or to make a case that the behaviour was unacceptable. The literature supports this, as studies have described competitiveness (Cleary, Walter, Horsfall and Jackson 2013), compensation for deficiency (Cleary, Walter, Horsfall and Jackson 2013; Balducci et al 2011), protection of self-esteem (Chang and Lyons 2012; Balducci et al 2011) and envy (Chang and Lyons 2012; Agervold 2009) as contributing factors that may threaten a person's position, job or status in an organisation. There was also mention by GHMTs of the very salient point that because management must accept accountability for meeting targets, any underperforming staff member begins to be viewed as a threat to that manager's position, job or status within the organisation.

Several participants made very strongly worded negative comments about their experience of the organisational culture within the healthcare sector regarding workplace bullying (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture). There was comment that lip service is paid to anti-bullying measures (e.g. a policy stating the organisation has a zero-tolerance approach to workplace bullying) but that policies are not seen to be enacted by the organisation. GHMTs reported that a great deal of workplace bullying incidents going on unchecked was common, between staff competing for resources and positions, between senior management, from management to staff (Livne and Goussinsky 2018; Cleary, Walter, Horsfall and Jackson 2013; Chang and Lyons 2012). GHMTs commented that often staff felt unable to approach management for help, support, mentoring or suggestions, for fear of being labelled incompetent. This negatively affected GHMTs' ability to improve their skills and performance levels or reach performance targets and had a negative effect on workplace culture. Repeated complaints were also made about management behaving in an unprofessional manner – for example, venting personal criticism of senior management to more junior staff, who were unhappy to be recipients of this. GHMTs commented that if one person in a workplace regularly behaved poorly without rebuke, no matter at what position in the organisation, it was not possible to make a case for the behaviour being unacceptable when displayed by someone else, causing workplace culture to deteriorate. Studies from Cleary, Walter, Horsfall and Jackson (2013) and Bartos et al (2008) describe managers who demonstrate hostile

behaviours towards individual employees as reinforcing inappropriate behaviours. There was a general statement by GHMTs that management must model correct behaviour in the workplace as an example for other staff, as there is a human tendency to take one's behavioural cues from authority figures.

The workplace culture which trickled down from these staff members meant initiatives by staff to improve the culture and create positive relationships were not supported and were ultimately unsustainable, with the staff members attempting to initiate change sometimes becoming victims of workplace bullying themselves. Franklin and Chadwick (2013), Jenkins (2013), Anderson (2011) and Chiaburu and Harrison (2008) describe how organisations can establish norms and patterns of behaviour across groups, teams or departments that may lead to a more positive workplace culture. One participant, FGP6, stated 'it is hard to stick up for people day in, day out', but also commented that not doing so gave them a burden of guilt which made the workplace a very unpleasant place to be. Other staff being aware of workplace bullying going on unchecked was viewed as enormously detrimental to workplace culture by GHMTs; it caused staff to be unhappy working there, which sometimes lead to high staff turnover, as staff believed there was nothing which could be done to change the situation and moving on was the only option, resulting in costs to the organisation in time, money and efficiency over time. The literature (Amrein 2012; Becher and Visovsky 2012; Bellot 2011; Hoobler et al 2010) supports these findings.

There was, again, recognition by GHMTs of the stress that management is under, how difficult the healthcare sector can be to work in (particularly in regard to limited money and resources), and the burn-out effect this can have when previously enthusiastic staff members feel unsupported or unable to achieve their goals and vision for their work for extended periods, perhaps decades. There was a view that problem staff members are repeatedly remediated or simply moved to other departments because of a lack of staff; the difficulty and expense of recruiting staff; the negative effect on continuum of care for patients; and the greater value placed on the staff member's ability to achieve results than on their behaviour and contribution to workplace culture. Therefore, the problem often recurs somewhere else. GHMTs made the point that a positive work environment may make staff easier to attract and retain, as well as increasing productivity, and it would likely be a factor in attracting a better calibre of employee. These views are lacking in the current literature and this adds to the knowledge of workplace bullying in a health context.

There was a perception among GHMTs that the strictly hierarchical and compartmentalised nature of the healthcare sector contributes to workplace bullying, with staff members having knowledge only of the needs of their particular area, creating conflict between staff members pushing quite different agendas. The implication is that some degree of overview would be helpful in being able to see the point of view of others and reach compromises. Limited resources were cited as a source of conflict and a cause of repeated workplace bullying in the healthcare sector. This is a finding that adds to the knowledge of workplace bullying in a health context.

GHMTs described feeling threatened as one of the criteria used to determine whether someone had been bullied. Feeling threatened was both a cause and a result of workplace bullying. Feeling threatened is an emotional quality that can lead to the spread of workplace bullying throughout an organisation, creating a detrimental workplace culture. This makes its antidote, feeling safe, of particular interest, and raises the question: how do we create a culture of feeling safe in the workplace? This will be explored further in section 7.5.1 and potentially adds to the knowledge of workplace bullying in a health context.

Management trainees had many ideas about the types of measures that contribute to positive workplace culture (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture). Having a senior executive group who are really committed to their vision and mission and who 'walks their talk' and models' professionalism and good workplace behaviour was the number one suggestion. A workplace that enacts and enforces its policies and procedures created greater respect for the workplace, than the particular manager and the policies and procedures themselves. GHMTs commented that a case could not be made for the behaviour being unacceptable if other staff, particularly management, were seen to display it with impunity.

GHMTs reported that short-term staffing issues created by taking a hard line with workplace bullying and terminating the employment of repeat offenders would eventually be offset by the organisation developing a reputation as a great place to work and attracting greater numbers, and a higher calibre, of job candidates. GHMTs lamented that this course of action seemed almost impossible in the public healthcare sector due to the potential impact on patient care, quality and safety. Staff want to see those engaging in workplace bullying dealt with and they also want to see under-performing or lazy staff

dealt with appropriately; this helped maintain their respect, motivation and confidence that their grievances would be taken seriously. These views add to the knowledge of workplace bullying in a health context by providing strategies for creating a positive workplace culture.

Management trainees agreed that performance management should be undertaken, but very carefully and with a view to improving staff's skills and abilities rather than as a thinly veiled excuse to pressure an unpopular staff member to leave. Performance management should be viewed as making an investment in the staff member and making staff feel valued. Public acknowledgment of good work, and appreciation voiced to individuals and to the team in general, was felt by GHMTs to have an extremely positive impact. A culture in which staff feel safe to admit they do not know something and ask for help and/or training without fear of being labelled incompetent, unsuitable for promotion or a troublemaker was thought to be extremely positive for performance in the long term (Theme 5.2: Organisational culture and Theme 6.2: Organisational culture). The shift in recent years to focusing on the development of skills to encourage positive behaviours and positive management styles (Johnson 2015; Jenkins 2013; Hutchinson et al 2010; Bryant et al 2009) was described by GHMTs having a greater long-term impact not only on behaviours but also on the culture of an organisation.

The behaviour and confidentiality of human resource departments was often called into question by GHMTs. Staff in healthcare organisations have often expressed a desire for a fully autonomous and external body for workplace complaints, particularly complaints about management or the human resources department itself. This would create more confidence and safety in the reporting process, which GHMTs stated would be very beneficial to workplace culture. This finding adds to the knowledge of workplace bullying in a health context.

Acknowledging good work and good performance (Theme 7.1: Acknowledging positive actions), but equally acknowledging and taking steps to improve underperforming staff members, was also seen as important by GHMTs. The literature supports this finding (Glaso and Notelaers 2012; Gumbus 2011; Lovell and Lee 2011; Broome and Williams-Evans 2010). This approach not only makes hard-working staff members feel validated; it also displays interest, and investment, in the underperforming staff member, showing that the organisation cares enough to spend time helping them to improve, shaping people rather

than being heavy-handed with discipline in the first instance. Another strategy put forward by GHMTs was to reflect on one's behaviour and performance each day and identify areas which could be improved.

Management trainees noted staff who may never otherwise behave that way may enact workplace bullying in an environment where there is a perception that it is acceptable, or even desirable (Cleary, Walter, Horsfall and Jackson 2013; Cleary et al 2009). A distinction was often made between management (a position in the organisation) and leadership (personal skill set), with leadership implying a person with very good emotional intelligence and interpersonal skills and the ability to model appropriate workplace behaviour.

GHMTs were often clear in their comments that at times it depends on the situation as to whether they viewed an incident as workplace bullying. There was also suggestion that whether a behaviour is workplace bullying depends on whether the perpetrator's intent was malicious, which might be elucidated by the perpetrator's reaction to being approached about it. There was a repeated disclaimer that much workplace bullying may be unintentional, and more about the perpetrator's lack of people skills or personal development, and this is also evident in the literature (Adams et al 2013; Safe Work Australia 2013; Cleary et al 2009). GHMTs provided examples such as talking negatively about people behind their back, which could be seen as workplace bullying or as normal human behaviour and venting. An important point was made by participants that a definition of workplace bullying for healthcare organisations must necessarily focus on the ability to build a case for claims of workplace bullying in order for appropriate procedures to be enacted; in other words, if the allegation cannot be proven – if behaviour cannot be shown to be an unambiguous breach of policy – the organisation's hands may be tied.

The provisional anti-bullying learning framework will address the culture in healthcare organisations by encouraging staff participation in learning and development opportunities and providing programs that contribute to the creation of a positive workplace culture. The values of the organisation help build a positive workplace culture, and this is addressed in the framework. The framework provides opportunities for the reinforcement of acceptable and respectful workplace behaviours that will improve the culture across healthcare organisations.

### 7.3.3 Reporting

GHMTs were also able to identify how a positive workplace culture and training assisted them in approaching these issues directly with colleagues, and how this was preferable to a making a formal complaint in the first instance. The research supports a multifaceted approach to dealing with workplace bullying (Askew et al 2012; Broome and Williams-Evans 2010; Cleary et al 2009). This message was noted for all types of workplace bullying. GHMTs stated it was not clear to whom to report workplace bullying, particularly in cases where the person one would normally report such behaviour to, such as a manager or human resources department staff member, was the perpetrator. GHMTs were not confident managers or human resources departments would keep their complaint confidential (one participant [FGP4] mentioned an instance of a human resources department staff member taking advice from the very manager about whom a complaint was made on how to deal with the complaint); that their needs would be given priority over the needs of the organisation; or that any action would be taken at all. A desire for a completely external and independent employee assistance program was frequently voiced by GHMTs.

GHMTs commented that staff often lacked the skills, confidence, and mandate to directly address problems with co-workers themselves, and this created a perception that management should step in and address problem behaviour before it escalates. However, there were also some comments by GHMTs that managers are too busy to notice interpersonal problems and must rely on staff to inform them of such problems.

Bullying in the workplace can affect the productivity of the entire team (Becher and Visovsky 2012; Bellot 2011; Hoobler et al 2010), and many GHMTs said that if it was happening to one person it was a problem for everyone; therefore, everyone should be involved in the solution by speaking out to the perpetrator and publicly supporting the victim (Theme 8.1: Responsibility). Related to this was confusion among GHMTs over where to take a complaint if the person one would normally report it to was in fact responsible for the workplace bullying (e.g. a manager or human resources department member). As noted above, GHMTs repeatedly voiced a desire for an external, objective body to which to take workplace complaints; the relevant trade union was mentioned as an option, but was also viewed as a last resort, likely to escalate the problem or create

other problems, as management often viewed a complaint to the union as an unacceptable action. An external EAP was also often mentioned by GHMTs as a positive strategy.

The provisional anti-bullying learning framework will address reporting of workplace bullying by assisting healthcare organisations to define workplace bullying in their individual contexts. Staff will then be able to recognise behaviours as workplace bullying and to report incidents. The framework encourages organisations to conduct staff induction training including information regarding the procedures for reporting workplace bullying and how these reports are managed within the organisation. The framework provides the opportunity for staff to engage with learning and development programs to develop the skills to respond appropriately to workplace bullying and points towards other avenues, both internal and external to the organisation, for further support and information. In addition, the framework provides for healthcare organisations to monitor incidents and reporting of workplace bullying to evaluate the efficacy of learning and development programs and other positive workplace initiatives. The provisional framework addresses processes, interventions and timeframes for healthcare organisations to respond to reports of workplace bullying.

## 7.4 Discussion of main findings

There was widespread awareness among GHMTs of workplace bullying having a detrimental effect on co-workers (Theme 1.1: Effect on the co-worker), even if they were not directly involved. The clearest effects were reduced productivity, including more sick leave taken, and difficulty retaining staff. Workplace bullying can contribute to difficulty in retaining staff, costing the organisation time and money. Efficiency, meeting targets and motivation were all seen to be impacted on among those observing workplace bullying. Staff often found leaving to work in another organisation to be the best solution.

The most common reason for workplace bullying incidents identified by GHMTs was competition for positions and resources (Theme 3.3: Threat). Personal grievances were the next most common. Participants reported personal grievances, stress from issues in a staff member's personal life, and lack of personal skills could all lead to workplace bullying (Theme 3.2: Personal issues). Personal grievances within the workplace, such as taking a personal dislike to someone in the workplace, was seen to be a major cause of

workplace bullying – a desire to make life unpleasant or uncomfortable for a person for various reasons.

GHMTs were unclear in many cases on how to determine whether or not workplace bullying was intentional. Some suggestions were: whether it was malicious (e.g. sometimes humour does not go over well but is not intended to bully); whether a person displays awareness of their behaviour or whether it is unconscious (lack of self-awareness); whether it could simply be thoughtlessness (lack of interpersonal skills); whether the perpetrator is capable of empathy and being aggressive rather than assertive (lack of communication skills). We hear more and more about senior executives in large corporations displaying sociopathic tendencies (Van den Brande et al 2017; Boyle and Wallis 2016; Branch and Murray 2015). GHMTs mentioned that some senior executives are results-focussed which can be perceived negatively by staff who desire a more social work environment. Others spoke about underperforming staff members choosing to view legitimate criticism or performance management as workplace bullying; and the suggestion the perpetrator's reaction to being confronted may convey information about whether or not the behaviour was intentional, for example an expression of surprise or contrition as opposed to immediate defensiveness and attempts to justify the behaviour.

There was little mention of the fact that reporting of workplace bullying is now mandatory within NSW Health (NSW Health 2018; NSW Health 2011). Many GHMTs were not aware of this (whereas older management trainees in the focus groups spoke about it) and therefore may be in danger of breaching their obligations. There was a view among GHMTs that bystanders have an obligation not to participate in workplace bullying, including refusing to be an audience for malicious gossip, and perhaps an obligation also to report it to management, but not to intervene directly. They stated there was no incentive and many drawbacks to getting involved, including worsening the situation for the victim or spreading the conflict to include more people. Other gaps identified in GHMT knowledge were to do with policy and correct procedure (Theme 9.2: Training needs). For example, some GHMTs knew there was a NSW Health policy on bullying in the workplace, but no one knew what it contained. This would need to be remedied for staff to be able to fulfil their mandatory reporting obligations. It was clear many GHMTs did not know the correct escalation pathway for their workplace, and while there were often beneficial policies and procedures in place, they are not utilised to their full potential because staff are

unaware of them. NSW Health's amended policy (2018) clearly articulates the procedure for making and managing a workplace bullying complaint (NSW Health 2018), but the previous version (2011), which the GHMTs at the time of this study were using, was more complicated. Salin (2008) analysed formal anti-bullying policies and found that most indicated that staff were advised to contact their immediate superiors. Branch, Ramsay and Baker (2013) found that human resources departments are more likely to be responsible for formulating policy and procedures than addressing the issue directly. D'Cruz and Noronha's (2010) research found participants in their study reporting an increase in workplace bullying when they 'actively pursued the matter with HR' (p.525). These studies reinforce the view that a health and safety approach to workplace bullying should be adopted in healthcare organisations.

There was clear consensus that overt forms of workplace bullying were easily identified (Theme 6.3: Overt), including such behaviours as shouting at people, verbal abuse (in person or written, such as emails), physical threats, intimidation or harm, obvious ostracism (such as closing the door before people walk into the room to signify they are not welcome), or making derogatory remarks in public forums. Some GHMTs said they had been given a definition of workplace bullying which stated it must be a repeated pattern of behaviour towards a particular person; others said particular behaviours could be classified as workplace bullying whether or not they were repeated (implying that even one incident was unacceptable); and the question was also raised of whether a pattern of behaviour towards various people over time classified the perpetrator as a bully, even if never repeated towards a particular recipient.

It was evident that there was confusion among GHMTs as to what constitutes workplace bullying. This is partly because it is a personal experience, and what one person perceives as workplace bullying may seem reasonable to someone else. This was true particularly in regard to the GHMTs uncertainty regarding 'tough love' performance management of underperforming employees and the feeling that some positions, with particular reference to the healthcare sector, require a certain toughness (Theme 6.6: Recognition) – an authoritative, direct and decisive manner in order to be effective. Some classes of employee, such as senior clinicians, have the perceived right to behave in an authoritarian or brusque way, presumably because they are on the frontline in providing care to patients; therefore, there is a sense that what benefits them, benefits patients. GHMTs

also expressed difficulty in recognising covert workplace bullying, if not witnessed by a third party, and some commented on doubting their ability to identify workplace bullying (e.g. Is it just me? Am I imagining this and being overly 'thin skinned'?), particularly if it is veiled as humour, and in assessing whether the person is just having a bad day or personal problems and is venting. Passive-aggression was noted as being particularly hard to identify. A clear definition of workplace bullying in individual organisations would help this.

During the time this study has taken to complete, findings from subsequent NSW Health and NSW Public Service Commission surveys have been reported. Results from the 2015 'Your Say Workplace Culture Survey' demonstrated modest improvements across NSW Health. In 2017, this survey become part of the NSW Public Service 'People Matter Employee Survey'. The 2018 'People Matter Employee Survey' report states that workplace bullying remains an area of concern (NSW Public Service Commission 2018). Table 7.3 below compares results from these two surveys (NSW Public Service Commission 2018).

**Table 7.3:** Summary of results from 2017 NSW Health and NSW Public Service Commission Surveys

| Question | NSW Health Sector | NSW Public Sector |
|---|---|---|
| In the last 12 months I have witnessed bullying at work | YES 40%<br>NO 51%<br>Don't know 9% | YES 33%<br>NO 58%<br>Don't know 9% |
| In the last 12 months I have been subjected to bullying at work | YES 22%<br>NO 72%<br>Don't know 6% | YES 18%<br>NO 76%<br>Don't know 6% |
| Please indicate the role of the person who has been the source of the most serious bullying you have been subjected to in the last 12 months | Senior manager 19%<br>Immediate manager/supervisor 24%<br>Fellow co-worker at your level 31%<br>Subordinate 6%<br>Client or customer 2%<br>Member of the public 1%<br>Other 5%<br>Prefer not to say 12% | Senior manager 22%<br>Immediate manager/supervisor 24%<br>Fellow co-worker at your level 27%<br>Subordinate 8%<br>Client or customer 2%<br>Member of the public 1%<br>Other 4%<br>Prefer not to say 13% |

These survey results reinforce the importance of this study, as the findings from the GHMTs indicate that most of them experience workplace bullying from a colleague or their direct manager/supervisor and that staff who experience workplace bullying are less productive and are impacted by workplace bullying.

### 7.4.1 Unexpected results

Swedberg's (2016) work on theorising in social science research discusses unexpected results as 'breakthroughs' on the part of the researcher. Several findings emerged from the data which were unexpected by the researcher as they were mentioned by only one or two participants, although the literature describes these as evident in workplace bullying in healthcare organisations. Racial discrimination was mentioned a few times but was not indicated as a major concern; workplace bullying based on appearance, particularly weight, was also mentioned on a couple of occasions. GHMTs who said they had been exposed to racism expressed confusion over what to do about it and who to raise it with, for similar reasons to those expressed by other participants concerning workplace bullying in general – that is, complicated procedures for dealing with complaints in human resources departments, concerns about confidentiality, and concerns about the potential effect of making a complaint on career progression. The comment was made that one of the positives about the workplace bullying training that currently exists was witnessing people from various cultures explain what is racist to them and what is not. The point was also made by GHMTs that this training was optional, and they recommended that this training should be mandatory. Some staff members (i.e. senior clinicians) were felt to have a greater moral authority than others, due to directly interacting with patients and therefore impacting quality of patient care. GHMTs also expressed confusion over where to draw the line on poor behaviour from these staff.

## 7.5 Implications for healthcare management

These findings have implications for healthcare management in the future which could assist organisations, senior managers and human resource managers in developing clear policies, procedures, systems and education for addressing workplace bullying.

### 7.5.1 Positive work environments

It was widely acknowledged that workplace bullying could lead to poor workplace culture, frustration, irritation, poor performance for the victim, and wasted money for the organisation. A sense of not being valued by employers and/or management was seen by GHMTs to have a direct negative effect on motivation and, therefore, on results. Even one team member being unmotivated, stressed, distracted, unproductive and disengaged contributes to a poor workplace ambience that may affect the work of other team members.

GHMTs acknowledged that written communication, including emails and text messages, were more difficult mediums in which to gauge tone and intent. They also said it was very easy to use emails as a forum for workplace bullying by copying everyone into the conversation. Communication skills (Theme 7.2) were identified as being valuable in being able to deal with other staff in a direct way without being accused of workplace bullying. This included written communication skills for use in emails and text messages. With no non-verbal cues, it was possible for people to perceive workplace bullying where none was intended (NSW Health 2018; Escartin 2016; Safe Work Australia 2016). Direct and concise work-related messages could be viewed as curt and unfriendly, and one participant noted they now use the strategy of 'fluffing up' emails after composing them to convey a more friendly and conciliatory tone. The GHMT who commented on this topic said that this was an unreasonable expectation in a high-pressure environment, and that limiting communications to work-related subjects on a need-to-know basis was preferable, although they acknowledged a tendency for co-workers to view that as unfriendly and bordering on workplace bullying.

There was a clear understanding among GHMTs that personal qualities, background, life experiences, personal skill sets and episodes of acute stress (Theme 3.2: Personal issues) were far more likely to be predictors of workplace bullying than any demographic information (Chatziioannidis et al 2018; Viejo 2016; Sikka et al 2015). Workplace bullying, it was noted, may be more prevalent in the public sector than in the private sector due to the latter's better access to resources; for example, the private sector was perceived as having less difficulty attracting quality staff because of higher pay and better working conditions, and therefore had fewer barriers to taking a zero-tolerance approach to

workplace bullying by following the policy through to its natural conclusion of termination of employment if the behaviour did not improve or change.

Another type of threat identified as being a cause of workplace bullying was acute stress, whether personal or work-related; it was acknowledged stress created a feeling of being threatened and was responsible for most out-of-character workplace bullying. There was also brief mention of a team, branch, department or organisation feeling collectively threatened by another, and encouraging a feeling of negativity or negative talk about them, which may spread through their team to the detriment of the workplace culture.

The disclaimer that much workplace bullying is unintentional was made by several GHMTs (Theme 3.4: Unintended). Lack of emotional intelligence and communication skills, poor behaviour modelled by management, out-of-character outbursts when under acute stress, and differing boundaries and personal standards for acceptable behaviour were all cited as reasons workplace bullying may be unintentional.

There was an often-expressed view that positive workplace culture was achieved through positive relationships between all people involved. Developing trust, communication and respect between staff, and between staff and management, should be a priority. Making it normal practice to appropriately challenge behaviour that colleagues find unacceptable in order to prevent escalation of grievances was thought to be key. It was often stated there is little time available in the high-pressure environment of the healthcare industry to spend time on building relationships, and this was of major detriment to the development of positive workplace culture.

Poor behaviour being publicly 'called out' by other staff was an idea that received a lot of support. Having courage, normalising discussing feelings and behaviour, having the human resources department report to the entire organisation on how many incidents of workplace bullying there had been each month and tracking trends and prevalence. Improving personal stress management skills, spending positive social time together outside of work were also suggested. Other suggestions included: having regular discussions about staff members' experience of the workplace; management being open to complaints and suggestions about behaviour; giving staff the opportunity to understand, develop and learn from behavioural mistakes rather than implementing disciplinary procedures immediately (Theme 5.4: Strategies for dealing with bullying in the

workplace); and encouraging staff to learn to take criticism and try to learn from poor behaviour (e.g. how not to behave as a manager and was there anything valid in what they were saying, even though it was expressed poorly).

Opportunities to socialise outside work were mentioned as desirable and beneficial, although it must be optional and free of consequences if a staff member does not wish to attend. Strategies GHMTs had seen work in the past included holding meetings in the local coffeeshop instead of a meeting room and having a weekly muffin meeting where the manager supplied a basket of muffins for attendant staff. Several participants noted that sharing food or eating together had a beneficial effect on relationships (Theme 7.4: Understanding).

Corporate culture plays an important role in organisational life, particularly in healthcare, and has implications for managerial action. There is evidence outlining the impact on work environments in providing safe, quality healthcare and effective healthcare systems, which require an engaged and productive workforce (Sikka et al 2015). The American Association of Critical Care Nurses looks at six key standards for establishing healthy work environments: (1) skilled communication; (2) true collaboration; (3) effective decision-making; (4) appropriate staffing; (5) meaningful recognition; and (6) authentic leadership (Viejo 2016). These aspects were also mentioned by participants to encourage positive work environments. GHMTs felt that meaningful recognition was important to them and the 'lack of meaningful recognition can lead to discontent, compassion fatigue, burnout and suboptimal care outcomes' (Viejo 2016, p.29).

There is increasing evidence that without meaning and joy at work, people cannot perform to their full potential (Perlo et al 2017; National Patient Safety Foundation 2013). A core component of workforce engagement is experiencing meaning and joy at work – that is, the sense of accomplishment and importance in the individual's contributions. Environments in which there are incidents of workplace bullying can lead to the absence of meaning and joy in the healthcare workforce, and this can impact on morale and productivity and result in lack of teamwork, disrespect between colleagues and a disengaged workforce (Sikka et al 2015; Drabek and Merecz 2013; Johnson 2011; Cleary et al 2009; Review Equal Opportunities 2004; Turney 2003). The former Chair and CEO of Alcoa, Paul O'Neill, has posed three critical questions for healthcare workers focusing on joy and meaning: (1) Am I treated with dignity and respect by everyone, everyday? (2) Do

I have the things I need to make a contribution to this organisation which gives meaning to my life? (3) Am I recognised and thanked for what I do? (cited in Perlo 2017 and Sikka et al 2015). These questions have implications for healthcare management if staff are unable to answer them in the affirmative on a regular basis.

GHMTs commented that healthcare organisations are rife with inequalities, such as the unequal distribution of resources; disproportionate allocation of space (i.e. privacy, hot desks, comfort); hierarchical structures and power relationships; limitations on career progression; and lack of opportunities to engage in meaningful work [FGP2, FGP5, IP3, IP4, RVP1] (Lucas and Gist 2015). 'Across the healthcare workforce, ambiguity of roles, wasteful and non-value-added work, lack of teamwork, and an environment of disrespect are robbing people of the experiences that bring meaning and joy into their working lives' (National Patient Safety Foundation 2013, p.1). A culture of trust and mutual respect is essential for employees to find meaning and joy in their work. Healthcare today relies more and more on multidisciplinary teams to ensure patient quality and safety, but this is impossible to achieve if individuals do not have mutual respect.

### 7.5.2 Impact on individuals

Workplace bullying creates stress, which affects not just a person's workplace performance but potentially also their home life. Problems with one's home life can, in turn, have a negative effect on performance at work. Workplace bullying can lead to depression and the need to seek professional help. Exposure to witnessing workplace bullying is also associated with lower levels of psychological health (Chatziioannidis et al 2018; MacCurtain et al 2018). Some victims may become withdrawn, some may become hostile and belligerent, and even begin enacting workplace bullying themselves.

Deliberately humiliating someone was viewed as workplace bullying (Theme 2.4: Public humiliation), whether this included demeaning people in front of others, to their face or behind their back. Demeaning people in front of others was viewed as an attempt to elicit favour with the group and cement one's own position, to initiate a 'gang mentality' [FGP4] against the victim to the advantage of the perpetrator. Behaviours viewed as humiliating included name-calling, deliberately excluding staff and making deliberate attempts to portray them, their work or their behaviour in a poor light. This was viewed as distinct from truthfully and directly addressing poor performance or behaviour.

GHMTs spoke about personal issues outside the workplace. There was agreement some people are just 'generally horrible' [FGP1], but further discussion elicited some understanding of what might cause a person to come across that way. Negative life experiences, perhaps in a person's childhood, were thought to predispose a person to workplace bullying. Family issues, illness, relationship problems were all seen as contributing to stress levels, which contributed to the likelihood of workplace bullying manifesting.

GHMTs also mentioned a personal skill set. Acute crisis or acute stress, within or outside the workplace, was repeatedly put forward as a significant cause of workplace bullying, implying that personal ability to deal with stress is an important factor when seeking to reduce incidences of workplace bullying. Personal qualities such as resilience; anger management skills; feeling supported by the workplace; and having support in one's personal life would therefore all be important in reducing the incidence of workplace bullying. General personal insecurity, and job insecurity more specifically, were viewed as a very significant cause of workplace bullying, suggesting better self-esteem and self-confidence would be of benefit in reducing workplace bullying.

Many GHMTs were able to outline the impact of workplace bullying on the individual's wellbeing and productivity at work. Those being bullied would likely go home upset and perhaps feel dread about continuing to go to work. There was an understanding that workplace bullying would have an impact on the individual's family and extended network as well.

Some GHMTs took the view that workplace bullying could also occur between organisations, not just individuals – for example, a manager talking very negatively about another organisation, thereby influencing the staff members' view of that team, branch or organisation.

It was also reinforced here that many GHMTs view workplace bullying as situational – that is, a perpetrator may display bullying behaviour while under stress during acute crisis (work-related or personal). There was discussion as to whether disciplinary action was appropriate if workplace bullying ceased after the crisis was over. There was a magnanimous tendency to suggest it is not, along with a recognition that anyone is capable of engaging in workplace bullying under some circumstances, and perhaps some other

form of support for the perpetrator from the organisation may be more appropriate. The implication here is that acute stress is a mitigating factor, and workplace bullying occurs only in its absence. This, of course, requires a definition of acute stress in this context.

Recent surveys indicate the prevalence of workplace bullying in the Australian healthcare sector remains widespread; 40% of nurses surveyed in 2014 reported bullying or harassment in the previous 12 months (De Cieri et al 2015) and in a 2016 survey 25% of staff in health agencies had experienced workplace bullying (Victorian Auditor-General 2016). A senate inquiry in 2016 further evidenced that workplace bullying, discrimination and harassment levels remain high, despite the zero-tolerance approach adopted by many healthcare organisations.

Dignity at work is a phenomenon that is gaining importance in research (Lucas 2015; Lee 2008; Hodson 2001) and it also emerged during the focus groups and individual interviews. Lucas (2015, p. 622) defines dignity at work as 'a personal sense of worth, value, respect, or esteem that is derived from one's humanity and individual social position; as well as being treated respectfully by others'. Several GHMTs commented that in some of their organisations they were viewed essentially as role occupants and were easily replaceable if someone else could serve the organisation better. They believed that middle management were of the view they have no other interests or priorities outside of work, placing unrealistic expectations on their personal time [FGP4, FGP7, IP7, IP8] and treating them as 'bundles of human capital rather than as conscious, freely choosing agents' (Islam 2012, p.237).

The research on dignity at work describes factors that can impact on an individuals' dignity and personal sense of worth. Hodson (2001) states that overwork, mismanagement, and abuse of power all impact levels of participation and engagement at work. Studies indicate that promoting dignity at work is likely to reduce stress-related health problems and unplanned staff absences lead to a greater willingness to accept changes and learn new skills, and promote teamwork (Royal College of Nursing 2018; Glaso and Notelaers 2012; Gumbus 2011; Lovell and Lee 2011; Broome and Williams-Evans 2010).

Other studies have identified factors which contribute to indignity at work. These include behaviours that can be defined as workplace bullying, such as: verbal abuse and humiliation (Safe Work Australia 2016; Safe Work Australia 2013; Khademi et al 2012;

Stuesse 2010; Knox Haly 2008); stigma attached to certain kinds of work (Sheehan and Griffiths 2011; Agervold 2009; Bartos et al 2008; Chiappetta-Swanson 2005); and workplaces (Coursey et al 2013; House of Representatives Standing Committee on Education and Employment 2012; Caponecchia and Wyatt 2011; Lovell and Lee 2011; Bryant et al 2009; Otis 2008); demonstrating servility to others (Kensbock et al 2014; Adams et al 2013; Safe Work Australia 2013; Cleary et al 2009); implementation of practices which dehumanise staff and erode pride (Branch, Ramsay and Barker 2013; Van Rooyen and McCormack 2013; Crowley 2012; Glaso and Notelaers 2012; Piotrowski 2012; Balducci et al 2011; Hoobler et al 2010; Balducci et al 2009; Bryant et al 2009); and callousness and a lack of care while communicating about job loss (Becher and Visovsky 2012; Bellot 2011; Gunn 2011; Hoobler et al 2010). Research has also provided insights into how employees respond to threats to workplace dignity by creating and engaging in positive work environments, seeking identity in the work they do and developing a distinctive sense of self (Bothma et al 2015). GHMTs commented on the quality of interactions and communication between managers and team members and identified this as a factor in workplace dignity [FGP4, FGP5, IP3, IP7]. This suggests that improving the communication processes in healthcare organisations may increase the levels of respect and dignity amongst staff (Australian HR Institute 2019).

Identity at work is another phenomenon which is not as clear, but emerging evidence indicates that some individuals define their identity based on the work they engage in, that 'identity develops through the interaction (complex cognitive identity formation process) between an individual (with a distinctive self, self-concept and personal identity) and specific social foci or life spheres (e.g. the social and/or work-related environment)' (Bothma et al 2015, p .24). FGP6, FGP7, IP1 and IP4 mentioned that as they spend a great deal of their time at work and with their colleagues, and that central to their work identity is engaging in meaningful work, task significance and variety of skills used. They also commented on role identities, such as clinical or technical roles versus business or management roles, which provide the opportunity for them to identify with their healthcare organisation. Certain meanings, expectations, norms, beliefs and values are derived from the professions, organisations and work teams' individuals connect with, and these serve as a guide to the behaviour which is acceptable within this group (Kirpal 2004).

### 7.5.3 Health managers' changing roles

The delivery of healthcare relies on the capacity and competence of the workforce and, therefore, upon the ability of healthcare organisations to manage and engage their workforces effectively (Meier and O'Toole 2002). There is increasing recognition of the impact of management and leadership behaviours on organisational performance (Fontes et al 2019; Buchanan et al 2013; Pfeffer 2005). In recent years the number of managerial staff in large health organisations has decreased, but the overall number of managers may have increased as managerial responsibilities are often delegated or staff assume managerial titles, sometimes termed 'title creep', and health service manager responsibilities are devolved. Restructuring in health organisations has led to uncertainty for health managers as some roles have been decentralised or outsourced to consultants, whereas they have previously operated with relative job security with clear pathways for promotion. Emerging health managers are working longer hours, under more pressure to perform and fear losing their job through organisational restructures and changes to workforce needs. GHMTs had experienced that their roles are becoming more complex and interactions across multiple levels of management and organisational functions and organisational dynamics can be challenging (Buchanan et al 2013). This can lead to a loss of identity for health managers, damage to their sense of self, decreased morale, withdrawal of effort, and even anxiety and depression (Branch, Ramsay and Barker 2013; Van Rooyen and McCormack 2013; Glaso and Notelaers 2012; Piotrowski 2012; Balducci et al 2011; Hoobler et al 2010; Balducci et al 2009; Bryant et al 2009). This was also described by the GMHTs.

Workplace bullying is more likely to occur in environments which are in distress (Safe Work Australia 2016; Magee et al 2014; Safe Work Australia 2013). Emotional exhaustion in healthcare is emerging as a significant issue, often termed burn-out, and, as FGP7 commented: 'movement of the organisation towards its goals … performance, efficiency, meeting targets. The whole organisation gets stressed'. Studies have documented a relationship between lower trust in management and burn-out in nurses (Oh et al 2016; Allen 2015; Laschinger and Finegan 2005; Laschinger et al 2001). The healthcare workforce is also experiencing an increase in the ambiguity of roles (Van den Brande et al 2018; National Patient Safety Foundation 2013). As cited in Wong and Cummings (2009), there is a link between effective leadership styles and staff burn-out. Emotional exhaustion is a

known predictor of intention for staff to leave and low commitment to the organisation (Good et al 2018). This was mentioned by several GHMTs, the essence being captured in the following quote: 'when I was a trainee, I just felt like I was so exhausted, and I was actually crying. I was upset at work it's just devastating. I didn't want to go to work, didn't want to work in health anymore' [FGP6].

There were several references to workplace bullying based on gender; being young and female was seen as the biggest risk factor for being on the receiving end of workplace bullying overall, along with the observation that this was nowhere near as prevalent as was the case in the past, possibly due at least in part to the blurring of gender-specific roles (e.g. it is now not unheard of to see male nurses, female doctors, female senior executives, all of which were extremely uncommon in the not-too-distant past). There was no mention at all of workplace bullying based on sexual preference.

The role of emerging and middle managers in healthcare organisations is becoming more complex 'with the interactions between different levels of management and across different functions of the organisation increasingly difficult to comprehend' (Hyde 2009, p. 5). The role of middle managers is the one under most pressure in the changing landscape and one in which GHMTs identified as 'the place no one wants to be' [FGP2], as the perception is that middle managers are the scapegoat for all the issues in an organisation. This has implications for emerging health managers as they progress through their career. Inappropriate behaviours from middle managers are often not noticed by senior management and as noted by a few GHMTs, 'middle management tended to be the bully-ers or the people that would bully each other all the time' [FGP1], and 'I think for middle managers it's probably burn-out. I think they're sick of the health system saying no to them' [FGP7, IP2, IP8].

### 7.5.4 Effective leadership

Managers have an important role in supporting GHMTs to develop effective problem-solving skills and resilience, particularly when the demands are unrelenting (Good et al 2018). Training in communication, emotional intelligence, how to work as a team, and interpersonal conflict resolution skills was reported to have a very beneficial impact on workplace culture, particularly when it was revisited periodically. Such training should make all staff aware they are responsible for preventing workplace bullying, emphasising

that if one person is unhappy and has a problem it will impact everyone; therefore, everyone has a problem, and everyone is responsible for contributing to a positive workplace. Creating a situation where staff have both the skills and feel safe to speak up to a colleague whose behaviour is unacceptable, and confident they will be supported in this by management, was also desirable. Management also having the ability to be open to critique by staff, to reviewing their behaviour and admitting to mistakes was also seen as desirable. Mentoring of more junior staff was suggested as a way to provide a confidential but unofficial avenue for discussion with a person more experienced in the workings of a particular organisation. Participants stated that there was a downside to on-the-job training, and they would benefit from specific training on the appropriate escalation pathways in their organisation.

A program called EOC (NSW Health 2016) was praised highly by the GHMTs and reported to cover communication, integration and working better as a team (Theme 9.1: Existing training). Workplace behaviour advisors were mentioned several times (Theme 9.1: Existing training), although it was unclear how they communicated their recommendations to senior executives or how they were implemented; it seems they were largely about advising managers on how to deal with staff behaviour.

Many of the training needs identified by GHMTs were said by others to already exist (Theme 9.2: Training needs). This highlights inconsistency in delivery of information across the healthcare sector. GHMTs stated repeatedly that in many organisations training on workplace bullying was optional, and it was felt that some of the staff who needed it most were not attending; therefore, making it mandatory and regularly revisiting what was learned may be beneficial.

Many of the needs highlighted fell under the categories of communication and emotional intelligence: how to ask for help; how to be supportive of staff who ask for help; listening skills; becoming more comfortable with discussing emotional topics with staff; how to address grievances with colleagues in the first instance oneself to prevent escalation, dispute resolution; having practical tools, words and techniques they can begin using immediately; giving staff ways to identify workplace bullying if they observe it but are not the recipient. It was pointed out while some younger managers receive specialised training in these areas, the rest of the workforce does not, or has not, and so there is a great discrepancy in personal skill sets.

GHMTs wanted to be clear about how to implement policy and the development of soft skills such as emotional intelligence for positive results; policy alone was perceived at times to be cold and uncaring. They wanted management to have the interpersonal skills to be able to deal with grievances before they escalated to workplace bullying if the staff were unsuccessful dealing with it themselves. GHMTs wanted clarity on what workplace bullying actually is, and is not, and how it differs from constructive criticism or performance management. They wanted greater awareness of cultural differences in what is perceived as acceptable behaviour, and how to bridge those gaps.

GHMTs stated there needed to be more forums conducted across the health sector; however, some commented that workplace bullying would not be stopped no matter how many resources were available. The culture of the organisation may be key to this negative view. Escalation strategies were also mentioned, as GHMTs are often unaware to whom they should report workplace bullying or how to deal with the workplace bullying if it occurs. Enhancing communication skills, cultural awareness training and emotional intelligence training were viewed as being appropriate. The key points were: what is the context of the behaviour? Are there mitigating factors? Is there a pattern of behaviour which needs addressing, whether to one recipient or not?

A clear desire for management to have the skills to judge whether or not an incident was workplace bullying was identified. An interesting question therefore is: is a behaviour workplace bullying, or is the categorisation of workplace bullying dependent on the recipient's experience of the behaviour? How can management distinguish between genuine workplace bullying and petty grievances? This would require very good interpersonal skills and discernment on behalf of management, and the consensus of the GHMTs was that this is not currently the case.

Dutton et al (2013) found that leaders who model effective interpersonal skills, value teamwork and collaboration and display a level of empathy and compassion are those who encourage a learning culture in their organisations. The long-term view is that developing these key skills, attitudes and behaviours will become an embedded part of the healthcare profession. Healthcare delivery is transforming with the emergence of multidisciplinary teams and team-based integrated systems as the norm, and the paradigm of ethical leadership is therefore also evolving. Transformational leadership contributes to group cohesion and thereby impacts on group performance (Bass et al 2003).

There is an increasing correlation between healthy work environments, patient safety and the wellbeing of healthcare professionals (Allen 2015; Johnson et al 2015; Laschinger and Finegan 2005; Vahey et al 2004). 'Cases of disrespect … can compromise patient outcomes and the public's trust in the profession and the healthcare system' (Ho and Pinney 2016, p. 39). Healthy work environments are those in which staff have high job satisfaction and performance based on trust between staff and managers. Social support from colleagues is also a key to developing healthy work environments. Strong leadership promotes a culture of safety (Laschinger and Finegan 2005) and 'authentic leadership is proposed as the core of effective leadership needed to build trust because of its clear focus on the positive role modelling of honesty, integrity, and high ethical standards in the development … of relationships' (Wong and Cummings 2009, p. 6). Authentic leadership is aligned with emotional intelligence, which includes self-awareness, authentic behaviour and relational transparency (Wong and Cummings 2009); however, other key characteristics of authentic leaders emerged from the participants, such as being empowering, trustworthy and supportive [FGP2, FGP6, IP2]. Resilience is a key skill for dealing effectively with workplace bullying, but staff 'must first be able to recognise when they are adversely affected by stress and understand the difference between their own adaptive and maladaptive responses to stress' (Epstein and Krasner 2013, p.301).

### 7.5.5 Culture of safety and patient care

'Compelling evidence confirms that healthy work environments are essential to ensure patient safety, enhance staff recruitment and retention, and maintain an organisation's financial viability' (Viejo 2016, p. 36). It was felt by GHMTs that intimidation involved deliberate intent on the part of the perpetrator, and that most workplace bullying was an attempt to intimidate and thereby assert dominance. Any attempt to damage a person's self-esteem or create fear of the consequences of not being submissive to the perpetrator was viewed as intimidation. There was also a brief mention of racism impacting on the quality of care patients of different cultures receive. There was no suggestion by GHMTs this was widespread.

Many GHMTs saw benefit in the EAP available in some workplaces and relayed they would like to see an extension and greater promotion of that option. There was vague mention of a whistleblower helpline, but no one seemed to know much about it. It was thought this would improve the likelihood of staff reporting workplace bullying. There was also

mention of positive workplace culture consultants, who were thought to be beneficial although no one seemed to really understand what their role was, and there was a suggestion there were not enough of them to really make a difference to the healthcare system more widely. Approaching the union with a complaint was seen to be frowned on and discouraged by employers; it was felt this was not an appropriate attitude and that it should be made clear to staff that this was a viable option.

Psychological harm caused by workplace bullying is common in many healthcare organisations. Staff not being treated with respect and workplace learning by humiliation are often the norm [FGP3, FGP5, FGP6, IP5, IP7, IP8]. GHMTs stated that this leads to a culture of fear and intimidation which impacts on joy and meaning at work (National Patient Safety Foundation 2013). Cultural norms that are absent in workplaces create an environment in which both psychological and physical safety is compromised. The literature (Drabek and Merecz 2013; Becher and Visovsky 2012; Bellot 2011; Johnson 2011; Hoobler et al 2010; Cleary et al 2009; Review Equal Opportunities 2004; Turney 2003) emphasises the cost of burn-out, litigation, lost work-hours, employee turnover and the inability to attract new staff all adding to the burden of illness. There is an increased risk to patient safety if staff are continually treated with disrespect, from patients, caregivers, as well as colleagues and management. Parand et al (2014) found that managers are in the position to mandate policy, procedures and systems, thereby impacting on organisational culture. They also argue that 'healthcare managers possess an important and obvious role in quality of care, patient safety and that it is one of the highest priorities of healthcare managers' (2014, p. 1).

In a study on workplace aggression among nurses in Australia, two-thirds of the participants stated that they had made errors in patient care because they were upset over an incident of aggression (Farrell et al 2006). Patient care is also negatively impacted by workplace bullying, in that individuals report decreased job satisfaction, are more easily upset and have less energy, with many nurses indicating they did not want to come to work and were at times less tolerant of their patients. A culture of safety is shaped by effective leaders through management practices (Van Rooyen and McCormack 2013; Alterman et al 2011; Broome and Williams-Evans 2010; Felblinger 2009). If management practices result in extreme pressure to achieve efficiencies and encourage toxic cultural norms, there is increased risk to the workforce and patient care.

There is emerging, yet less well understood, evidence of the risk to patient safety when unprofessional behaviours are accepted in healthcare settings and there needs to be 'greater leadership engagement to ensure a culture of safety' (Parand et al 2014, p. 1). These unprofessional behaviours include those which can be named as workplace bullying (e.g. passive aggression, public criticism, humiliation). Riskin et al (2015) found that rudeness among staff resulted in less communication and information-sharing between multidisciplinary teams compared to teams who were treated with respect. This had a resultant impact upon diagnostic performance and reduced help-seeking behaviour among staff. Westbrook et al (2018) state that when team members feel unable to speak up due to negative consequences, patient care will be compromised.

Roche et al (2010) demonstrated a link between workplace bullying and medical errors. This suggests an impaired functioning and impact on the wellbeing of those who are experiencing workplace bullying, which translates to the quality of patient care. Studies by Lallukka et al (2011) explored nurses' sleeping disorders and found that this negatively affected their day-to-day functioning. It could be argued that workplace bullying could also negatively affect the day-to-day functioning of those working in healthcare and thereby impact on the quality of patient care and safety. Cultural change is key to achieving patient safety, but there is still a dominant culture in healthcare of blaming individuals. This impedes the advancement of a culture of safety for both staff and patients (Agency for Healthcare Research and Quality 2019).

### 7.5.6 Developing effective anti-bullying organisations

There are limited studies demonstrating how workplace bullying affects organisational effectiveness as 'prevention of (workplace) bullying requires a proactive approach … management tends to be reactive and problem-focused' (Gillen et al 2017, p. 7). The presence of workplace bullying impacts on the organisation's engagement and social capital (Johnson et al 2018), which can be defined as a 'resource reflecting the character of social relations within the organisation' (Leana and Van Buren 1999, p. 538).

Healthcare organisations need to become more effective, with greater levels of reliability. This can be evidenced by teamwork, transparency, continuous learning and improvement (Branch, Ramsay and Barker 2013; Einarsen et al 2011; Bryant et al 2009; Cleary et al 2009). GHMTs commented that knowing their organisation prioritises staff wellbeing, and

being provided opportunities to engage in meaningful and satisfying work, they are less likely to experience burn-out and fatigue, leading to the delivery of effective and safer care: 'employee satisfaction and engagement are related to meaningful business outcomes' (Harter 2002, p.276). Currently in NSW Health, the Leading Better Value Care program has been transforming how healthcare is delivered by adopting a systematic approach, embedding good practice and measuring health outcomes (NSW Health 2018). The premise is that values-based healthcare will influence all aspects of work, including clinical care, procurement, capital and service planning, health technologies and workforce capability through training and education.

Whole-of-organisational programs are a recent and new approach in an attempt to manage inappropriate behaviours in healthcare settings, although there is limited evidence of effective organisational interventions. Gillen et al undertook a review in 2017 of interventions to prevent workplace bullying and they identified only five studies internationally, noting low quality of available evidence. There was also little evidence of their effectiveness in reducing workplace bullying or creating significant organisational cultural change, or of how these programs work in practice. These intervention programs focused on the medical profession and there is increasing evidence to support that workplace bullying is pervasive across the entire healthcare workforce (Westbrook et al 2018; Victorian Auditor-General 2016; De Cieri et al 2015).

Interventions to prevent workplace bullying may work by: (1) strengthening the policies and culture of intolerance of bullying in the workplace by processes of engagement with employees; (2) providing a safe environment within which mediation and negotiation may take place when problematic behaviour is first identified; (3) undertaking risk assessments of job-related precursors to bullying; and (4) providing awareness-raising or education sessions that will encourage employees to reconsider their behaviour and how they interact with colleagues (Gillen et al 2017, p. 8). In Australia, a program titled 'Ethos' was implemented in 2017 across St Vincent's Health Australia with the aim of endeavouring to define normal and, thereby, what is acceptable behaviour across all levels of the organisation. 'The program uses trained peer envoys who provide feedback about reported behaviour to colleagues in an informal, non-punitive manner. The program includes organisation-wide training of staff to increase their skills in identifying and dealing with unprofessional behaviour' (Westbrook et al 2018, p. 381); however, some

employees have been quoted in the media expressing concerns about Ethos' implementation. 'The anonymity has led to frivolous complaints and some staff feel a divide growing between the messengers and ordinary staff. Ethos is providing a system of no accountability for complainants, no just hearing and no records for due process' (Unnamed staff member, The Age February 2019).

Effective healthcare organisations are learning organisations which model professionalism, collaborative behaviour and transparency and value the individual learner. Studies have demonstrated that how effective an organisation is, and its culture, has an impact of the health of the workforce (Mardon et al 2010; Castle et al 2009; Etchells et al 2005; Piirainen et al 2003; Clarke, Sloane and Aiken 2002), and that the workers' perception of safety is aligned with better patient outcomes. A study conducted by Carmen, Elder and Wallace (2000) also demonstrated that effective organisations which provide programs aimed at improving the health and safety of all employees (e.g. influenza vaccinations, sharps handling) had improved patient outcomes. The importance of psychological safety is often not given the same attention in healthcare settings as physical safety and prevention of injury. Rodwell et al (2012) found that workplace bullying is present across all healthcare occupations, and that some employees, particularly part-time staff, may need to be managed differently to the full-time workforce.

Evidence demonstrates that organisations which have strong policies; provide information and training to staff regarding reporting and responding to workplace bullying; and engage in practices that create cultures of safety and respect, are effective organisations (Johnson et al 2018; Institute for Healthcare Improvement 2005). These organisations also have clearly defined processes for the timely review of reported incidents and in monitoring progress. The pursuit of excellence is also an indication of an effective healthcare organisation (Dutton et al 2013; Hannah et al 2008). Studies have also demonstrated that staff who are engaged in meaningful work are more likely to deliver safer care for patients; more satisfied; less likely to experience burnout; and are less inclined to leave the organisation or the healthcare profession (Boulding et al 2011; Reed et al 2008; Laschinger et al 2003). Effective organisations demonstrate leadership that eliminates hierarchical authority, as this can inhibit teamwork – as mentioned by several GHMTs [FGP3, FGP6, IP1, IP4, RVP5].

## 7.6 Strengths and limitations of the study

This research had several strengths and some weaknesses. The study involved the design and development of a provisional anti-bullying learning framework focused on effective strategies and guiding principles for dealing with workplace bullying in a health context. The provisional anti-bullying learning framework was designed to develop key skills and attributes for emerging health managers identified in the literature (Ginter et al 2018; Woodrow and Guest 2017; Reich et al 2016) and from the findings of phase one of this study. A strength of the study was the inclusion of the expert reference group with considerable experience and expertise in workplace bullying across healthcare settings globally.

There was richness in the data collected by the participants in the focus groups and the individual interviews. As the subjects were volunteers who self-selected, bias may have been evident from participants across all the data sets. However, the study findings build on and confirm the literature on workplace bullying, at both national and international levels. A number of common themes and patterns were identified across the three data sets which provided for in-depth discussion, although a larger sample size, particularly for the expert reference group, may have been able to address the research questions more broadly though the experts were able to aid in analytic rigour in this study

The involvement of a small number of participants, and the limited contact with participants could be viewed as a limitation to this study, though it is not uncommon for studies relating to workplace bullying, harassment or discrimination (Hager and Leadbetter 2016; Einarsen et al 2011; Einarsen et al 2009). While the literature continues to build on, and in many instances, confirms previous findings, the small sample size may have prevented some analysis and general conclusions have been drawn. The number of participants for the focus groups and individual interviews was drawn from a maximum target population of 60 previous or current GHMTs from the 2009-2014 cohorts. The total number of participants, 15, equated to 22% of the maximum target population. The geographical coverage of this study was NSW, Australia. The focus groups were conducted in Sydney and the participants who nominated to be part of the study currently either lived or worked in the Greater Sydney area. Participants for the individual interviews resided and/or worked in either Sydney or wider NSW. Participants for the respondent validation interviews were also drawn from this target group. This study did not set out to

identify geographical differences, but this aspect could be investigated further. Conducting focus groups and interviews across a broader geographical area may provide further evidence relating to workplace bullying across a range of healthcare settings (i.e. rural vs metropolitan, and size of the health service organisation) and find additional similarities and comparisons in the identified themes. Exploring the impact of workplace bullying for people working in geographically isolated areas would add to the body of research.

A focus of future research could also explore whether younger GHMTs experience and perceive workplace bullying differently from older GHMTs who may have previous experience working in healthcare settings though in a different role or who have experience working in different sectors. In addition, future research could also explore the emotions of GHMTs and how this applies to the Affective Events Theory model as referenced by Branch, Ramsey and Barker 2013.

GHMTs who participated in the study may already be confident in speaking about workplace bullying due to their prior knowledge and awareness of bullying behaviour and were interested in being a 'voice' for those who were either unwilling or unable to talk about workplace bullying. Alternatively, they may have negative experiences of workplace bullying and individual staff and wanted the opportunity to express their views and be heard. Providing the opportunity for GHMTs to participate in individual interviews as well as focus groups provided one way in which participants who may have been otherwise reticent in speaking up about workplace bullying an opportunity to do so. GHMTs who nominated to participate in the individual interviews rather than the focus groups may have had direct experiences of workplace bullying being perpetrated against them and have believed a one-on-one phone interview was a safer environment for them to discuss their lived experience.

A proof of concept was adopted to explore evidence of effective strategies for learning and development focused on workplace bullying in healthcare settings. The purpose of this study was to elucidate perceptions of workplace bullying rather than exploring the efficacy of intervention and prevention modules. Exploration of effective intervention and prevention modules would be another study for future research.

## 7.7 Conclusion

The current chapter has provided a comprehensive examination of GHMT perceptions of workplace bullying and a detailed exploration of phase one and the three key data sets (focus groups; individual interviews and respondent validation interviews). This chapter also provides a detailed discussion regarding the nine identified themes emerging from the focus groups and the individual interviews, namely: Theme 1 (level of awareness of workplace bullying); Theme 2 (behaviours which constitute workplace bullying); Theme 3 (causes of workplace bullying); Theme 4 (consequences of workplace bullying); Theme 5 (dealing with workplace bullying); Theme 6 (nature of workplace bullying); Theme 7 (positive relationships); Theme 8 (reporting of workplace bullying); and Theme 9 (training needs).

The results from the focus groups and the individual interviews produced generally equivalent themes. Comparatively more discussion of particular themes was evident in the individual interviews than in the focus groups participants, which provided for the richness in the findings. This was to be expected due to the sensitive nature of the topic and, perhaps their direct experience with workplace bullying, some participants preferred to participate in the one-on-one phone interview with the researcher. Respondent validation interviews were conducted to further explore key themes and discussions which evolved from the focus group participants and individual interviews.

The final chapter will focus on a discussion on the implications and recommendations for future directions to close this study.

# Chapter 8: Conclusion

## 8.1 Introduction

The findings from this study have been detailed in Chapters 4, 5 and 6, while Chapter 7 generated discussion relating to workplace bullying from a GHMT perspective. This chapter highlights the importance of this research and proposes implications for future directions.

## 8.2 Importance of this research

This section will discuss the importance of this research and describe the original contribution of this thesis. The volume of literature available regarding bullying and workplace bullying is growing. This study explored the available literature for the causes of workplace bullying in healthcare settings, but there was a significant gap when examining how health management trainees feel about workplace bullying, particularly in an Australian context. This was a significant gap given their role as future leaders in this sector, where they have the opportunity to improve patient care and to change systems. Health managers need to contribute to creating and maintaining safe working environments in which teams work collaboratively and productively in order to meet the needs of patients and realise efficiencies across the organisation and systems. By addressing and dealing appropriately with workplace bullying, a safer working environment for all staff and a safer healthcare environment for patients will be created.

The findings from this study have provided additional knowledge to the field of workplace bullying in healthcare settings and have advanced our understanding of workplace bullying from the perspective of GHMTs. The level of reporting of workplace bullying across Australian healthcare settings remains static and this study has contributed to understanding how GHMTs experience and conceptualise workplace bullying. This is key for developing interventions which will target workplace bullying and support GHMTs to develop effective strategies to deal with, respond to, and prevent workplace bullying. This study is also important for several reasons; recently three teaching hospitals in NSW have had their accreditation revoked, there is an increase in the number of reported suicides amongst health professionals and workers' compensation claims are estimated to be over $9 million per annum.

Significantly, this research has contributed to further knowledge of workplace bullying in healthcare settings in regard to power, namely positional power and power differentials; organisational culture, in particular the hierarchal nature of healthcare settings and reporting, under- and over-reporting. The overarching theme of perceptions of workplace bullying from a GMHT perspective has contributed to the knowledge in the field as limited studies have been undertaken for this group. The richness of the findings from the qualitative data and depth of individual responses from the three data sets has provided key implications for future directions in policy and practice and research in the area of workplace bullying in healthcare organisations. These implications will be discussed in the following section.

## 8.3 Implications for future directions

The results of the present study highlight key implications for policy and practice, anti-bullying training and future research. The following section will provide a discussion on these implications for healthcare organisations based on the findings from this study.

### 8.3.1 Implications for policy and practice

There is a lack of clarity and awareness in the health profession regarding the appropriate mechanisms for reporting workplace bullying, and where procedures are in place they are often not well understood. Healthcare organisations need to develop a clear process for managing workplace bullying complaints and cascade this process through the entire organisation via appropriate communication pipelines. These processes should include information on confidentiality, how to lodge a complaint and the role of human resources units in managing complaints, and provide tiered responses aimed at early intervention and resolution strategies. Incorporated into these processes should be mechanisms to protect staff who report workplace bullying or who cooperate in the investigation of a complaint. Outlining the steps in facilitating possible mediation, where appropriate, needs to be included. In addition, speciality colleges and professional organisations within the healthcare and medical profession need to be committed to fulfilling their obligations to their members to address how to deal with workplace bullying and undertake systematic reviews ensuring policies and procedures are in place to manage complaints relating to

workplace bullying. All healthcare organisations, specialty colleges and professional organisations need to include regular compliance checks to ensure policies and procedures are up-to-date and staff are provided with information and relevant anti-bullying training.

A comprehensive policy addressing workplace bullying is critical in healthcare settings. The policy needs to be adopted across the organisation and accessible by all staff and patients. Organisations need to develop a process which supports the implementation, review and monitoring of a workplace bullying policy. Other policies and procedures need to be reviewed to ensure they support current government policy in specific jurisdictions (e.g. NSW Health). Codes of conduct should be developed for all staff and reviewed regularly. Provisions within the policy outlining both internal and external assistance available for staff to access appropriate counselling, care and support services if requested are also essential. It is noted by the researcher that this may not be practical in large public health organisations but could be achieved by targeting the key influencers, decision-makers and appropriate level of management within the organisation.

A risk management approach needs to be adopted across all healthcare settings with clear procedures for identifying and assessing the risk of workplace bullying; implementing risk controls; and monitoring, reviewing and evaluating these risk controls. Risk identification should also include an understanding that social media is used as a mechanism to enact workplace bullying, and that staff should not engage in, ignore or excuse these behaviours.

The organisational and hierarchical structure in healthcare settings needs to be considered in addressing workplace bullying. Redefining job roles and even performance targets may promote collaboration and high-performing teams. Performance management practices which are transparent, and fair could incentivise staff to model positive and appropriate behaviours. These need to be targeted at future leaders in the healthcare profession (i.e. emerging health managers). Work streams or units should be encouraged to develop and commit to positive ways of working collaboratively together. It is likely that staff will decide on a set of conditions which they believe will maintain a safe, mutually supportive and collaborative working environment.

Monitoring the incidence of workplace bullying by undertaking recurring surveys which monitor workplace culture is key. These surveys need to be supported by reliable data to monitor the impacts of workplace bullying interventions or programs on staff and patient

safety over time. Surveys such as the NSW Health 'Your Say Workplace Culture' and the NSW Public Service Commission 'People Matter Survey' provide data comparisons across years. A range of international surveys and questionnaires developed and used specifically for the healthcare profession could also be used to assess the culture of organisational safety and to gauge burnout of staff. These include the Safety Attitudes Questionnaire (Viejo 2016) to assess safety culture, identify areas for improvement and highlight strengths across the organisation; the Agency for Healthcare Research and Quality Patient Safety Culture Survey (Agency for Healthcare Research and Quality 2019) to assess the current safety culture within an organisation, raise awareness of patient safety issues, identify areas for improvement, highlight strengths and provide the ability to view the data over time; the Maslach Burnout Inventory (Viejo 2016) to measure respondents' relationship to work; or the Mini Z Burnout Survey (Viejo 2016) to determine stress levels in healthcare organisations and how they compare with others in the field.

### 8.3.2 Implications for anti-bullying training

Whole-of-organisation anti-bullying training may prove to be a strong measure to address the issue of workplace bullying in healthcare organisations. Prevention programs need to take a socio-ecological perspective that includes an effective organisational approach. This current study provides support for this approach. The development of an effective workplace anti-bullying program should incorporate the guiding principles and effective strategies contained within the provisional anti-bullying learning framework developed for this study.

The implementation of programs addressing workplace bullying in healthcare settings has been sporadic at best. Significant variations exist between the requirement for mandatory training, off-the-shelf training and compliance. A coordinated approach to anti-bullying training and monitoring attendances which are linked to annual performance reviews could be enacted by human resource departments.

### 8.3.3 Implications for future research

The findings of this study serve as a catalyst for guiding future research. The study explored GHMTs' perceptions of workplace bullying. The topic of workplace bullying is broad and of international significance; however, the focus was on an Australian context, within health settings and among graduate and/or emerging health managers. The study

did not seek to address the global issue of workplace bullying in a health context but rather to provide an Australian perspective. Future research could investigate a similar cohort of emerging health managers internationally and provide for comparisons across healthcare settings.

The development and establishment of cultural improvement programs could endeavour to address the fact that workplace bullying is accepted as part of the culture in healthcare settings, particularly among clinicians. However, changing organisational culture is challenging and there is limited literature on how this could be achieved, which may suggest avenues for future research. Researchers could also investigate factors such as the cultural norms within the healthcare profession in Australia that have allowed workplace bullying to flourish.

The role of medical colleges and other medical providers and professional organisations in advocating for cultural change among clinicians and within healthcare settings and new attitudes towards workplace bullying are vital. Further research into well-developed and publicised policy regarding workplace bullying would be important to create a safe working and training environment that would ultimately sustain standards of patient safety and care.

Focusing on, and promoting, workplace mental health would reframe the deficit model adopted by many organisations (i.e. fixing what is wrong) by developing staff strengths and capabilities and positive aspects of working collaboratively. 'Positive outcomes include subjective wellbeing, psychological capital, positive mental health, employee engagement and positive organisational attributes (for example authentic leadership, supportive workplace culture, workplace social capital)' (Beyond Blue 2013, p.126).

Future research into workplace bullying in the healthcare sector should seek to identify trends in the broader population (i.e. nationally) and how these relate to international trends. In addition, research could explore perceptions of workplace bullying amongst different workers at the emerging leader stage of their career within the healthcare profession such as nurses, doctors, allied health and aged care workers. This type of research could also seek to examine how staff working in these specialised areas conceptualise workplace bullying.

## 8.4 Conclusion

The current study proposed to address the gap in the literature in relation to workplace bullying from a GHMT perspective, with a focus on an Australian context. This has been achieved by the findings from the data sets across the two phases of the study and the development of a provisional anti-bullying learning framework. Implications for healthcare policy and practice, anti-bullying training and future research have been identified.

The delivery of effective healthcare relies on the capacity and competence of the workforce and therefore upon the ability of healthcare organisations to manage and engage their workforces effectively (Meier and O'Toole 2002). There is increasing recognition of the impact of management and leadership behaviours on organisational performance (Buchanan et al 2013; Pfeffer 2005). There is also an increasing correlation between healthy work environments, patient safety and the wellbeing of healthcare professionals (Laschinger and Finegan 2005; Vahey et al 2004). 'Compelling evidence confirms that healthy work environments are essential to ensure patient safety, enhance staff recruitment and retention, and maintain an organisation's financial viability' (Viejo 2016, p.36).

The study demonstrated that GHMTs' perceptions and experiences of workplace bullying have an impact on the individual, the patients, the organisation and the system as a whole. The findings add important evidence to what is currently known about workplace bullying in healthcare settings. A summary of the key findings will be made available through publications in relevant health management, health and education journals to add to the body of knowledge in relation to workplace bullying and to leverage the benefits from this significant study. Opportunities for presenting the findings of this study at conferences, both nationally and internationally, will be sought. Key findings have emerged from this study and these will be highlighted in future publications and conference presentations.

Long-term, sustained change in healthcare settings for dealing with workplace bullying will be evidenced through the development, implementation and evaluation of policies and procedures. The delivery of anti-bullying training and professional development for staff will also be a key metric in assessing the efficacy of systemic change within the healthcare profession. The healthcare profession needs to identify strategies for the

prevention of workplace bullying and effective interventions to address the issue when it occurs. Findings from this study have substantive and methodological implications for researchers studying workplace bullying in healthcare settings.

# Appendices

## Appendix 1: List of studies identified for the literature review


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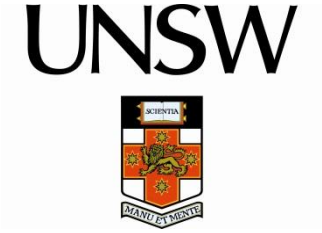
## Appendix 2: Invitation to participate – focus groups




Approval No (HC 13347)

THE UNIVERSITY OF NEW SOUTH WALES

**Letter/email Invitation to Participants**

Date

Name

Address

Dear

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

Sharlene Chadwick, from the Australasian College of Health Service Management is studying for her doctorate at the University of New South Wales.

She is conducting research to explore graduate health management trainees perceptions of bullying behaviours. She is undertaking this study under the supervision of Dr Joanne Travaglia and Dr Lesley Halliday, in the School of Public Health and Community Medicine.

You are being invited to participate in this study as you are either a current and/ or former trainee in the Graduate Health Management Program (GHMP). You are invited to consider participating in this project, the details of which appear below.

Collection of the data for the project will be conducted during March-May 2014. It will involve the participation in focus group discussions for at least 60 minutes. You will be

given a pseudonym to protect your identity. You will be asked a range of questions and the discussions will be recorded. Groups will consist of between 6-8 participants and be conducted at The University of New South Wales.

No findings will be published which could identify any individuals or organisations. Access to data is restricted to her supervisors. Coded data will be stored for seven years, as prescribed by University regulations.

Participation in this research is entirely voluntary, and if you agree to participate, you may withdraw your consent at any time by informing the University in writing. Your decision whether or not to participate will not prejudice your future relations with The University of New South Wales or your involvement with the GHMP or ACHSM.

Thank you for willingness to participate in this important research.

If you are interested in participating and would like to receive further details and participant consent forms, please contact me on the details below.

Kind regards,

Audrey Panetta

Office Manager
Australasian College of Health Service Management
PO Box 341
North Ryde NSW 2100
p: 02 9787 1222
e: Audrey.panetta@achsm.org.au

Should you have any concerns about the conduct of this research project, please contact

Supervisor:

| | | |
|---|---|---|
| Dr Joanne Travaglia | OR | Dr Lesley Halliday |
| Director | | Lecturer |
| Health Management Program | | Health Management Program |

University of New South Wales
p: 02 9385 8339
e: j.travaglia@unsw.edu.au

University of New South Wales
p: 02 9385 1009
e: l.halliday@unsw.edu.au

## Appendix 3: Provisional anti-bullying learning framework

| Guiding Principles | | Effective Practices |
|---|---|---|
| **Leadership**<br><br>Visible leadership to inspire positive workplaces | Chief Executives and senior executives play an active role in building a positive workplace environment where the whole organisation feels included, connected, safe and respected. | • Learning and development programs are supported by health service leadership.<br>• Communications align with the messages delivered within the training and inform employees about: how to access training; the requirement to undertake training; and how the training applies within the workplace.<br>• Managers and leaders are trained in additional areas such as understanding their legal obligations and the skills required to identify psychological hazards and ensure appropriate control measures are in place.<br>• Combined learning and development sessions are conducted with managers and staff, which support understanding of different roles, common understanding of acceptable workplace behaviours and collaboration across disciplines.<br>• Health service leaders are committed to building the capability of their workforce by modelling best practice, encouraging staff participation in learning and development opportunities and providing programs that contribute to the creation of a positive workplace culture. |
| **Inclusion**<br><br>Inclusive and accepting workplace culture | All staff in the organisation are active participants in building a culture which values diversity, and fosters positive, respectful relationships. | • Learning and development programs match the values of the health service and help build a positive work-place culture.<br>• Learning and development programs reinforce acceptable and respectful workplace behaviour in a positive way, also recognising the need for improvements in culture across the healthcare sector.<br>• Learning and development needs of different types of employees are assessed regularly.<br>• Learning and development programs are accessible and appropriate for building knowledge and skills.<br>• Learning and development programs emphasise the collective responsibility of management and staff to promote a safe and respectful workplace culture and improve capabilities such as leadership, performance management, communication and values-driven practice. |
| **Participation**<br><br>Staff participation | Individuals are active participants in their own learning and wellbeing, feel connected and use their social and emotional skills to be respectful, resilient and safe. | • Learning and development programs support the identification, development and promotion of acceptable workplace behaviours, including the importance of speaking out about inappropriate and negative workplace behaviours.<br>• Learning and development provides opportunities for staff to reflect, embrace key messages and acquire new skills.<br>• Learning and development programs are offered in different modes to support different learning styles.<br>• Delivery of training and development is appropriate for the audience and purpose of the training.<br>• Learning and development maximises engagement, self-reflection, shared learnings, acquisition of knowledge and skill development.<br>• Learning and development programs are based on best-practice evidence.<br>• Learning and development programs are composed of discrete modules which support the efficient delivery of relevant information and skills development. |

| Guiding Principles | | Effective Practices |
|---|---|---|
| **Support**<br><br>Wellbeing and support for positive workplace behaviours | All staff share and encourage an understanding of wellbeing and support for positive workplace behaviour. | • Learning and development programs should be based on the definitions of workplace bullying, harassment and discrimination. (acknowledging these terms can be defined in different ways by different organisations and groups).<br>• Staff members receive induction training that, at a minimum, includes information on:<br>— the standards of behaviour expected in the workplace including the use of social media, if relevant<br>— how workplace bullying, harassment and discrimination should be reported and how such reports are managed<br>— where to go internally and externally for more information.<br>• Learning and development programs include information on:<br>— how individuals can respond to inappropriate behaviour including workplace bullying, harassment and discrimination and support others to respond<br>— how to report workplace bullying , harassment and discrimination<br>— the various processes, interventions and time frames for responding to workplace bullying, harassment and discrimination. |
| **Safety**<br><br>Workplaces support a culture which values staff and patient safety | All staff are committed to enhancing a culture, within a system, that supports safety, continuous improvement and quality outcomes. | • Mechanisms exist to incorporate findings from analysis of measures such as training outcomes, indicators and incidents into actions across organisational culture, quality and safety domains. |

## Appendix 4: Quantitative survey – expert reference group

### Welcome to the Expert Reference Group Feedback Survey

Thank you for participating in reviewing a provisional learning framework for workplace bullying as part of research being undertaken by doctoral student, Sharlene Chadwick, University of Technology Sydney.

Please find following 3 sections to complete.
**Section 1** provides for demographic information.
**Section 2** provides for specific feedback on the provisional learning framework provided in the accompanying email.
**Section 3** provides for broader discussion regarding workplace bullying.

Could you please provide feedback by completing this survey by **16 September 2016**.

The researcher thanks you for your time and expertise.
Thank you.

## Section 1

**Demographic Information**
**Please indicate the appropriate response to each of the following**

### 1. Please indicate your gender

- ◯ Male
- ◯ Female

### 2. Please indicate your professional role

- ◯ Research and teaching
- ◯ Teaching
- ◯ Clinician
- ◯ Other (please specify)

### 3. Please indicate your professional discipline

- ◯ Medicine
- ◯ Nursing
- ◯ Education
- ◯ Psychology
- ◯ Other (please specify)

### 4. Please indicate your highest qualification

- ◯ Doctorate
- ◯ Medical Doctor
- ◯ Masters
- ◯ Honours
- ◯ Other (please specify)

5. Please indicate your length of experience in your current role

- ◯ >10 years
- ◯ 5-10 years
- ◯ <2 years
- ◯ Other (please specify)

6. Please indicate in which country you reside

Section 2

**Please respond to the following questions on the provisional learning framework and content in regard to this particular learning framework**

## 7. Provisional Learning Framework

| | Strongly disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|---|
| aims and learning outcomes clearly stated | ○ | ○ | ○ | ○ | ○ |
| duration of each session is adequate | ○ | ○ | ○ | ○ | ○ |
| language used is appropriate, sensitive and free of jargon | ○ | ○ | ○ | ○ | ○ |
| blend of engaging learning experiences | ○ | ○ | ○ | ○ | ○ |
| opportunities for participants to contribute to discussion | ○ | ○ | ○ | ○ | ○ |
| teaching methods used are appropriate and will enhance learning | ○ | ○ | ○ | ○ | ○ |
| evidence of peer interaction in sessions | ○ | ○ | ○ | ○ | ○ |
| opportunities for collaborative learning | ○ | ○ | ○ | ○ | ○ |
| facilitators notes provide sufficient direction | ○ | ○ | ○ | ○ | ○ |
| activities aresequential and build on knowledge and concepts | ○ | ○ | ○ | ○ | ○ |

Please comment if you have marked 'disagree' or 'strongly disagree' for any of the statements

## 8. Professional Learning Framework - workplace bullying learning content

What are the best aspects of this framework? Please indicate why.

Discuss the weakest aspects of this framework and recommend changes

Discuss the suggested target participant group or indicate an alternate participant group

Discuss the training which may be required to facilitate a workplace bullying learning module

What areas need more examples, different examples or further explanation?

Would additional activities provide more useful learning. Please outline.

Discuss whether the content has been clearly defined - skills, knowledge, attitudes

Discuss the key principles which should be included in a workplace bullying learning module. Are these key principles evident?

Discuss the value of the Worksheets for the group activities. Please suggest alternatives if appropriate.

What suggestions can you make to enhance the learning experience?

## 9. Please comment on anything else or additional recommendations.

## Section 3

Please respond to the following in regard to your knowledge in the field of workplace bullying.

10. What is unique about workplace bullying in healthcare?

11. Describe any 'cutting edge' approaches to dealing with workplace bullying in your country

12. Describe approaches to dealing with workplace bullying in a healthcare context in your country

13. What other workplace bullying programs have you been involved with?

14. How do these compare with other programs you may be aware of?

15. Describe 'best practice' implementation for workplace bullying programs

## Appendix 5: Invitation to participate – expert reference group

Approval No (HREC ETH 16-1055)

**Letter/email Invitation to Participants**

Date

Name

Address

Dear

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

Purpose: Expert Reference Group – review provisional learning framework

Sharlene Chadwick, from the Australasian College of Health Service Management (ACHSM) is studying for her doctorate at the University of Technology Sydney.

She is conducting research to explore workplace bullying in the Australian health context, specifically with emerging health managers. She is undertaking this study under the supervision of Dr Joanne Travaglia Faculty of Health.

You are being invited to participate in an Expert Reference Group as you are either have expertise in workplace bullying or health both nationally or internationally. You are invited to consider participating in this review, the details of which appear below.

A provisional learning framework has been developed as part of this study which aims to raise awareness regarding workplace bullying in healthcare settings. The provisional learning framework outlines guiding principles and effective strategies for healthcare

organisations to consider for learning and development programs to address workplace bullying.

**Background:** Education and awareness raising as an intervention strategy is needed to address bullying behaviours in the workplace. Targeted training in the form of awareness raising could address the issue of organisational culture which may encourage conformity and acceptance of workplace bullying. Assisting organisations to change attitudes towards workplace bullying is vital if we are to deal effectively with the increase in, and the impact of, workplace bullying in Australia.

**Details:** You will be provided with the provisional learning framework and a link to the online survey during June-July 2016. You will be given a pseudonym to protect your identity.

No findings will be published which could identify any individuals or organisations. Access to data is restricted to her supervisors. Coded data will be stored for seven years, as prescribed by University regulations.

Participation in this review is entirely voluntary, and if you agree to participate, you may withdraw your consent at any time by informing the University in writing. Your decision whether or not to participate will not prejudice your future relations with the University of Technology Sydney.

Thank you for willingness to participate in this important review.

If you are interested in participating and would like to receive further details and consent forms, please contact me on the details below.

Kind regards,

Sharlene Chadwick
Australasian College of Health Service Management
PO Box 671
Gladesville NSW 1675
p: +61 2 8753 5100
e: Sharlene.chadwick@achsm.org.au

Should you have any concerns about the conduct of this review, please contact

Supervisor:

Dr Joanne Travaglia
Associate Professor
Faculty of Health
University of Technology Sydney
T +61 2 9514 4553
E: Joanne.Travaglia@uts.edu.au

## Appendix 6: Participant information and consent form – expert reference group

Approval No (HREC ETH 16-1055)

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

Participant selection and purpose of study

You are being invited to participate in an Expert Reference Group as you are either have expertise in workplace bullying or health both nationally or internationally. You are invited to consider participating in this project, the details of which appear below.

Knowledge about workplace bullying in Australia is limited and national definitions, policies and frameworks are yet to be developed. We hope to learn about the perceptions of bullying behaviours and the effect of the organisational culture and the actions and interactions of health managers.

Description of study and risks

If you decide to participate, you will be provided with a provisional learning framework and a link to the online survey during June-July 2016.

Confidentiality and disclosure of information

You will be provided with pseudonyms to avoid identification, and your responses will be coded. Confidentiality with regards to your identity and responses will be protected at all times.

If you give us your permission by signing this document, we plan to publish the results. This may include, but not be limited to, educational and health journals, print media,

conference abstracts and reports. In any publication, information will be provided in such a way that you or your organisation cannot be identified.

Complaints

Complaints may be directed to the Ethics Secretariat, University of Technology Sydney, Broadway NSW 2007 AUSTRALIA (phone (+61 2 9514 1336, email grs@uts.edu.au). Any complaint you make will be investigated promptly and you will be informed of the outcome.

Feedback to participants

You will be provided with a summary of the research findings in the form of a briefing paper at the completion of the study. This summary will be forwarded to your nominated email address.

Your consent

Your decision whether or not to participate will not prejudice your future relations with the University of Technology Sydney. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, Sharlene Chadwick, +61 2 8753 5120, Sharlene.chadwick@achsm.org.au will be available to answer them.

You will be given a copy of this form to keep.

UNIVERSITY OF TECHNOLOGY SYDNEY

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM (continued)

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided above, you have decided to participate.

…… ……

Signature of Research Participant Signature of Witness

…… ……

(Please PRINT name) (Please PRINT name)

……. ……

Date Nature of Witness

REVOCATION OF CONSENT

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with University of Technology Sydney.

…… …….

Signature Date

……

Please PRINT Name

The section for Revocation of Consent should be forwarded to Dr Joanne Travaglia joanne.travaglia@uts.edu.au

## Appendix 7: Confidentiality agreement for participants

Approval No (HC 13347)

THE UNIVERSITY OF NEW SOUTH WALES

CONFIDENTIALITY AGREEMENT FOR PARTICIPANTS

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

You are agreeing to maintain the confidentiality of discussions within this group on (date).

You agree to not discuss with any 3rd party any details regarding other participants or the contents or any discussions within the group.

We agree to protect your identity by assigning a pseudonym and changing all details which may allow your workplace to be identified.

Your signature indicates that, having read the information provided above, you have decided to participate.

……

Signature of Research Participant

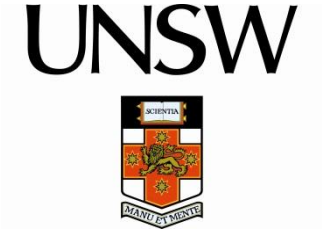
……

(Please PRINT name)

……

Date

## Appendix 8: Participant information and consent form – focus groups




Approval No (HC 13347)

THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

Participant selection and purpose of study

You are invited to participate in a focus group discussion to explore your perceptions of workplace bullying behaviours. You were selected as a possible participant in this study because you are either a current or previous participant in a graduate health management program in NSW.

Knowledge about workplace bullying in Australia is limited and national definitions, policies and frameworks are yet to be developed. We hope to learn about the perceptions of bullying behaviours and the effect of the organisational culture and the actions and interactions of health managers.

Description of study and risks

If you decide to participate, we will be conducting either focus group discussions or 1:1 telephone interviews. The focus group discussions will involve groups of approximately 6-8 participants and will last for at least 60 minutes. We will conduct the focus group discussions at The University of New South Wales at a time and date suitable to you.

Telephone interviews will be conducted individually for at least 20 minutes at a time and date suitable to you.

Digital recording devices will be used to record discussions or interviews. The purpose of these recordings is only to transcribe the discussion during the focus groups. Your written consent permits these focus groups or telephone interviews to be recorded.

Confidentiality and disclosure of information

You will be provided with pseudonyms to avoid identification, and your responses will be coded during transcription of the recordings. Confidentiality with regards to your identity and responses will be protected at all times and you will be required to sign a confidentiality agreement prior to the focus group to ensure a safe environment is provided for all participants to encourage openness.

If you give us your permission by signing this document, we plan to publish the results. This may include, but not be limited to, educational and health journals, print media, ACHSM website, conference abstracts and reports. In any publication, information will be provided in such a way that you or your organisation cannot be identified.

Complaints

Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone (02) 9385 4234, fax (02) 9385 6648, email ethics.gmo@unsw.edu.au). Any complaint you make will be investigated promptly and you will be informed of the outcome.

Feedback to participants

You will be provided with a summary of the research findings in the form of a briefing paper at the completion of the study. This summary will be forwarded to your nominated email address.

Your consent

Your decision whether or not to participate will not prejudice your future relations with The University of New South Wales or ACHSM or your involvement with the GHMP. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, Sharlene Chadwick, 02 9878 2200, Sharlene.chadwick@achsm.org.au will be available to answer them.

You will be given a copy of this form to keep.

THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM (continued)

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided above, you have decided to participate.

…… ……

Signature of Research Participant Signature of Witness

…… ……

(Please PRINT name) (Please PRINT name)

……. ……

Date Nature of Witness

REVOCATION OF CONSENT

Title: Graduate Health Management Trainees' perceptions of workplace bullying behaviours: an Australian perspective

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with The University of New South Wales, ACHSM or my involvement in the GHMP.

…… …….

Signature Date

……

Please PRINT Name

The section for Revocation of Consent should be forwarded to Dr Joanne Travaglia j.travaglia@unsw.edu.au

## Appendix 9: Handout of resources for participants

Approval No (HC 13347)

THE UNIVERSITY OF NEW SOUTH WALES

The following support services and websites can provide further confidential information if any participant is in need of advice or counselling.

The **Australian Human Rights Commission** (1300 656 419) has a complaint handling service that can investigate and resolve complaints of discrimination, harassment and bullying that are covered by federal discrimination law
http://www.humanrights.gov.au/complaints_information/index.html

**Lifeline** (13 11 14) is a free and confidential service staffed by trained telephone counsellors. www.lifeline.org.au

**Kids Help Line** (1800 55 1800) is a free and confidential, telephone counseling service for 5 to 25 year olds in Australia. www.kidshelp.com.au

**Reach Out** is an online community for young people that can help with mental health and wellbeing related issues they also provide opportunities for connecting with young people. http://au.reachout.com

**Salvo Care Line (1300 36 36 22)**

A 24 hour telephone counselling service with trained counsellors to listen and explore options with you.

**Beyondblue infoline (1300 22 4636)**

Provides information on depression, anxiety and related disorders, available treatments and referrals to relevant services. The Translating and Interpreting Service (TIS) is available if you require a translator.

Other useful resources

To find out about cyberbullying and how to get help you can also go to the Australian Communications and Media Authority (ACMA) Cybersmart Program

http://www.cybersmart.gov.au/report.aspx

National Centre Against Bullying

http://www.ncab.org.au

The Australian Human Rights Commission has information on cyber racism and actions that can be taken to report cyber racism.

http://www.humanrights.gov.au/racial_discrimination/publications/cyberracism_factsheet.html

WorkCover NSW has a range of resources, support and advice.

http://www.workcover.nsw.gov.au/newlegislation2012/health-and-safety-topics/human-behaviour/Pages/bullying.aspx

## Appendix 10: Descriptions of themes and sub-themes

*WBB workplace bullying behaviours

*HCO healthcare organisations

| Theme | Sub-theme | Description |
|---|---|---|
| 1. Level of awareness of workplace bullying | 1.1 Effect on the co-worker | • Negative impacts of *WBB on colleagues |
| | 1.2 Victim's experience | • Negative impacts on those experiencing WBB |
| | 1.3 Wrongdoing | • Inappropriate behaviour or actions |
| 2. Behaviours which constitute workplace bullying | 2.1 Abuse of authority | • Staff in positions of perceived power using their position to enact WBB or to influence the behaviour of others |
| | 2.2 Intimidation | • Being afraid of the person enacting WBB |
| | 2.3 Isolating | • Feeling separated from other people in the team or wide work environment in *HCO |
| | 2.4 Public humiliation | • Disgracing or deliberately embarrassing someone whilst others are watching on |
| | 2.5 Racism | • Discrimination or prejudice directed at someone of a different race |
| | 2.6 Talking about others | • Being spoken negatively about to other people in HCO |
| 3. Causes of workplace bullying | 3.1 Demographics | • Categories of particular population groups in HCO |
| | 3.2 Personal Issues | • Problems in someone's private life which impact on their behaviour at work |
| | 3.3 Threat | • Inflict damage to someone's reputation |
| | 3.4. Unintended | • Unforeseen or unexpected consequences of WBB |
| 4. Consequences of workplace bullying | 4.1 For those engaging in bullying | • Effects or outcomes for those people who enact WBB |
| | 4.2 For those being bullied | • Effects or outcomes for those people who are impacted by WBB |
| 5. Dealing with workplace bullying | 5.1 Manager to staff | • Ways managers can engage and communicate with their staff across the HCO in relation to WBB |
| | 5.2 Organisational culture | • Components which govern how people behave and interact in HCO |

| Theme | Sub-theme | Description |
|---|---|---|
| | 5.3 Staff to staff | • Ways staff can engage and communicate with each other across the HCO in relation to WBB |
| | 5.4 Strategies for dealing with bullying in the workplace | • Actions designed to positively reduce incidents WBB |
| 6. Nature of workplace bullying | 6.1 Grievances | • Cause for complaint in being treated unfairly in the HCO |
| | 6.2 Organisational culture | • Components which govern how people behave and interact in HCO |
| | 6.3 Overt | • Obviously apparent, observable incidents of WBB |
| | 6.4 Patterns | • Repeated or recurring incidents of WBB |
| | 6.5 Power | • Capacity to influence the behaviour of others |
| | 6.6 Recognition | • Acknowledging someone for their achievements and contributions |
| 7. Positive relationships | 7.1 Acknowledging positive actions | • Affirming someone for their positive interactions or efforts |
| | 7.2 Communication | • Effective, positive and transparent exchange of information in HCO |
| | 7.3 Other strategies | • Examples provided which did not align to a theme |
| | 7.4 Understanding | • Being aware of, and sensitive to, other people feelings |
| 8. Reporting of workplace bullying | 8.1 Responsibility | • Being accountable for own behaviour and acknowledging individuals' duty to deal with WBB |
| 9. Training needs | 9.1 Existing training | • Current methods of training and professional development to address WBB across HCO |
| | 9.2 Training needs | • Modes of training and professional development to address WBB across HCO |

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