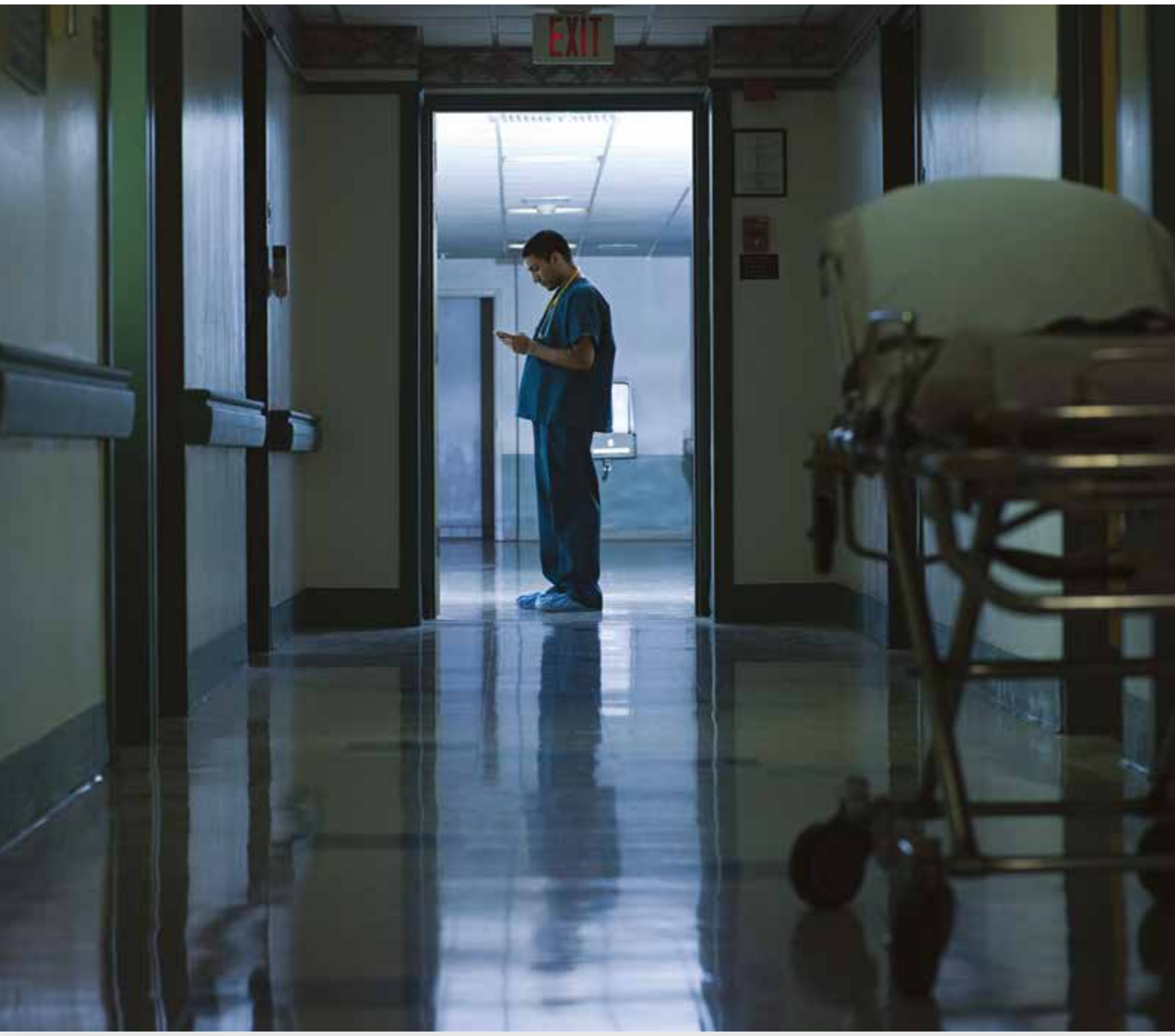
Bullying in the New Zealand senior medical workforce: prevalence, correlates and consequences



HEALTH DIALOGUE
ISSUE 14 | NOVEMBER 2017

ASMS
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Foreword

I must admit when I first read the *Health Dialogue* on bullying, I became quite emotional. I felt a deep sense of sadness. I knew workplace bullying has been a concern for some time and continues to be an ongoing problem in our public health service. However, the high prevalence and nature of it shocked me. I found the illustrative comments in table 4 particularly distressing. My sadness was slowly replaced by disappointment and a sense of anger. As a profession, we practise medicine following the well-known rule: "First, do no harm". We try, to the best of our abilities, to achieve that for our patients but not necessarily when dealing with colleagues, with over two-thirds of respondents in this study reporting that they witnessed bullying to some degree.

After I calmed down, I reflected more and tried to make sense of it all. These behaviours do not occur in a vacuum. It occurs in a public health system that is under tremendous pressure. This pressure is taking its toll. We know from Dr Charlotte Chambers' previous research that nearly 90% of senior doctors report going to work while they are sick and 50% of our senior medical officers report symptoms of burnout. Nearly a quarter (24%) indicated that they are planning to leave medicine or the DHB they work for in the next 5 years. We now have evidence that bullying is commonplace. The reflection in the mirror is becoming clearer, and it is not flattering. We cannot ignore the potential impact bullying has on patient safety and care. You cannot "attack" a doctor without the risk of harming the patients he or she cares for.

Considering the above, has this become a vicious cycle? The result of a vicious cycle is that things get worse and worse over time. A virtuous cycle leads to desirable outcomes and these keep getting better over time. Both systems of events have feedback loops in which each iteration of the cycle reinforces the previous one. The cycles will continue in its direction of travel until an external factor intervenes and breaks the cycle. As an employer, District Health Boards have a duty to provide its employees with a safe work environment and therefore a duty to intervene and break the vicious cycle. To that end, the ASMS has been challenging poor workplace policies and insisting on sensible processes for dealing with bullying and other complaints, emphasising that prevention is the best 'cure'. As a caring profession, we also have a duty to intervene and break this vicious cycle. The ASMS encourages members to take part in the various courses and programmes now being promulgated by various DHBs and medical colleges.

The Government also has a responsibility to resource our health services to ensure all health sector employers are able to provide safe environments for patients and staff. This includes ensuring that workload pressures are manageable and that there is adequate workforce capacity to deliver the services upon which our patients depend.

DHBs, and their political and bureaucratic masters, have created systemic conditions conducive to bullying. I am fully aware that the new Government has inherited a public health service that has been under-resourced for a number of years. I implore the new Minister of Health, the Director General of Health, and Treasury not to distance themselves from this, but to recognise their responsibility and be part of the solution.

Bullying is not a diagnosis, it is a symptom - a symptom of a health system that has significant systemic problems.

Dr Hein Stander
ASMS National President

Executive summary

This *Health Dialogue* reports the first study into the prevalence of workplace bullying among senior doctors and dentists of different specialties working in New Zealand's public health system. It is based on the findings of a survey conducted in June 2017 of 4307 members of the Association of Salaried Medical Specialists (ASMS), of whom 1759 (40.8%) responded. The study aims to provide a benchmark of bullying prevalence in this senior medical cohort; little is known about senior doctors and dentists as victims of bullying. The research also describes the rates of reported bullying as well as barriers to formally reporting bullying behaviour, and seeks to understand the correlates and consequences.

The research finds more than a third of respondents (38.1%) are regularly exposed to a wide range of negative behaviours at work as defined and measured by the internationally recognised Negative Acts Questionnaire (revised) (NAQ-r). Work-related bullying behaviours were found to be especially common (49.9% experienced work-related bullying 'to some degree'). More than a third (37.2%) self-reported as being bullied, and more than two-thirds (67.5%) reported witnessing bullying of colleagues. The prevalence of bullying in New Zealand's senior doctors appears higher than shown in comparable international surveys of health sector workers.

Significantly, the research finds the frequency of all measures of bullying is strongly associated with high workplace demands, and low peer and non-clinical managerial support. These findings are consistent with the literature that emphasises bullying as a phenomenon with multiple antecedents, including high workloads, stressful workplaces with poor organisational structures, and workplace cultures where bullying may be normalised as a coping strategy.

While the results suggest workplace bullying is experienced across the board, it occurs more often for certain groups of respondents:

- International medical graduates (IMGs) reported significantly higher personal-related bullying scores than their New Zealand-trained counterparts (mean score 16.7 vs 15.9, p=0.012).
- IMGs also reported significantly higher rates of negative behaviours such as the spreading of gossip or rumours, being ignored or excluded, and practical jokes from those they don't get on with.
- New Zealand-trained respondents were more likely to report being exposed to an unmanageable workload than IMGs (mean score 2.4 vs 2.2, p=0.008).
- Women were significantly more likely to self-report bullying compared with their male counterparts (39.9% vs 32.3%, p=0.002).
- Respondents aged 40–59 reported the highest overall levels of bullying compared with other age groups (overall NAQ-r mean score 33.3, p<0.001).
- Of the medical specialties, emergency medicine had the highest mean NAQ-r score and the highest rate of self-reported bullying prevalence 'to some degree' (47.9%), while general surgery and specialist surgery 'other' also reported high rates.
- The research found significant variation in the prevalence of bullying by place of work. Tairawhiti (n=21), Whanganui (n=10) and Southern (n=94) district health boards (DHBs) had the three highest mean NAQ-r scores, while Taranaki (n=32), Lakes (n=20) and West Coast (n=10) DHBs had the three lowest mean scores.

Other senior medical staff [1] were the most commonly cited perpetrators for self-reported and witnessed bullying behaviour (52.5% overall). This echoes the findings of other studies. Non-clinical managers were also cited as a regular source of bullying (31.8%), as were those in clinical leadership positions (24.9%).

Nearly 70% of those who self-reported as bullied disclosed that they had not formally reported the behaviour experienced. Of those, 43.5% did not report the bullying because they felt they would not be supported, and 42% feared that reporting the matter would make it worse.

Of those that did formally report the bullying experienced, 30.8% reported that the issue was not addressed and the behaviour continued. Only 6% reported that the behaviour stopped and did not recur.

Qualitative data reveals the wide-ranging consequences of bullying affecting workplace environments, personal well-being and subjective quality of patient care.

The results of this study indicate considerable work remains to be done not only to strengthen DHBs' existing systems to prevent bullying and negative behaviours but also to address the broader implications of growing workloads, under-resourcing and under-staffing for the health and well-being of this medical workforce and their patients.

The ASMS has put considerable effort into encouraging the widespread adoption of better systems to deal with bullying complaints, and continues to recommend the approaches advocated by the Cognitive Institute. Whatever system is adopted must be perceived as safe for the victims of bullying – victims must be assured that they will not be disadvantaged in making a complaint, and moreover, that the principles of natural justice are adhered to so that everyone involved gets a fair hearing.

Overall, these results draw attention to the wider conditions and pressures in the public health system that may encourage bullying. They emphasise the importance of fostering workplaces with strong collegial support networks as well as the value of high quality leaders who can nurture robust relationships with other staff. Most importantly, the results of this survey indicate a need for a comprehensive series of interventions to address problematic behaviours and consider the broader implications of growing workloads, under-resourcing and under-staffing for the health and well-being of this medical workforce and their patients.

1 This category of perpetrator excluded clinical leaders, who were listed separately.

Introduction

In 2015, research commissioned by the Royal Australasian College of Surgeons (RACS) found almost half of all surgeons in New Zealand and Australia had experienced some form of inappropriate behaviour, with trainees reporting the highest levels of bullying among those surveyed (Knowles, Szoke et al. 2015). Surgical directors or consultants were found to be the main perpetrators (Crebbin, Campbell et al. 2015).

In the same year, the New Zealand Resident Doctors' Association (RDA) undertook a survey of resident doctors which found that half of those surveyed had experienced at least one episode of bullying behaviour, with the main perpetrators being senior doctors or nurses (RDA 2015). Following both reports, a working group was convened by the Ministry of Health (MOH) to consider the issue of workplace bullying and to establish a joint approach to the problem. The Association of Salaried Medical Specialists (ASMS) is part of this working group.

While there has been considerable attention to the problem of bullying for resident doctors, medical students and trainees, little is known about the prevalence and consequences of bullying experienced by consultants and specialists. Of the known studies that have focused on this medical cohort, the focus has been on bullying prevalence in specific medical specialties – for example, Australian general surgery consultants (Ling, Young et al. 2016), Australasian fellows of the College of Intensive Care Medicine (Venkatesh, Corke et al. 2016) and obstetrics and gynaecology consultants working in the British National Health Service (NHS) (Shabazz, Parry-Smith et al. 2016). To the best of the author's knowledge, there have been no studies to date to specifically assess the prevalence of bullying in medical specialists in a multi-specialty, multi-centre national survey.

This study addresses this gap by investigating the prevalence of bullying among senior doctors and dentists working in New Zealand's public health system. It aims to provide a benchmark of bullying prevalence in this senior medical cohort, two years since the findings of 2015. Previous research by ASMS has detailed the concerning rates of burnout (Chambers, Frampton et al. 2016), working through illness (presenteeism) (Chambers, Frampton et al. 2017), and the association between low job satisfaction and intentions to leave (Chambers 2017). This research provides another lens on the correlates of health and well-being of ASMS members who provide high quality care in increasingly stretched and stressed environments.

Since the MOH working group was convened, many district health boards (DHBs) have worked hard to improve reporting systems. This study accordingly details rates of bullying and barriers to formally reporting this behaviour. In addition, the study explores associations between those experiencing bullying – or 'negative behaviours' – and perceived levels of workplace demands and support from peers and non-clinical managers. In doing so, it contributes to the literature on the antecedents of workplace bullying and helps us understand the broader workplace dynamics that contribute to this behaviour. The study also explores correlations between negative behaviours and demographic factors, including medical specialty, place of work, gender and ethnicity. ASMS hopes that any trends found in this regard will help us identify members who may benefit from additional research by ASMS and further support through our industrial activities. Finally, the study examines the consequences of bullying on the professional and personal lives of respondents by analysing individuals' experiences of bullying in their own words.

Structure

This *Health Dialogue* briefly reviews workplace bullying literature with specific reference to the antecedents of workplace bullying in

medical contexts. It provides an overview of the methodological approach to the study before detailing the key findings. A discussion on the salience and implications of the results follows. The report ends with what can be learned from this study and identifies questions that remain unanswered. Quotes from ASMS members who self-reported as bullied are highlighted throughout this *Health Dialogue*. Each quote is from a separate survey respondent.

Workplace bullying

The prevalence of workplace bullying in medicine is an ongoing issue of concern. Described as the most "destructive phenomenon plaguing medical culture" (Jamieson, Mitchell et al. 2015), workplace bullying poses significant risks to patient safety and quality of patient care (Paice and Smith 2009), staff morale and job satisfaction (Quine 1999), and the physical and psychological well-being of doctors and their co-workers (Kivimäki, Virtanen et al. 2003, Hogh, Conway et al. 2016). Doctors who are bullied are more likely to consider leaving medicine (Paice, Aitken et al. 2004), and there are strong associations between prevalence of burnout and bullying (Karsavuran and Kaya 2017).

Workplace bullying is defined as an escalating process where individuals repeatedly and over a period of time experience negative actions and behaviours from the people they encounter at work (Einarsen and Raknes 1997, Einarsen 2000). Bullying behaviours may range from overt aggression and violence to subtle and indirect acts such as being subjected to false accusations, having views or contributions ignored, being socially excluded or being deliberately assigned heavy workloads (Matthiesen and Einarsen 2010 p218). Importantly, many authors emphasise that the intent behind the behaviour(s) is not the primary consideration; it is the impact on and perception of the victim that is key to determining whether or not bullying has occurred (Salin 2003, Matthiesen and Einarsen 2010). The definition of bullying adopted for the purposes of this study can be summarised as follows: bullying at work refers to situations where one or more persons feel subjected to negative and/or aggressive behaviour from others in the workplace over a period of time and in a situation where they for different reasons are unable to defend themselves against these actions (adapted from Einarsen and Skogstad 1996).

The antecedents of workplace bullying are many and complex. Factors known to encourage bullying include stressful and demanding work environments (Hoel and Salin 2003), hierarchical and unsupportive workplace cultures (Matthiesen and Einarsen 2010) and a normalisation of incivility and rudeness in common conduct (Bradley, Liddle et al. 2015). Other authors note the importance of power imbalances in workplaces as having the potential to encourage bullying, and cite factors including poor organisational processes and procedures, as well as informal organisational alliances as likely to encourage bullying behaviours (Blackstock, Harlos et al. 2015).

Research by Bentley, Catley et al. (2009) emphasises the connections between work environments and bullying. They note that the high levels of stress found within the New Zealand public health sector is a contributory factor and emphasise the influence of poor resourcing, staffing shortages, and long working hours as a potent mix of conditions increasing the likelihood of workplace bullying. This point is reiterated in research on the NHS which found that structural factors such as poor resourcing and under-staffing can precipitate bullying as acceptable behaviour under challenging circumstances (Crowe, Clarke et al. 2017). Research into incivility and dismissive behaviours by Bradley, Liddle et al. (2015) also found having a high workload and/or working in unsupportive environments were frequently characterised by higher levels of rudeness among doctors.

"I don't feel valued as a conscientious SMO, because the pressure to work harder with very little extra resource is crippling."

Organisational culture is also deemed a key factor in shaping the conditions for workplace bullying (Salin 2003). In workplaces where negative behaviours have become normalised as a 'way to get things done', bullying can become entrenched or viewed as tacitly acceptable. Katrinli, Atabay et al. (2010) note that competitive and tough organisational cultures as well as competitive rather than cooperative organisation cultures are commonly associated with bullying. They note that some individuals may deliberately engage in bullying behaviour as a form of competitive strategy in order to 'get ahead' in the workplace and suggest that this can be exacerbated at times of change and restructuring. Further, if there is poor modelling of ethical behaviours or no intervention in the form of alternative strategies by those in positions of leadership or responsibility, those engaged in bullying behaviours may feel that they can 'get away' with the negative behaviour, in lieu of reprimand or consequence (Hoel and Salin 2003).

The high rates of bullying experienced in medicine have frequently been ascribed to the hierarchical culture of medical training, with bullying described for junior doctors and trainees as a necessary but unpleasant 'rite of passage' (Jamieson, Mitchell et al. 2015, Fink-Samnick 2016). Research by Crowe, Clarke et al. (2017), for example, details the range of negative behaviours medical students will endure from their supervisors, including belittlement, intimidation and humiliation in order to show 'worthiness' or competence in their training programme. They suggest these experiences engrain and re-inscribe key power relations that manifest into 'prescribed ways of being for doctors' which can perpetuate after training. As noted by Ferguson (2015), this can readily lead to the 'normalisation' of poor behaviour "to the extent that it is no longer recognised as wrong" (p8).

It is commonly accepted that organisations with hierarchical management styles are more at risk of workplace bullying due to the normalisation of power imbalances (Salin 2003) and the ensuing 'power distance' between bullies and their victims (Einarsen and Skogstad 1996). While workplaces with 'top-down' and highly bureaucratic management styles have structural characteristics likely to foster workplace bullying (Ferris, Zinko et al. 2007), Einarsen, Hoel et al. (2009) also note that power imbalances may be informal, relating to differences based on demographic characteristics such as gender and ethnicity. Other workplace characteristics likely to be associated with greater prevalence of workplace bullying include restructuring and change, poor work autonomy and limited job control (Katrinli, Atabay et al. 2010).

In New Zealand, participants in research by Bentley, Catley et al. (2009) described the organisational model of DHBs as 'autocratic', with the top-down management styles active in shaping conditions for bullying. Similarly, research by Salin (2003) found correlations between working in highly competitive and politicised environments and the prevalence of bullying. In such conditions, it is possible that bullying as a form of 'command and control' is likely to flourish, particularly if those in leadership positions choose to 'bully' in order to push through initiatives or shape broader organisational objectives. While such bullying behaviours may be overtly negative, bullying from those in positions of power articulated by Ferris, Zinko et al. (2007) can be implicit and subtle, with the overarching goal to:

> *"[influence] the target individual(s) to act in some preconceived direction or manner… subordinate the focal individual(s) to a position of weakness or helplessness… [reinforce] and [strengthen] the leader's own power, and [increase] the probability of goal accomplishment."* (p198)

Unsurprisingly, it is well documented that working in a workplace with a bullying culture can lead to a reluctance to speak out or challenge problematic behaviours, not in the least because the perpetrators of bullying behaviour may be those in positions of responsibility but also because of the culture of fear that may ensue. As detailed in research commissioned from Converge International by RACS in 2015, fear was identified as "the major

"Bullying wrecks a whole week. It leads to self doubt and second guessing. It takes a long time to recover from. It is poorly recognised. It is difficult as an SMO to call out on bullying as it is a sign of weakness. Therefore, many of us put up with it especially in a system where we are overworked with unrealistic schedules and no hope of making an improvement."

component in acceptance of a cycle of negative and degrading behaviours and the perpetuation of a negative workplace culture" (RACS 2015 p7, emphasis in original). Accordingly, many fear reporting bullying for fear of reprimand or reproach from seniors or because of concerns that it may make the situation worse (Timm 2014). In the RACS report, for example, it was found that few sought to formally report bullying or harassment for fear that it would compromise their future career opportunities (Knowles, Szoke et al. 2015).

Fear of speaking out can also lead to dysfunctional team dynamics which ultimately may pose significant risks for patient safety (Paice and Smith 2009, Ferguson 2015). Wild, Ferguson et al. (2015) note, for example, that a culture of bullying was identified as a major contributory factor in the series of events that led to the Mid Staffordshire enquiry, and Rosenstein and O'Daniel (2006) found that 'disruptive behaviours' were strongly associated with an increased likelihood of medical error and poor quality of patient care.

Bullying prevalence in the New Zealand context

Research into the rates of workplace bullying in New Zealand suggest that bullying prevalence in health care settings is high by international standards (Bentley, Catley et al. 2009). Bentley, Catley et al. (2009) established bullying prevalence in the wider health sector of 18.4%, second only to 22.4% in education. Other research into the prevalence of bullying in fellows of the College of Intensive Care Medicine revealed bullying prevalence of 32% in members, with the main perpetrators being consultants and, specifically, ICU consultants (Venkatesh, Corke et al. 2016). A 2008 study into workplace bullying of junior doctors at Auckland City Hospital found 50% had experienced at least one episode of bullying behaviour (Scott, Blanshard et al. 2008). The recent findings from the Australasian College for Emergency Medicine (ACEM) revealed bullying prevalence of 34.5% in all respondents, including fellows of the college and trainee specialists (ACEM 2017). Methodological differences, including varying time frames (retrospective assessment over 3-month, 6-month and 12-month periods) and different self-labelling approaches, make direct comparisons difficult but, overall, suggest that there is a widespread problem with bullying in the New Zealand (and Australasian) medical context.

Measuring bullying prevalence

A review of the literature suggests two main approaches to establishing the prevalence of bullying. The first approach is to assess the rate of respondents' perceived exposure to a definition of bullying in what is defined as the self-labelling or 'subjective approach'. At the core of this approach is the understanding that the victim's perception is central in defining bullying prevalence. Problems with this approach include a lack of awareness on behalf of the respondent as to what behaviours may constitute bullying, as well as the possibility that many respondents are reluctant to recognise or concede that they may have been bullied (Mikkelsen and Einarsen 2001). It is common for this approach to result in a significantly lower estimation of the prevalence of bullying because of the issues noted above (Bentley, Catley et al. 2009).

The other technique is to assess respondents' self-reported exposure to an inventory of behaviours that are not explicitly labelled as bullying. This is generally defined as the 'operational method' (Matthiesen and Einarsen 2010). This approach

is considered a more 'objective' method of establishing bullying prevalence because it doesn't explicitly label behaviours as bullying per-se and therefore doesn't rely on the respondent's own interpretation as to what constitutes bullying. Further, this approach enables an understanding of the types of behaviours experienced that collectively constitute bullying (Einarsen 2000, Einarsen, Hoel et al. 2009). It is not unusual for this approach to result in a less conservative estimate of bullying prevalence than the self-labelling method.

Many studies now use a combination of both techniques to ascertain the prevalence of workplace bullying to enable an understanding of the types of behaviours most commonly experienced by individuals as well as how many individuals perceive themselves to be victims of bullying. One of the most commonly used approaches is the Negative Act Questionnaire (revised) (NAQ-r) developed by Einarsen, Hoel et al. (2009). The NAQ-r is accepted as a robust tool to quantify bullying in international contexts as it combines both an operational approach to establishing bullying prevalence as well as incorporating a single item measure of perceived victimisation (self-labelling approach) (Einarsen, Hoel et al. 2009).

"You pull back and do the bare minimum to keep a service running. Bringing the behaviour to the attention of managers further up the pecking order has made no difference. Patient health is at risk."

Methods

Participants

Participants were all members of the ASMS (medical and dental specialists, and other non-specialist registered medical officers), employed by New Zealand's 20 DHBs and other employers around the country such as the Accident Compensation Corporation (ACC), hospices, rural hospitals, New Zealand Blood Service and community health providers. For ease of description, these ASMS members are referred to as senior doctors or as the senior medical workforce. At the time of the survey, the ASMS represented over 90% of all senior doctors and dentists and other non-vocationally registered medical specialists employed within New Zealand's DHBs, and around 77% of non-DHB employers where ASMS has members.

The entire ASMS membership (4307 individuals) was invited by email to participate voluntarily in an anonymous electronic survey in June 2017.[2] The survey was open for one month, and four reminders were sent out to encourage participation. Demographic information including age, gender, main place of work, ethnicity, and country of primary medical qualification was requested, summarised and described. A copy of the survey is included as Appendix 1.

Measures

Prevalence of workplace bullying was measured with the Negative Acts Questionnaire (revised) (NAQ-r), developed by Einarsen, Hoel et al. (2009). The first part of the NAQ-r asks respondents to score how often they have experienced 22 types of behaviours over the past 6 months (never=1, now and then=2, monthly=3, weekly=4, daily=5). Overall scores were computed for each individual with a possible range of 22 (never experienced any behaviours) to 110 (experiencing all behaviours on a daily basis). The NAQ-r comprises three interrelated subscales of bullying – work-related, person-related, and physically intimidating bullying – which enables an analysis of the prevalence of the different types of negative behaviours.

Following administration of the questions on types of negative behaviour, a definition of workplace bullying was provided: bullying at work refers to situations where one or more persons feel subjected to negative and/or aggressive behaviour from others in the workplace over a period of time and in a situation where they for different reasons are unable to defend themselves against these actions (adapted from Einarsen and Skogstad 1996). On the basis of this definition, respondents were asked whether they had witnessed bullying of other staff or colleagues and whether they had been subjected to bullying over the past 6 months. Responses were on a 5-point Likert scale (never; yes, very rarely; yes, now and then; yes, several times per week; and yes, almost daily).

Bullying prevalence from the NAQ-r was established according to Leymann's criteria as experiencing at least one negative act on a daily or weekly basis over a 6-month period (Leymann 1990). For both witnessed and self-reported responses, bullying was identified if any of the affirmative responses (ie, very rarely, now and then, several times a week, and almost daily) were endorsed.

Respondents who reported either witnessing or self-reporting bullying were asked to select the main categories of perpetrators of the bullying, and those who self-reported were asked whether they

2 The NAQ-r was piloted for sense and utility in mid-2016 at a single DHB with 368 valid responses. The survey was then modified to include measures of workload and levels of support within the DHB as well as additional questions pertaining to the perpetrator of self-reported and witnessed behaviour and questions concerning reporting behaviour.

had reported the behaviours, what the outcomes of reporting were, and if they had not reported them, the main reasons why.

Levels of workplace demands (including factors such as workload and the work environment) and support from colleagues and non-clinical managers were measured using 17 items from the Health and Safety Executive (HSE) Management Standards Analysis Tool (HSE 2017) asking about experiences at work over the past six months. Peer and non-clinical managerial support was measured on a 5-point likert scale where never=1 to always=5, and workplace demands reversed never=5 to always=1. Total scores for each of these three subscales were calculated and the scores for workplace demands reversed, so that higher scores reflected fewer demands.

A chi-square goodness of fit test was used to compare the mixture of gender and DHB groups in the respondent group with the known distributions for the full ASMS. Differences in the means scores for the individual questions in the NAQ-r and the HSE management scales between demographic, specialty and country of training (NZ vs IMG) groups were tested using one-way analysis of variance (ANOVA). The differences in the percentages of respondents experiencing the different types of bullying were compared among the groups using chi-square tests. Spearman's correlation coefficients were used to test the associations between HSE scales and the NAQ-r scales and the frequency of witnessed bullying and respondents' self-reporting of being bullied. ANOVA was used to test construct validity between those scoring as a victim of bullying using self-report data and those with higher total sum scores on the NAQ-r. A two-tailed p-value <0.05 was used to define statistical significance.

Qualitative data was taken from comments from respondents who self-identified as bullied. These respondents were asked to describe the impact of bullying on their personal and professional lives. Data from the comments section were imported into NVivo pro (V.11), read through in detail and open coded. This initial coding resulted in 23 recurring themes, which were grouped into three umbrella categories in relation to the severity of the consequences of the bullying behaviour – significantly; moderately; and little effects/managing – consistent with a study by Shabazz, Parry-Smith et al. (2016). This process followed the broad tenets of grounded theory where qualitative data is organised into emergent themes through iterative coding with the resultant themes understood to reflect the perspectives of the research participants (Charmaz 2008). Comments selected for inclusion were those that best expressed the various themes. Comments were transcribed directly, and where sections were omitted, ellipses ('…') were used to signify the break. Any words replaced or altered to preserve anonymity or correct for tense or sense are noted within square brackets ('[ ]').

Limitations of the approach

It is possible that the topic of the survey may have motivated those who have experienced bullying to respond, thus resulting in responder bias. Nevertheless, the primary author received a number of emails from individuals who self-identified as bullied who chose not to participate in the study for a variety of reasons, including fear of identification. Therefore, it is possible that research in this area may contradict the common conception that responder bias favours those affected by the issue at hand. Regardless, the moderate response rate cannot be presumed to be representative of the views or experiences of the senior medical workforce in New Zealand as a whole. The cross-sectional design of the survey also means that causal relationships cannot be inferred, and any discussion of the associations between demographic and other factors is not meant to imply causality or direction.

Results

Responses were received from 40.8% (n=1759) of the ASMS membership.[3] Of these, 56.8% (n=862) were male and 43.2% (n=655) female (Table 1). A total of 242 respondents did not disclose their gender, and occasionally other items were not completed. Most respondents were New Zealand-trained (58.1%) and identified as New Zealand European or Pākehā (59.4%). A total of 59 specialty and sub-specialties were represented in the study, and these were grouped into 26 major specialty categories for analyses. Ethnicities and country of primary medical training were also summarised and grouped, with the latter split into two groups comprising New Zealand-trained senior doctors, and international medical graduates (IMGs). Places of work were also grouped to protect respondents' anonymity, as well as to provide enough statistical power for the analysis. The various specialty and place of work groupings are detailed in Appendix 2. Comments left in open text boxes expressed fear of identification, and this was also raised in four emails. Analysis was undertaken on the most complete data available for each summary or comparison, and the actual numbers available are specified throughout. A full demographic summary of respondents is provided in Table 1.

The chi-square goodness of fit tests indicated a slight over-representation of females in the sample (43% compared with 38% in the ASMS) and the over-representation of a single DHB in the sample (6% compared with 4% in the ASMS). Aside from these two examples, the respondents were generally representative of the full ASMS membership.

TABLE 1: DEMOGRAPHIC COMPOSITION OF SURVEY RESPONDENTS

GENDER	n	%
Females	862	56.8
Males	655	43.2
Not disclosed	242	
AGE BRACKET	**n**	**%**
30–39	182	11.6
40–49	577	36.8
50–59	545	34.8
60–69	235	15.0
70 and over	29	1.8
Not disclosed	191	

3 A total of 27 'out of office' email responses were received and 6 wrote in to report they were unable to access the survey due to proxy server issues. A further 4 wrote in to note that they did not wish to participate in the survey due to the risk of being identified but agreed for their emails to be used in the qualitative analysis where appropriate.

TABLE 1: DEMOGRAPHIC COMPOSITION OF SURVEY RESPONDENTS (CONTINUED)

ETHNICITY CATEGORIES	n	%
NZ European/Pākehā	919	59.4
Māori/Pasifika (Samoan, Cook Island Māori, Tongan, Fijian)	31	2.0
Asian/Indian (Southeast Asian, Chinese, Indian, Other Asian)	165	10.7
European/Other European	315	20.4
Other (Middle Eastern, Latin American/Hispanic, African, 'Other')	117	7.6
Not disclosed	212	
COUNTRY OF PRIMARY MEDICAL QUALIFICATION	**n**	**%**
New Zealand	888	58.1
International medical graduate	638	41.9
Not disclosed	230	
MEDICAL SPECIALTY	**n**	**%**
Anaesthesia	199	14.3
Cardiology	30	2.1
Dentistry	31	2.2
Emergency medicine	94	6.7
General medicine	73	5.2
General practice	35	2.5
General surgery	48	3.4
Geriatric medicine	38	2.7
Intensive care medicine	31	2.2
Nephrology	18	1.3
Obstetrics/Gynaecology	56	4.0
Occupational and public health medicine	18	1.3
Oncology	28	2.0
Ophthalmology	27	1.9
Orthopaedic surgery	48	3.4
Other	30	2.1
Otolaryngology	21	1.5
Paediatrics	113	8.1
Palliative medicine	24	1.7
Pathology	29	2.1
Psychiatry	178	12.8
Radiology	75	5.4
Respiratory medicine	19	1.4
Rural hospital medicine	18	1.3
Specialist internal medicine other	71	5.1
Specialist surgery other	44	3.2
Not disclosed	363	

Prevalence of negative behaviours

The overall mean NAQ-r score was 31.4, with a maximum score of 102. Based on the NAQ-r:

- 93% (n=1575) of respondents had experienced at least one negative behaviour at least once over the last 6 months
- 38.1% (n=645) had experienced at least one negative behaviour on a daily or weekly basis (Figure 1)
- 24.9% had experienced two negative behaviours on a weekly or daily basis
- 6.7% (n=114) had experienced at least 5 negative behaviours on a daily or weekly basis.

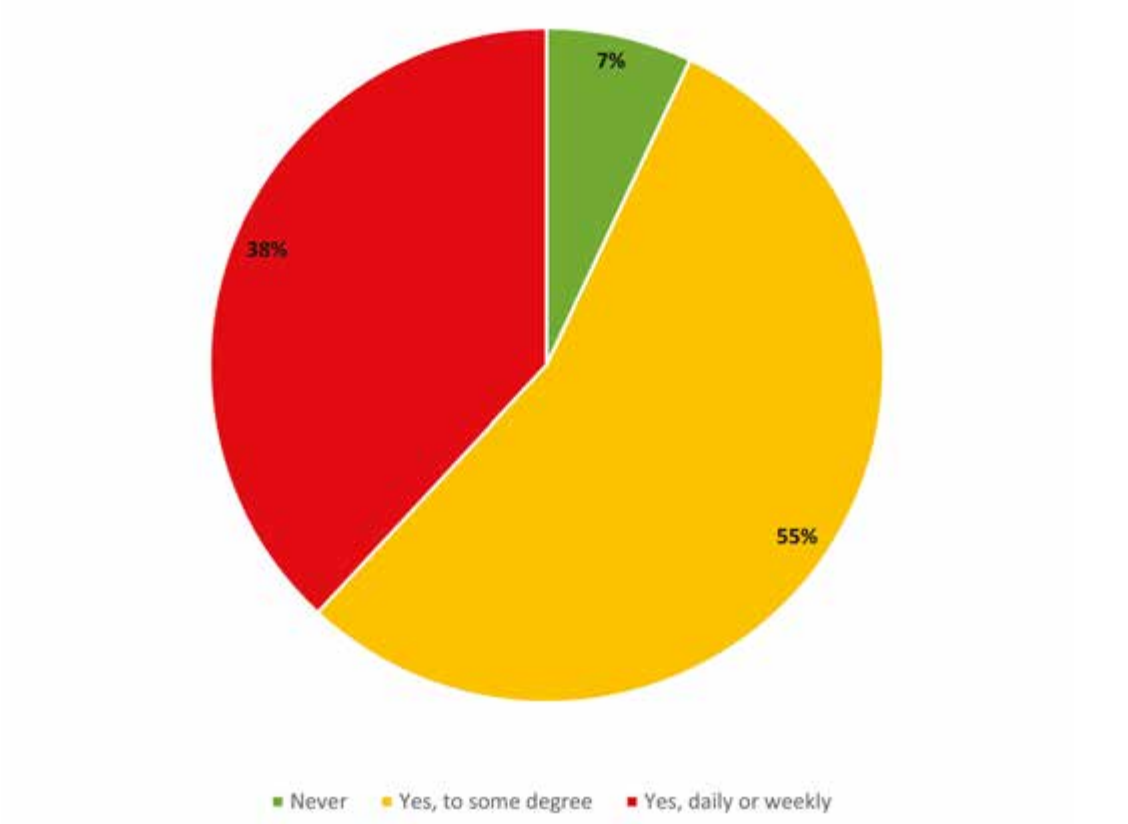


FIGURE 1: PREVALENCE OF EXPERIENCING AT LEAST ONE NEGATIVE BEHAVIOUR FROM THE NAQ-R

Analysis of the NAQ-r subscales revealed negative work-related behaviours (49.9%) were more prevalent and occurred on a more regular basis than negative person-related (25.3%) or physically intimidating behaviours (16.7%). The most prevalent work-related behaviours experienced on a daily or weekly basis were 'being exposed to an unmanageable workload' (21.2%) and 'being ordered to do work below your level of competence' (14.4%). Fifty-eight percent of respondents had opinions and views ignored 'to some degree'. Summary prevalence of work-related bullying behaviours are illustrated in Figure 2.

Being ignored or excluded and having key areas of responsibility removed or replaced with more trivial or unpleasant tasks were the most frequently experienced negative person-related behaviours on a weekly or daily basis (9% and 7.3% respectively). Forty-three percent reported being ignored or excluded 'to some degree', and 31% reported humiliation or ridicule in connection with their work 'to some degree'. Summary prevalence of person-related bullying prevalence is illustrated in Figure 3.

While low in prevalence, 24 respondents (1.4%) had experienced being shouted at or spontaneous

anger on a weekly or daily basis, and 11 (0.7%) had experienced threats of violence or actual abuse at the same frequency. Fifteen percent experienced intimidating behaviour such as shoving and invasion of personal space 'to some degree'.

Summary prevalence for physically intimidating bullying behaviours are presented in Figure 4. Detailed scores for all 22 NAQ-r behaviours are presented in ranked order in Figure 5.

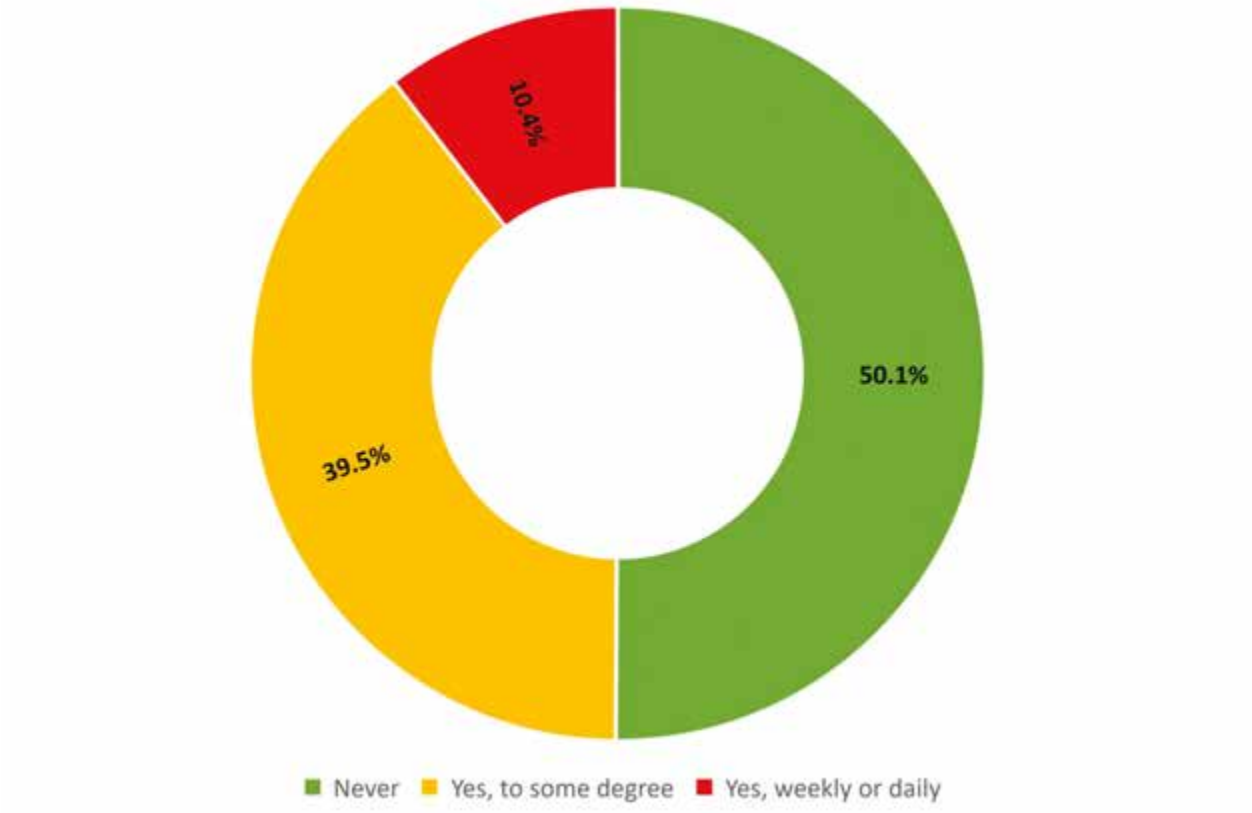


FIGURE 2: SUMMARY PREVALENCE OF WORK-RELATED BULLYING BEHAVIOURS

"I sometimes dread going to work, I am wondering what is going on behind my back, I wonder why certain changes are made in my schedule, I wish I was included in knowing what is happening in our dept, there are various 'cliques' and the behaviour between these is elitist (for no particular reason as we are a rural hospital). I receive no acknowledgement, praise or support for any work I do, but judgement, silence and exclusion can be a feature of my work life. I would love to be a valued contributing member of our team, but this is precluded by the 'cliques'. I do a lot of reflection to examine myself to see what part I contribute and pray every day that what I do and say will be acceptable."

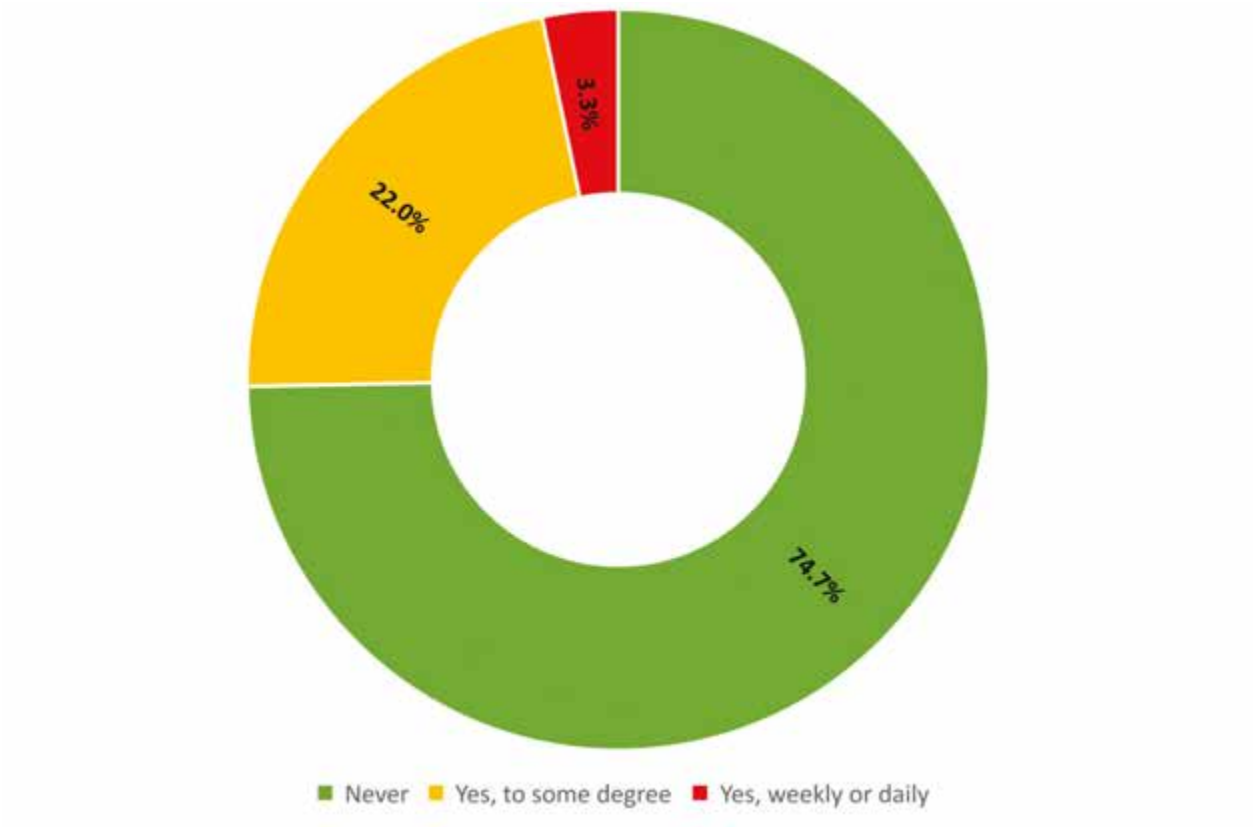


FIGURE 3: SUMMARY PREVALENCE OF PERSON-RELATED BULLYING BEHAVIOURS

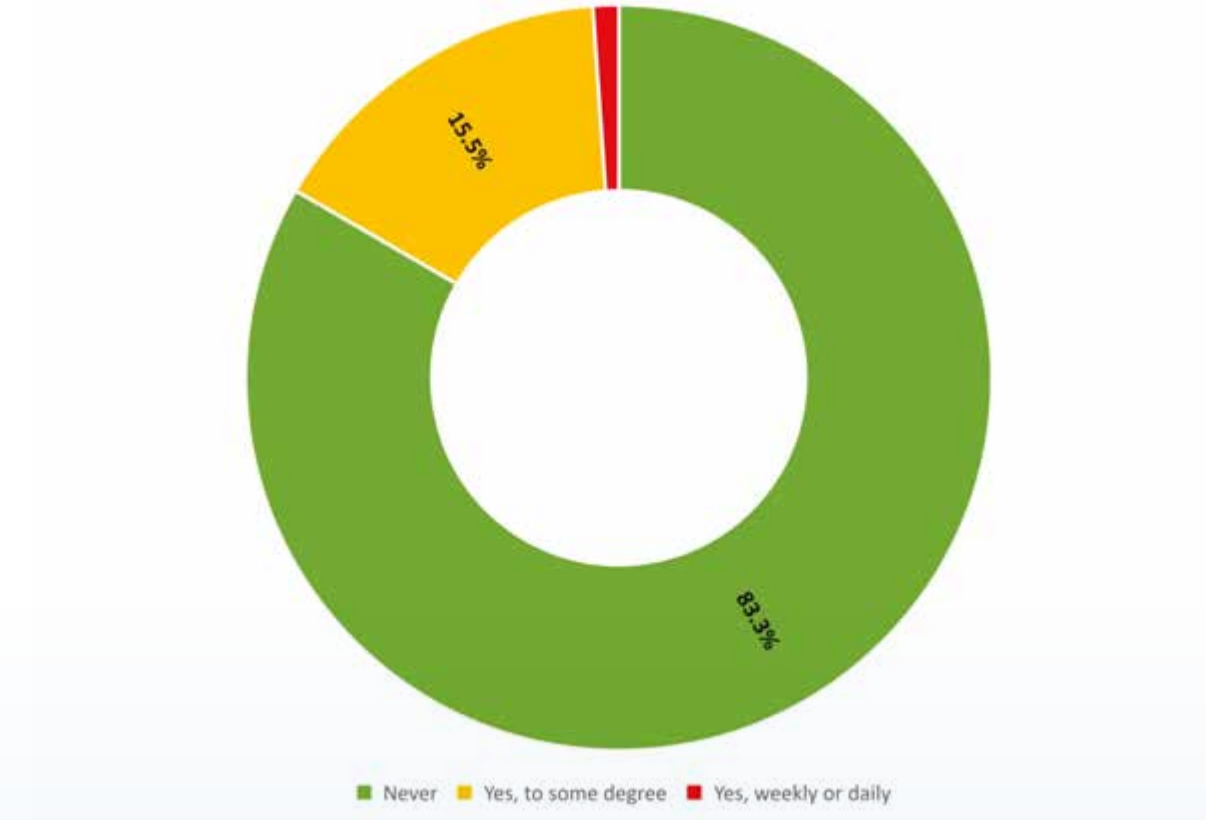


FIGURE 4: SUMMARY PREVALENCE OF PHYSICALLY INTIMIDATING BULLYING BEHAVIOURS

"Last year was the worst year of my life - and I'm a fourth-year consultant."

NAQ-r and demographic variables

There was no significant difference in the overall mean NAQ-r score by gender (female mean=32.7, male mean=32.3) although women (mean 3.72) had a significantly higher mean NAQ-r sub-scale score for physically intimidating behaviour than men (mean 3.55, p=0.011). A higher proportion of female respondents experienced at least one or more negative behaviours than their male counterparts (94.8% vs 91%, p=0.004). Specific questions in the NAQ-r for which women had a higher mean score are noted with # in Figure 5.

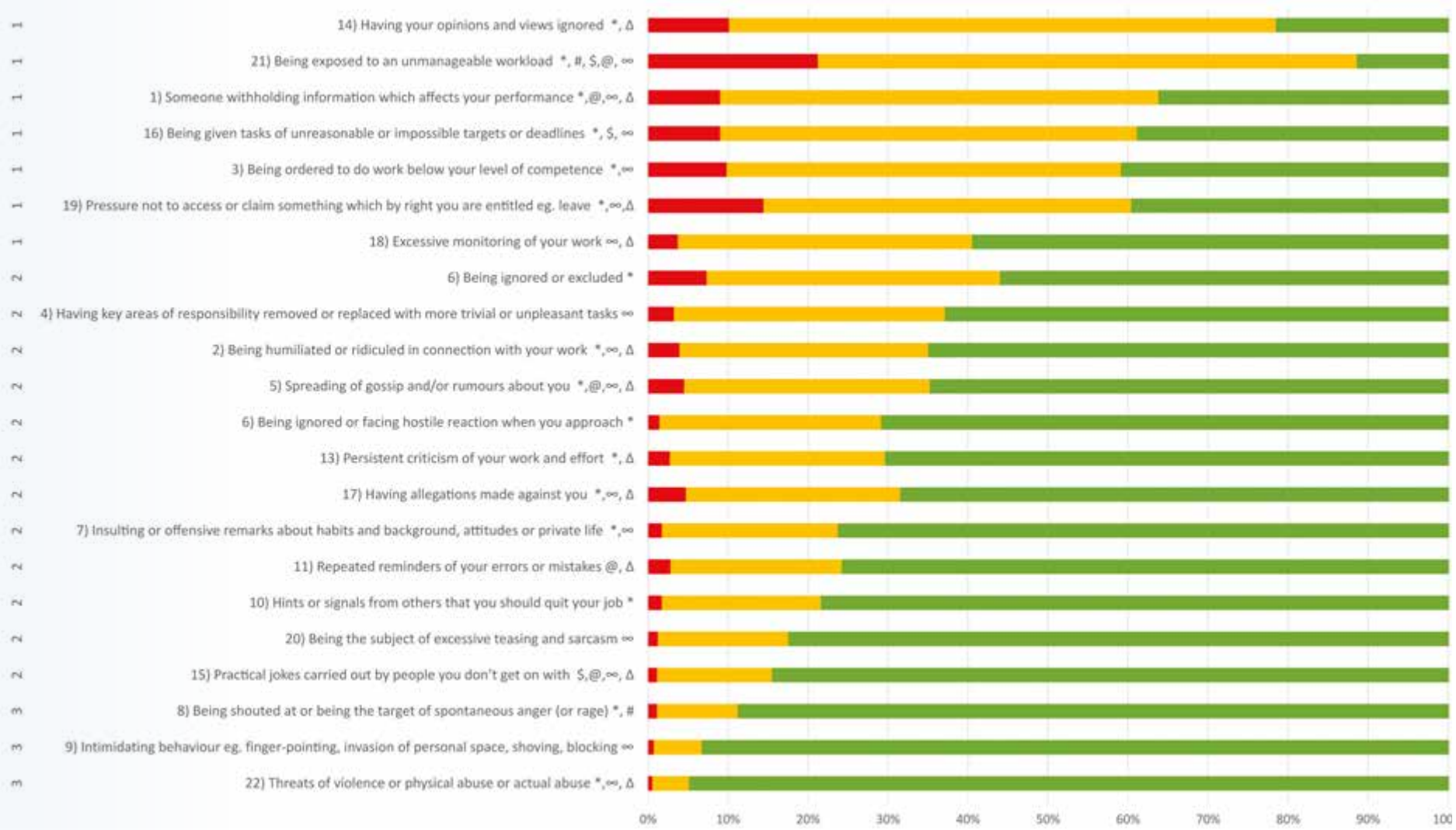
There were significant differences in mean scores by age group (p<0.001). Respondents aged 40–49 and 50–59 had higher than average NAQ-r scores, and further analysis of frequency scores found respondents aged 40–49 and 50–59 also experienced significantly higher prevalence of bullying behaviours than other age groups. Respondents in their sixties and seventies were more likely to report receiving hints or signals that they should quit their job (mean score 1.26 and 1.31 respectively, p=0.01). Specific questions in the NAQ-r for which there was significant variance by age group are noted with * in Figure 5.

There was a significant effect of ethnicity in experiencing one or more negative behaviours (p=0.037), with Asian ethnicities reporting the lowest prevalence (89.1%) overall. There were no significant effects of ethnicity on overall or sub-scale mean scores, but some ethnicities experienced higher levels of some behaviours (noted by $ in Figure 5). IMGs reported significantly higher mean scores for person-related bullying than New Zealand-trained specialists (mean score 16.7 vs 15.9, p=0.012) and reported higher levels of experiencing five behaviours such as the spreading of gossip or rumours, being ignored or excluded and practical jokes (noted with @ in Figure 5) than New Zealand-trained specialists.

There were significant differences among the medical specialties in the NAQ-r overall mean (p=0.032) and subscale scores as well as prevalence of behaviours (p=0.006). Specialists in emergency medicine and general surgery reported the two highest mean overall NAQ-r scores (35.8 and 35.7 respectively). Respondents from emergency medicine had the highest mean sub-scale scores for work-related and physically intimidating bullying behaviour (14.4 and 4.2 respectively) as well as the highest prevalence of bullying behaviours experienced on a weekly or daily basis (55.7%). Behaviours with significant effects of medical specialty are noted with ∞ in Figure 5, and categorised NAQ-r scores by medical specialty are summarised in Figure 6.

There were significant differences in overall mean NAQ-r score (p=0.027) and work-related and person-related sub-scale means by place of work (p=0.065 and 0.012 respectively). Respondents from Tairawhiti and Whanganui DHBs reported the highest mean overall NAQ r scores (36.2 and 35.4 respectively) as well as the two highest person-related bullying scores (18.9 and 18 respectively). Wairarapa DHB reported the highest work-related bullying score (13.8). Specific behaviours with significant variance by place of work are noted with Δ in Figure 5, and mean NAQ-r scores by place of work are presented in Figure 7.

"Only really happened when I was appointed as an SMO. The fact that an SMO post was given to a non-NZ trained doctor caused a great deal of consternation with other SMOs. Whilst nothing was said to me directly enough people were kind enough to let me know what was being said at surgeons' meetings."



Sub-scale questions: 1 = work-related bullying; 2 = person-related bullying; 3 = physically intimidating bullying
*** behaviours with significant variance by age group**
 # behaviours with a significantly higher prevalence for female respondents compared to male respondents
$ behaviours with significant variance by ethnicity
@behaviours with significantly higher prevalence for IMG respondents compared to NZ-trained respondents
∞ behaviours with significant variance by medical specialty
Δ behaviours with significant variance by place of work

FIGURE 5: FREQUENCY AND PERCENTAGE OF RESPONDENTS EXPERIENCING NEGATIVE BEHAVIOURS OVER THE PAST 6 MONTHS (NAQ-R)

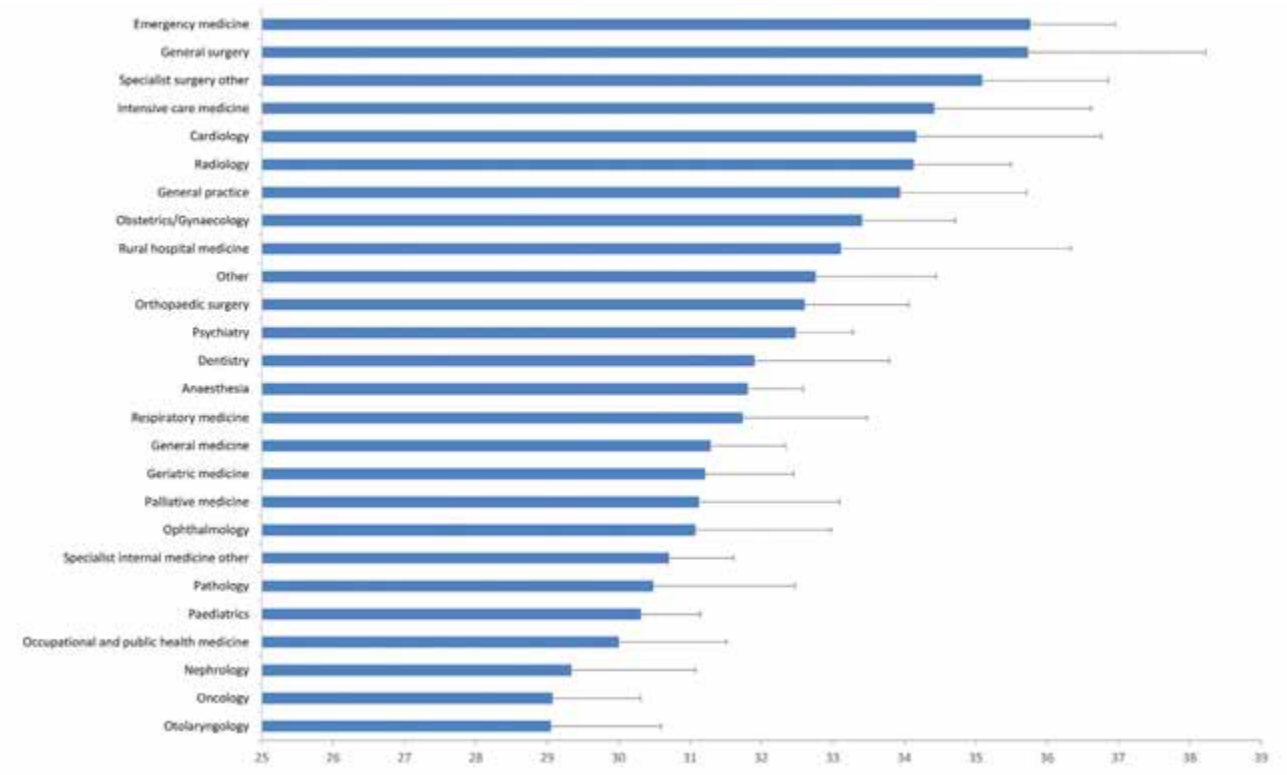


FIGURE 6: MEAN NAQ-R SCORE BY SPECIALTY (p=0.032)

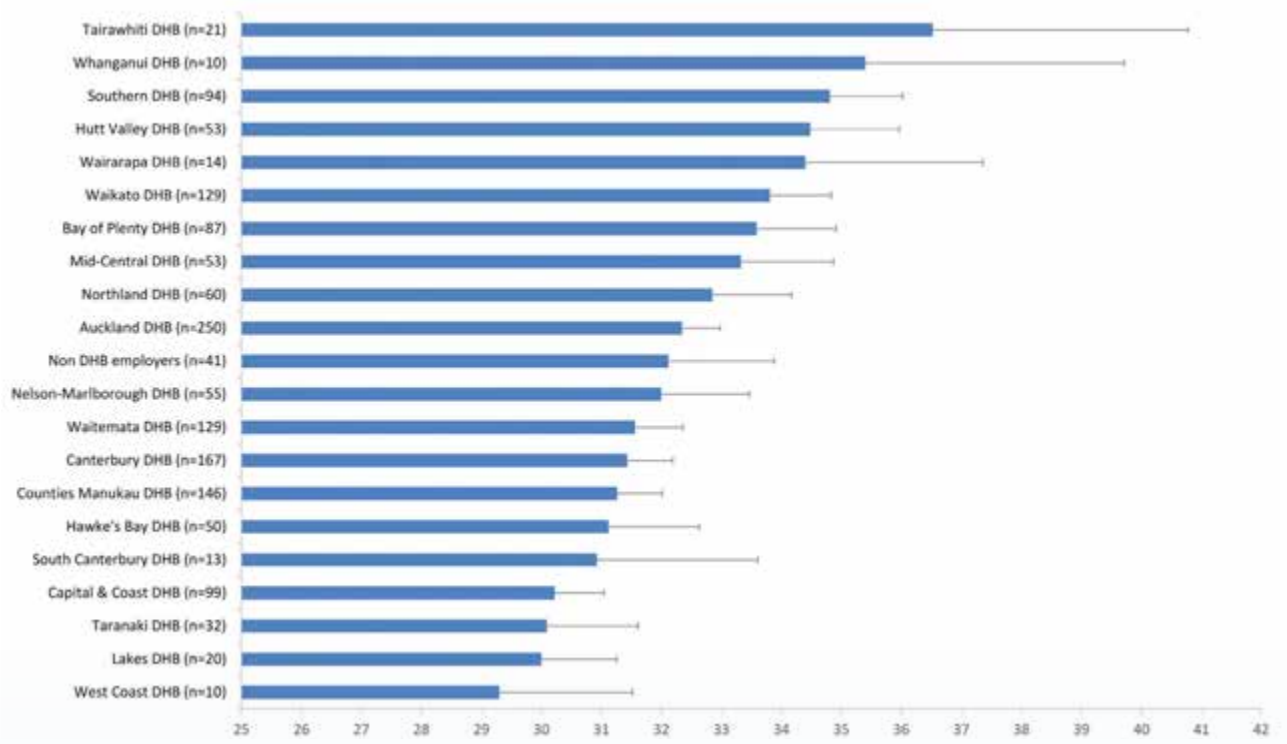


FIGURE 7: MEAN NAQ-R SCORE BY PLACE OF WORK (p=0.027)

Overall prevalence of self-reported and witnessed bullying

A total of 37.2% (n=606) of respondents reported having been bullied to some degree (ie, from very rarely to almost daily) in the past six months. Of these, 2.5% (n=40) reported that they had been bullied either several times a week or almost daily. The corresponding figures for witnessing bullying were almost twice as high, with 67.5% (n=1109) reporting that they had witnessed colleagues being bullied to some degree (ie, from very rarely to almost daily) in the past 6 months. Of these, 4.7% (n=78) reported that they had witnessed bullying either several times a week or almost daily. Women had a significantly higher rate of some degree of self-reported bullying compared with their male counterparts (39.9% vs 32.3%, p=0.002). There were also significant differences in rates of self-reporting 'to some degree' (p=0.033) and significant differences in frequency of witnessing bullying (p=0.001 'to some degree' and 'weekly or daily') by medical specialty.

There was significant variation by ethnicity for witnessing bullying 'to some degree' (p=0.036) with European/Other European having the highest prevalence (70.8%) and respondents identifying as Asian/Indian ethnicity reporting the lowest rates of witnessing (58.3%). There was no statistically significant variation in self-reporting or witnessing bullying by country of primary medical qualification, but IMGs reported a higher prevalence of bullying 'to some degree' than New Zealand-trained specialists (37.8% vs 33.7%, p=0.094). There were no other significant differences in rates of self-reported or witnessed bullying rates by other demographic variables. Prevalence data for self-reported and witnessed bullying is summarised overall and by gender in Table 2. Self-report prevalence and witnessed prevalence by medical specialty are detailed in Figure 8 and Figure 9.

TABLE 2: PREVALENCE OF SELF-REPORTED AND WITNESSED BULLYING WITH SIGNIFICANT VARIANCE BY DEMOGRAPHIC VARIABLE
Note: Totals for each block differ because of missing data

	SELF-REPORT AS BULLIED						WITNESSED BULLYING OF OTHER STAFF OR COLLEAGUES					
	No		Yes, to some degree		Yes, weekly or daily		No		Yes, to some degree		Yes, weekly or daily	
	n	%	n	%	n	%	n	%	n	%	n	%
Overall	1022	62.8	606	37.2	40	2.5	535	32.5	1109	67.5	78	4.7
Females	392	60.1	260	39.9*	17	2.6	199	30.4	455	69.6	34	5.2
Males	583	67.7	278	32.3*	21	2.4	299	34.8	561	65.2	40	4.7

***p<0.001**

Analysis of the qualitative data revealed a sense amongst respondents that bullies were often well known within their workplace settings, and yet were sometimes able to 'get away' with their behaviour with no challenge or consequence. This feeling was summarised in the following comment from a respondent:

"From my experience as [a resident medical officer (RMO)] and now [a senior medical officer (SMO)] there are multiple physicians in the Auckland Region who are well known for their bullying behaviour and yet NO ONE stops them. They continue to bully and harass both RMOs and SMOs and it seems the system/ people in it are resigned to their existence and just accept it and don't try to change it." (emphasis in original)

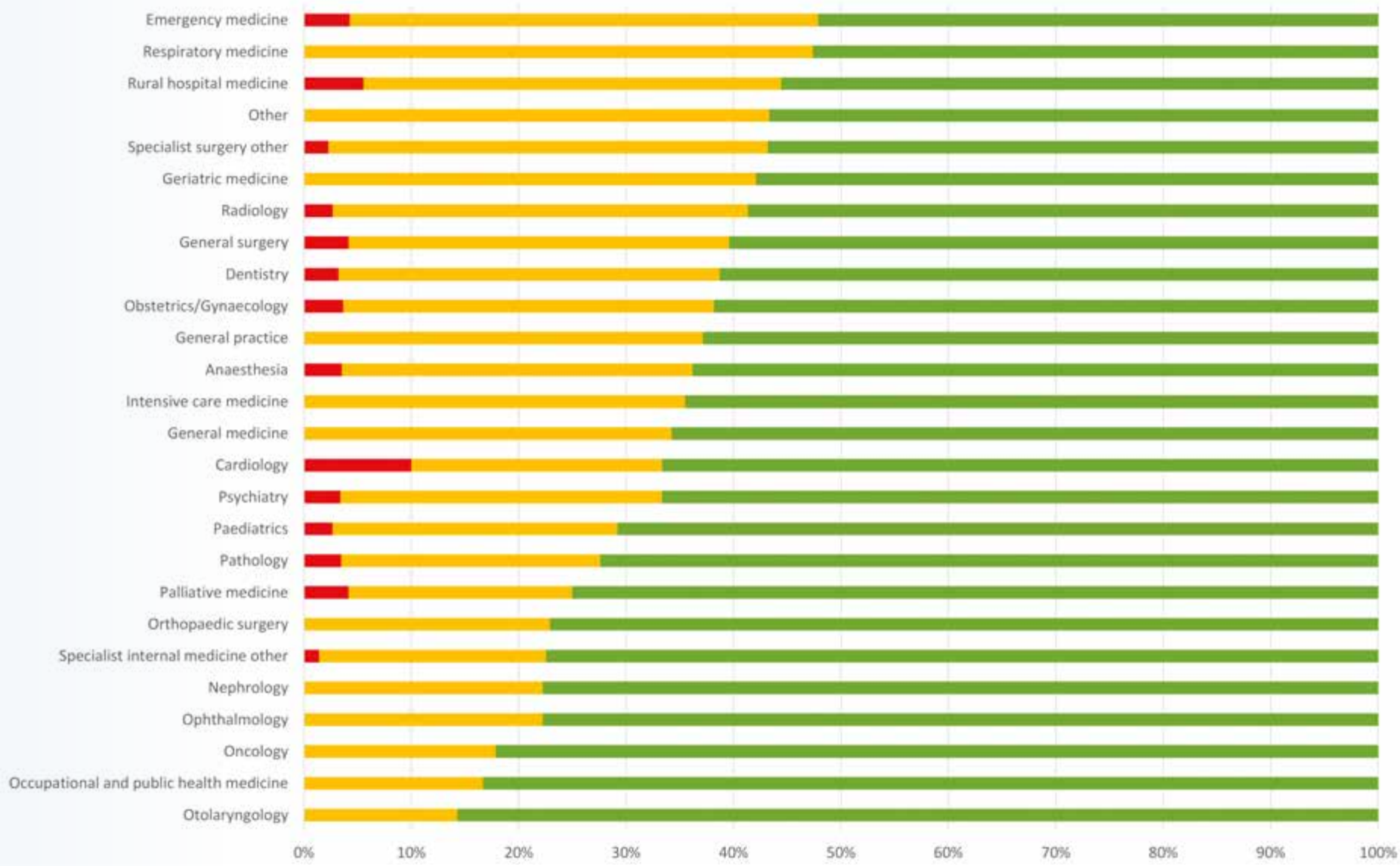


FIGURE 8: PREVALENCE OF SELF-REPORTED BULLYING BY MEDICAL SPECIALTY

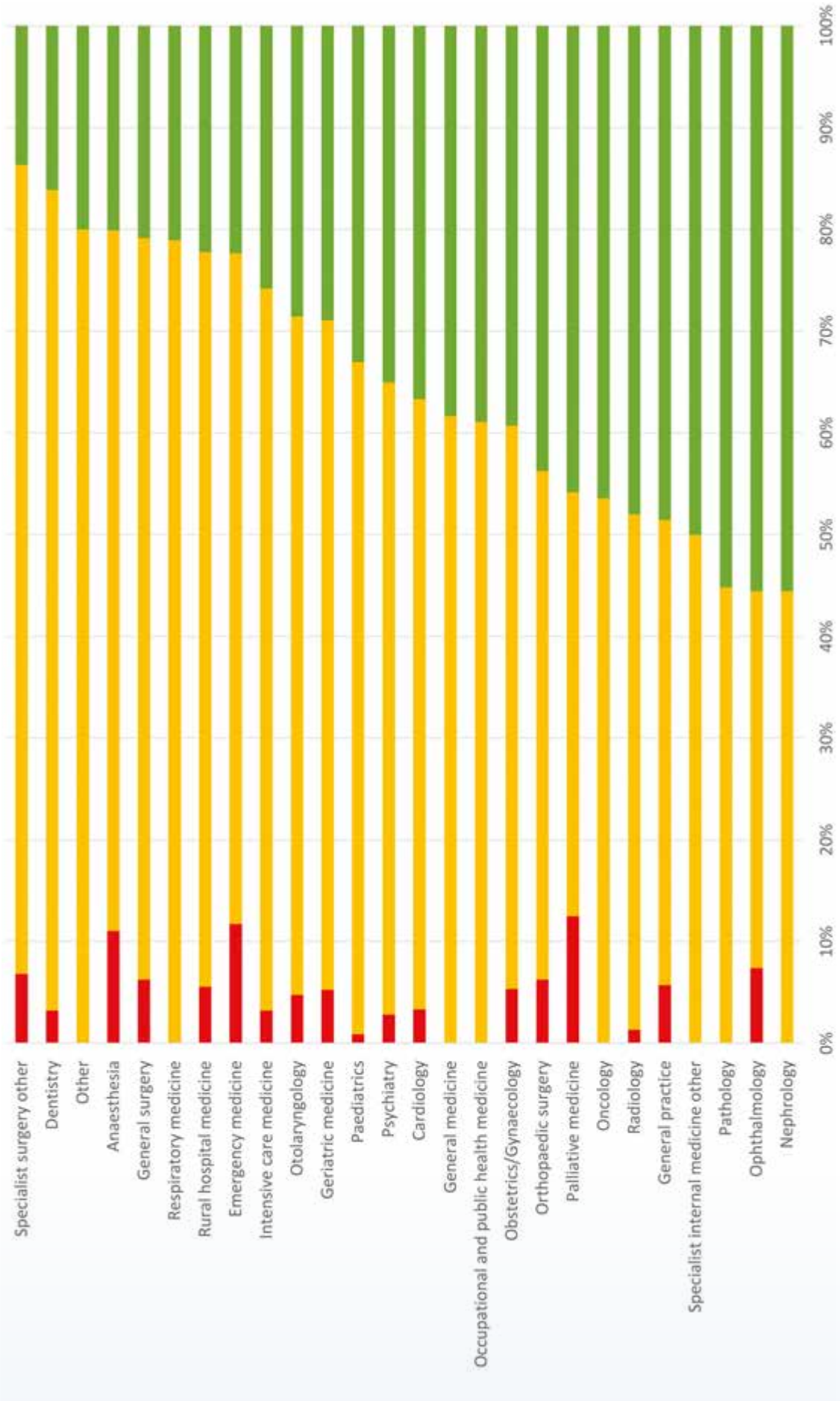


FIGURE 9: PREVALENCE OF WITNESSED BULLYING BY MEDICAL SPECIALTY

Workplace demands, peer support and non-clinical managerial support

Analysis of HSE subscales revealed good internal reliability for all three measures: workplace demands (α=0.88), non-clinical managerial support (α=0.87) and peer support (α=0.86). Analysis of the HSE scores found mean levels of non-clinical managerial support of 2.84 (1=never, 5=always), workplace demands of 3.31 and levels of peer support of 3.77. Individual scale item scores and total means for each sub-scale are summarised in Table 3. Note that a high score for the 'demands' sub-scale indicates a high level of workplace demands, and a low score for peer support and managerial support is indicative of low support.

TABLE 3: SUMMARY OF HSE SCORES

LEVEL OF WORKPLACE DEMANDS (never=1; always=5)	Mean	Std Dev	Valid n
I have to work very fast	3.52	0.865	1749
I have unrealistic time pressures	3.21	0.976	1744
Different groups at work demand things from me that are hard to combine	3.27	0.834	1749
I have unachievable deadlines	2.87	0.984	1743
I have to work very intensively	3.89	0.752	1748
I have to neglect some tasks because I have too much to do	3.30	0.965	1756
I am unable to take sufficient breaks	3.35	1.024	1752
I am pressured to work long hours	3.04	1.079	1750
Overall	**3.31**		
Total	**26.5**		
LEVEL OF NON-CLINICAL MANAGERIAL SUPPORT (never=1; always=5)	**Mean**	**Std Dev**	**Valid n**
I am supported through emotionally demanding work	2.88	1.115	1745
My non-clinical manager encourages me at work	2.76	1.284	1734
I am given supportive feedback on the work I do	2.85	1.044	1752
I can rely on my non-clinical manager to help me out with a work problem	2.85	1.160	1726
I can talk to my non-clinical manager about something that has upset or annoyed me at work	2.85	1.299	1726
Overall	**2.84**		
Total	**14.2**		
LEVEL OF COLLEGIAL SUPPORT (never=1; always=5)	**Mean**	**Std Dev**	**Valid n**
My colleagues are willing to listen to my work-related problems	4.02	0.875	1751
If work gets difficult, my colleagues will help me	3.71	0.949	1751
I get the help and support I need from colleagues	3.64	0.860	1754
I receive the respect at work I deserve from colleagues	3.71	0.917	1748
Overall	**3.77**		
Total	**15.1**		

Analysis of variance between mean total HSE scores found significant association with demographic variables, notably age and gender. All three HSE scales differed significantly ($p<0.05$) across the age groups. Respondents aged 60 and over reported the lowest levels of workplace demands (24.7) and the highest levels of non-clinical managerial support (15.2). Respondents aged 30–39 reported the highest level of peer support (15.8). Respondents aged 40–49 had the highest levels of total demands (27.4), and the lowest levels of managerial support (13.9) and peer support (14.9). Women reported higher total demands on average than men (27.1 vs 26.0, $p<0.001$), lower levels of support from non-clinical managers than their male counterparts (13.9 vs 14.6, $p=0.004$), and lower levels of peer support (15.1 vs 15.4, $p=0.05$).

Māori and Pasifika respondents reported the highest average workplace demands score (27.3, $p=0.034$). Analysis of scores by country of primary medical training suggested IMGs experienced lower average peer support (15.0 vs 15.4, $p=0.035$), but New Zealand-trained medical graduates reported higher levels of workplace demands (26.9 vs 25.4, $p=0.003$). Senior doctors from cardiology and ophthalmology reported the worst average scores for workplace demands (29.6 and 29.5 respectively – Figure 10). Intensive care medicine, respiratory medicine and radiology reported the lowest levels of non-clinical managerial support (12.5, 12.7 and 12.9 respectively – Figure 11), and respiratory medicine and cardiology reported the lowest mean peer support (14.0 and 14.1 respectively – Figure 12).

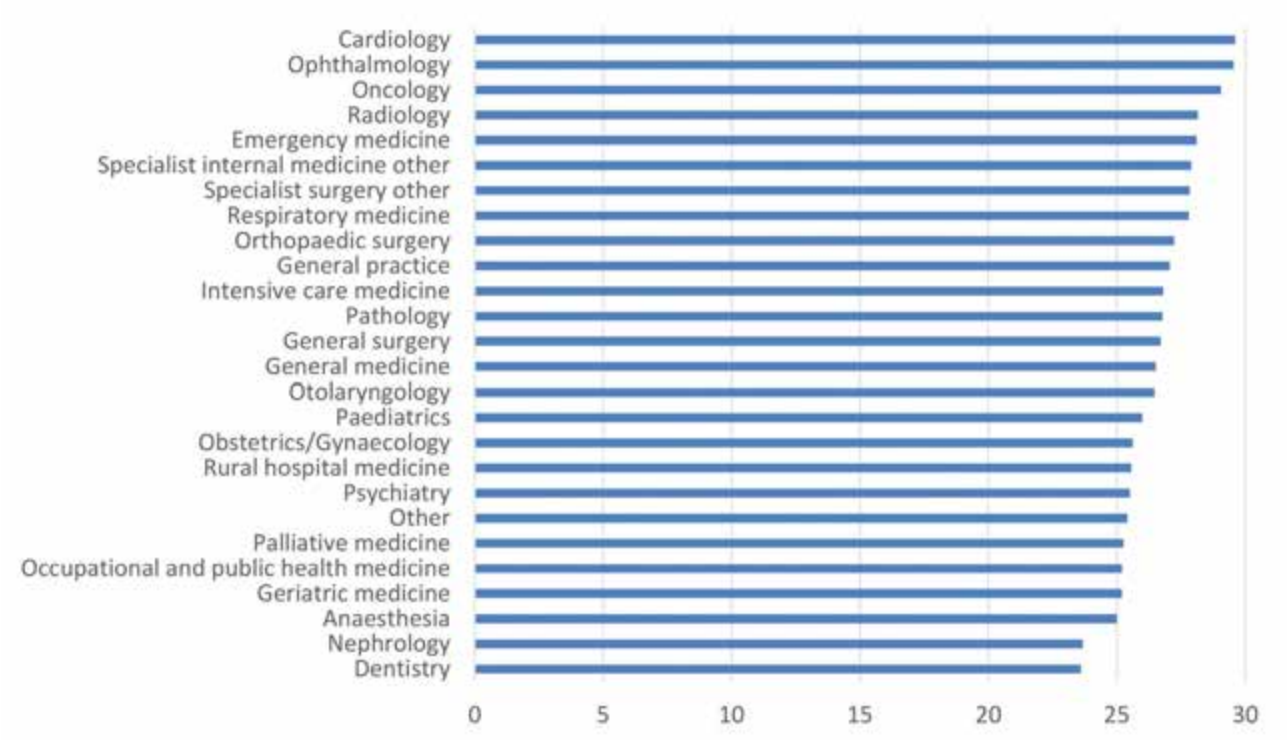


FIGURE 10: MEAN WORKPLACE DEMANDS BY MEDICAL SPECIALTY (HIGHER SCORE = HIGHER DEMANDS)

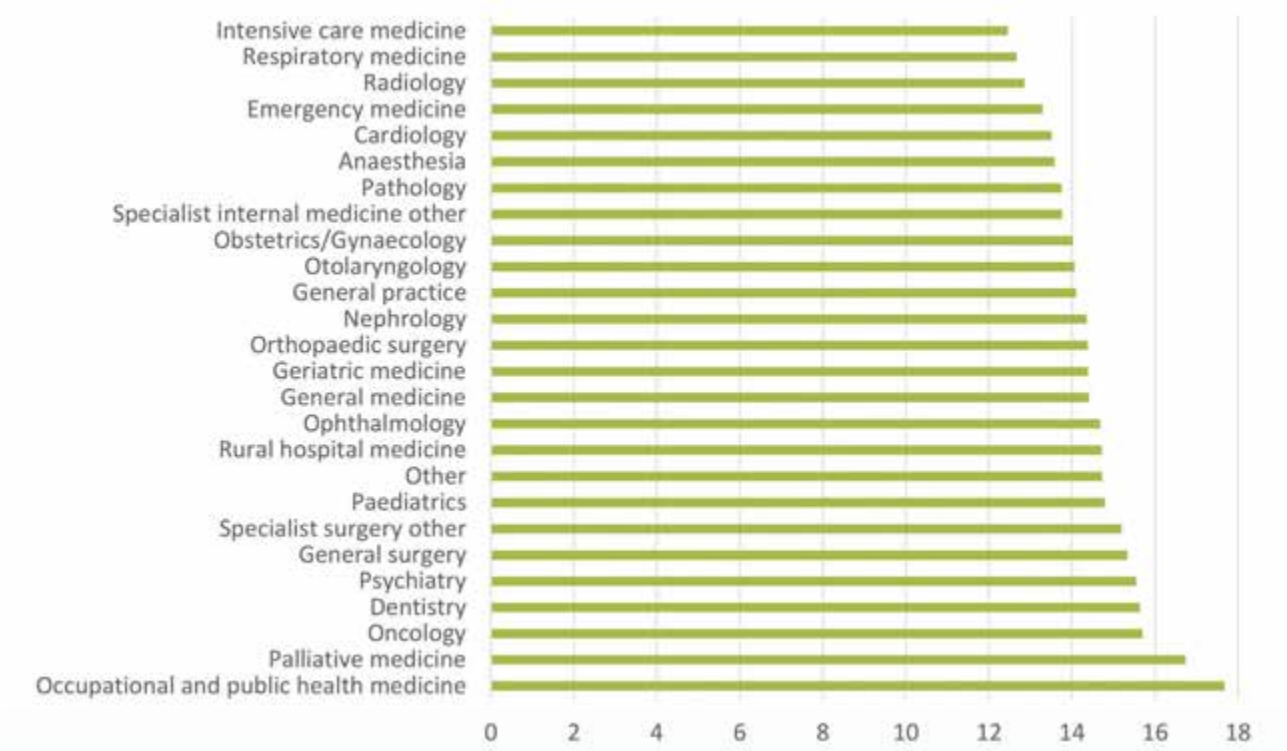


FIGURE 11: MEAN NON-CLINICAL MANAGERIAL SUPPORT SCORE BY MEDICAL SPECIALTY (LOWER SCORE = LESS SUPPORT)

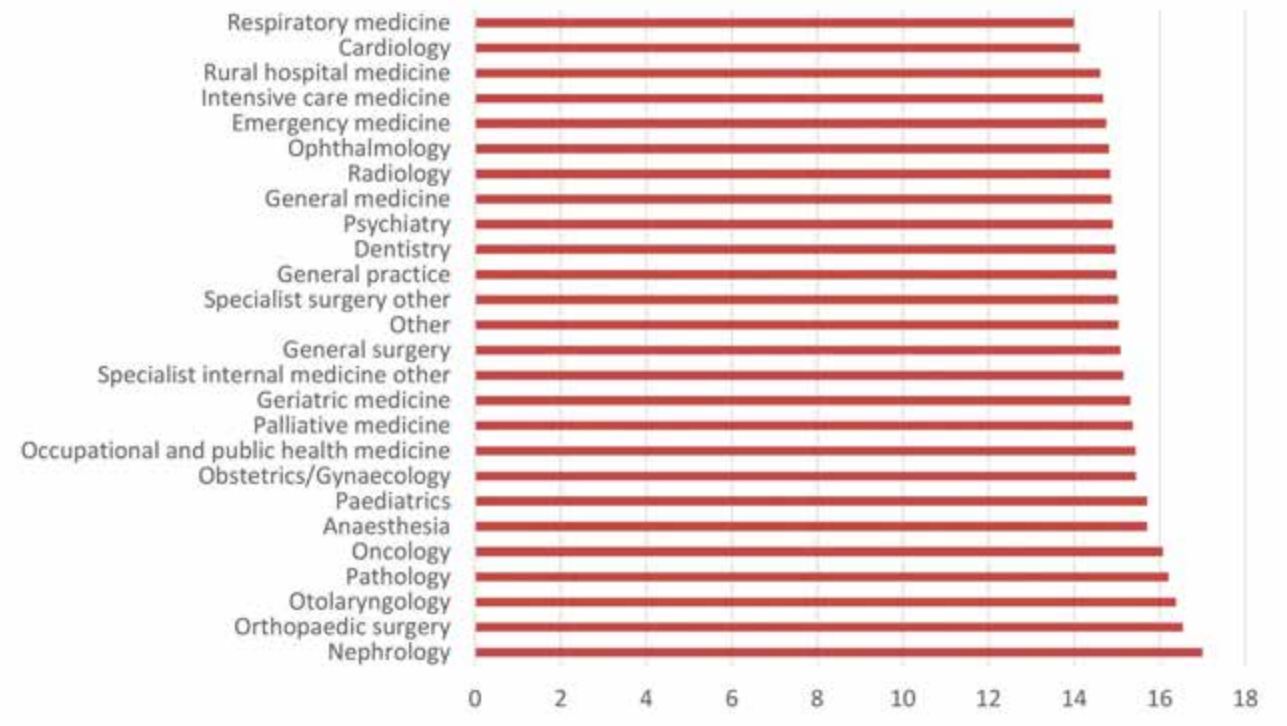


FIGURE 12: MEAN PEER SUPPORT BY MEDICAL SPECIALTY (LOWER SCORE = LESS SUPPORT)

There was significant variation in all three measures by place of work (p=0.001, <0.001 and 0.026) for workplace demands, non-clinical managerial support, and peer support respectively. Respondents from Whanganui DHB and Auckland DHB reported the two lowest scores for non-clinical managerial support, Tairawhiti DHB reported the lowest level of peer support, and Waikato DHB reported the worst level of workplace demands. The HSE sub-scale scores by place of work are detailed in Figure 13, Figure 14, and Figure 15.

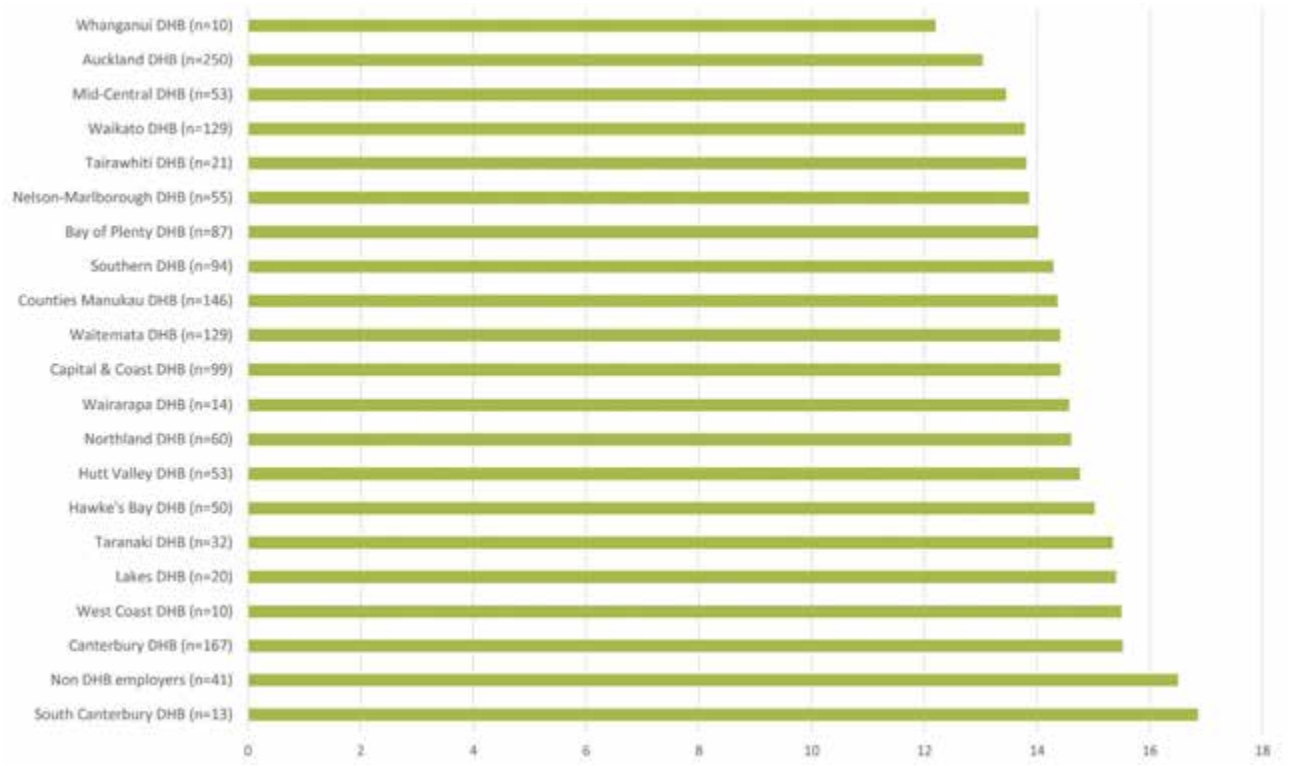


FIGURE 13: MEAN NON-CLINICAL MANAGERIAL SUPPORT BY PLACE OF WORK (LOWER SCORE = LESS SUPPORT)

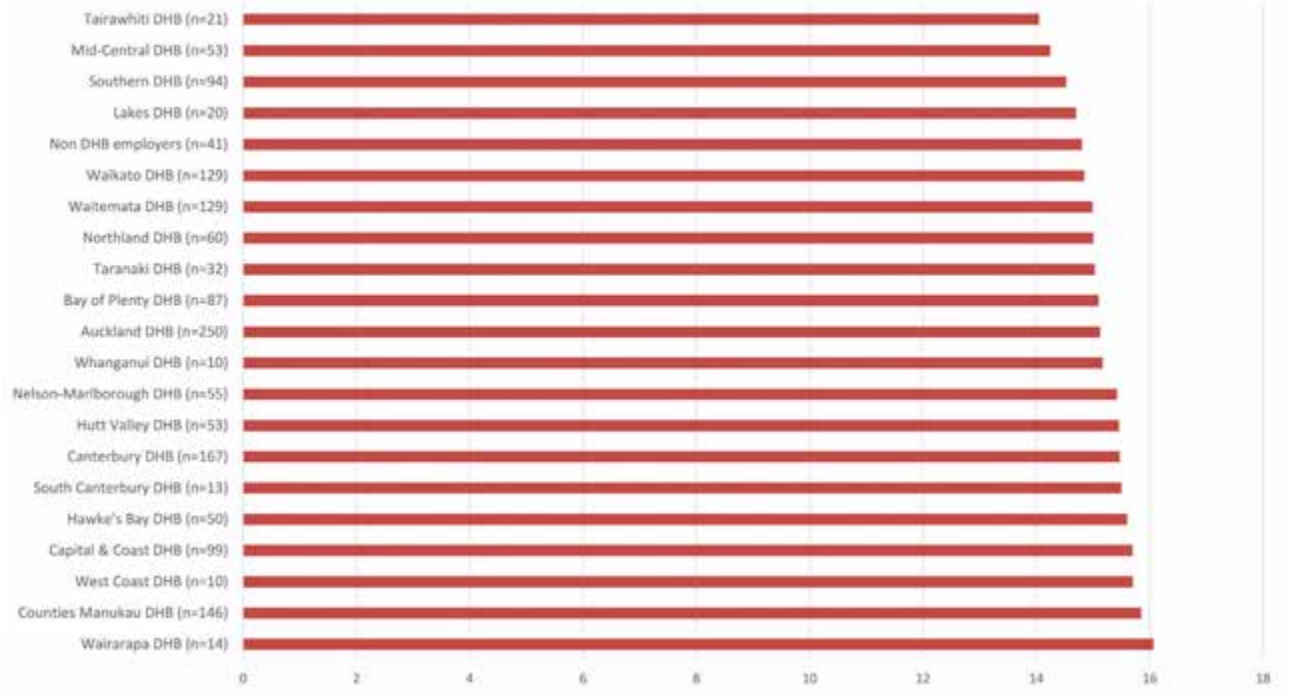


FIGURE 14: MEAN LEVEL OF PEER SUPPORT BY PLACE OF WORK (LOWER SCORE = LESS SUPPORT)

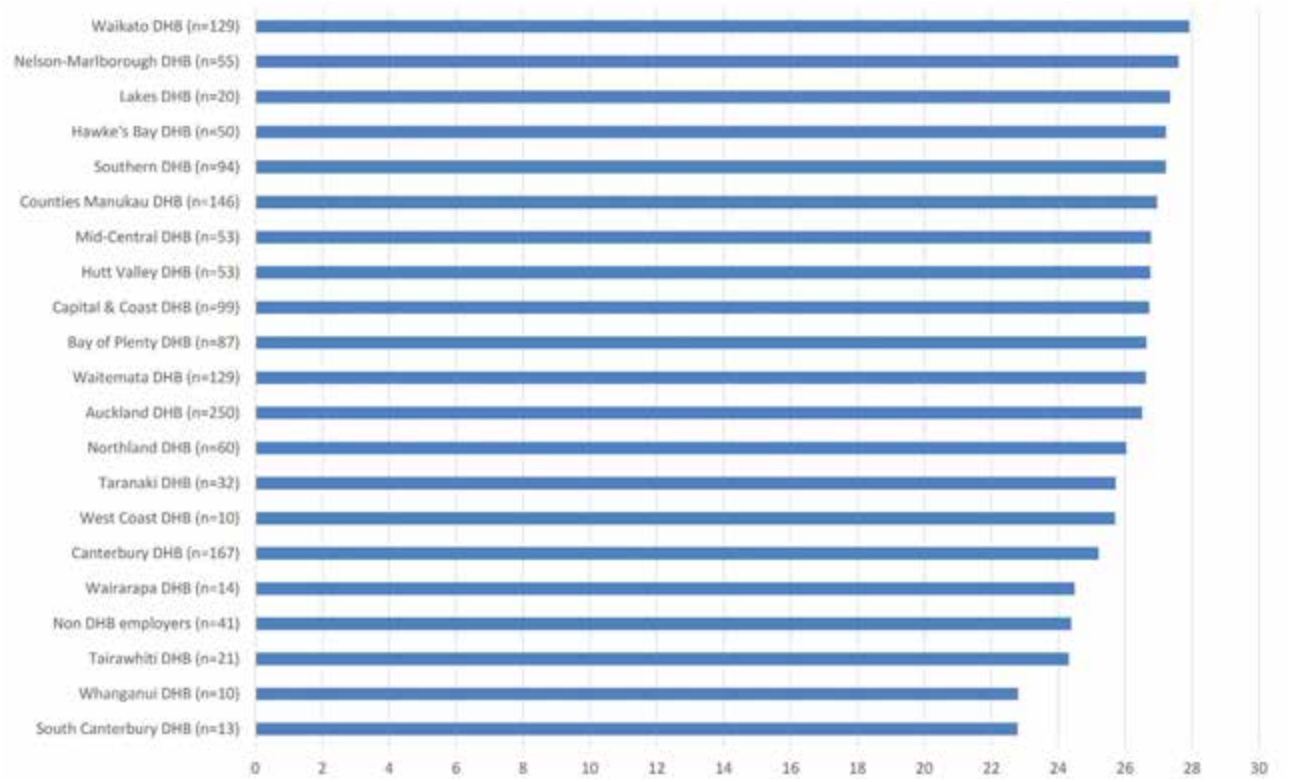


FIGURE 15: MEAN LEVEL OF WORKPLACE DEMANDS BY PLACE OF WORK (HIGHER SCORE = HIGHER DEMANDS)

Associations with bullying, workplace demands, peer support and non-clinical managerial support

Non-parametric Spearman's correlations found significant associations between the three HSE sub-scales with levels of workplace demands increasing with decreasing levels of peer and managerial support (all correlations >0.28). There was a strong association between being exposed to higher workplace demands, lower levels of peer support and managerial support, and increasing overall NAQ-r and NAQ-r sub-scale scores. Similarly, higher levels of workplace demands and lower levels of peer support and managerial support were associated with higher levels of work-related bullying. Witnessing and self-reporting bullying were also associated with high workplace demands, low levels of peer support and low levels of managerial support, as detailed in Table 4.

TABLE 4: CORRELATIONS BETWEEN BULLYING MEASURES AND LEVELS OF WORKPLACE DEMANDS, PEER SUPPORT AND MANAGERIAL SUPPORT

CORRELATIONS (Pearson correlation)	Level of workplace demands	Level of peer support	Level of non-clinical managerial support
Level of peer support	−0.306**		
Level of non-clinical managerial support	−0.277**	0.555**	
NAQ-r score	0.464**	−0.574**	−0.463**
Physically intimidating bullying sub-scale score	0.246**	−0.319**	−0.214**
Person-related bullying sub-scale score	0.284**	−0.565**	−0.408**
Work-related bullying sub-scale score	0.608**	−0.491**	−0.464**
Frequency of witnessing bullying	0.229**	−0.315**	−0.253**
Frequency of self-reporting as bullied	0.379**	−0.461**	−0.379**

****All correlations are statistically significant at p=0.001**

These correlations were further explored by examining the proportion of respondents who were identified as bullied using the NAQ-r (at least one negative act on a weekly or daily basis) by the level of workplace demands, peer support and managerial support. The HSE scores were grouped into either low (mean score <2.5), average (mean score 2.5 to 3.5) or high (mean score >3.5). As displayed in Figure 16, lower peer support was associated with the highest bullying prevalence (77%), while having low workplace demands resulted in the lowest bullying prevalence overall (7.3%).

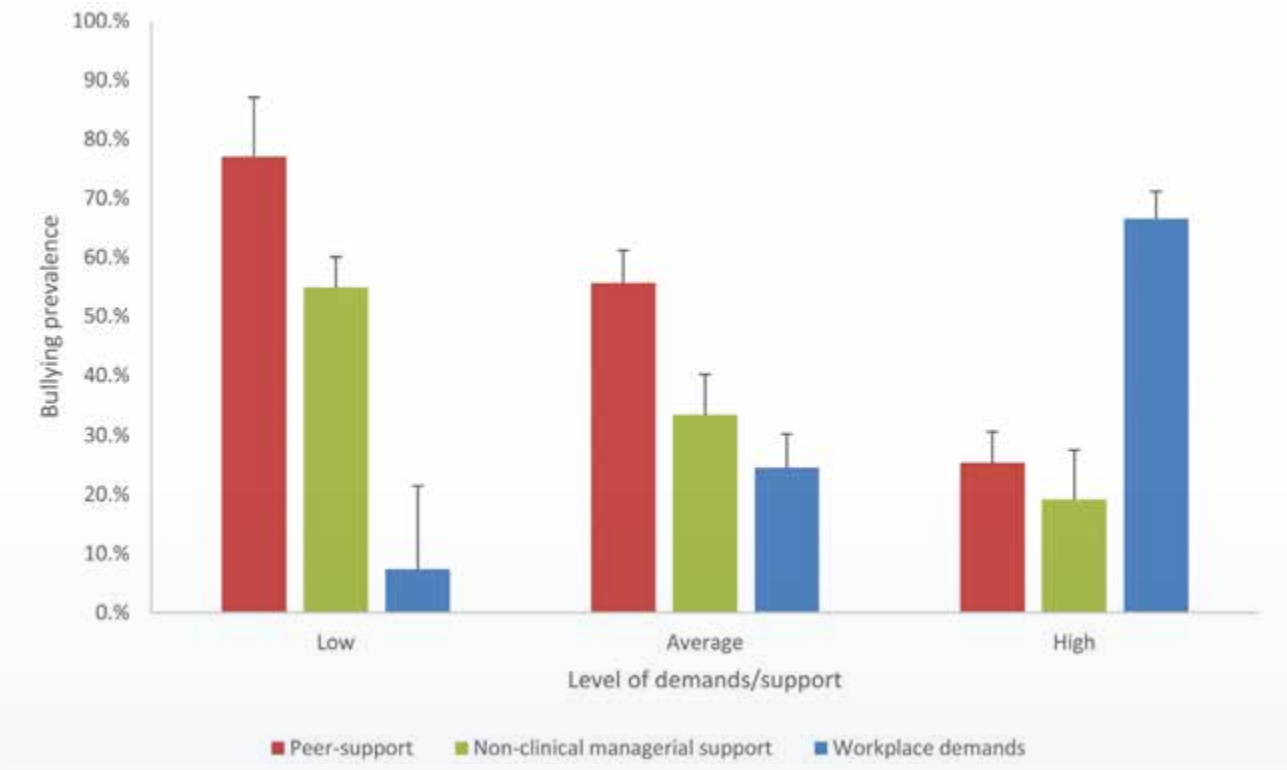


FIGURE 16: LEVELS OF PEER SUPPORT, NON-CLINICAL MANAGERIAL SUPPORT AND WORKPLACE DEMANDS BY BULLYING PREVALENCE

"I hate taking patients to PACU if a specific group of nurses is there. Some nurses there are great but a reasonable number are lazy, socialising, ignore my instructions or ideas about my patients. They don't like following instructions from a doctor and will tell me to go away they know how to look after patients and that my advice is wrong etc.. occasionally refuse to follow my instructions."

Perpetrators and reporting of bullying behaviour

Of the 606 respondents who self-reported as bullied, the bullying experienced was most commonly perpetrated by a specific person (40.4%). Other senior medical or dental staff were the most commonly cited perpetrators (52.5%) followed by non-clinical managers (31.8%) and clinical leaders (24.9%). Group and category of bullying perpetrator are detailed in Figure 17, and perpetrator by witnessed and self-reported bullying is shown in Figure 18. Nurses were cited as the second most frequent perpetrator of witnessed bullying (n=336), and bullying was more frequently witnessed from patients (n=251) than clinical leaders (n=222).
The largest share of respondents reported that perpetrators were mainly male (36.8%), followed by those reporting equal numbers of male and female (35.5%). Women were cited as the perpetrators by 27.8% of the 598 respondents who answered this section of the survey.

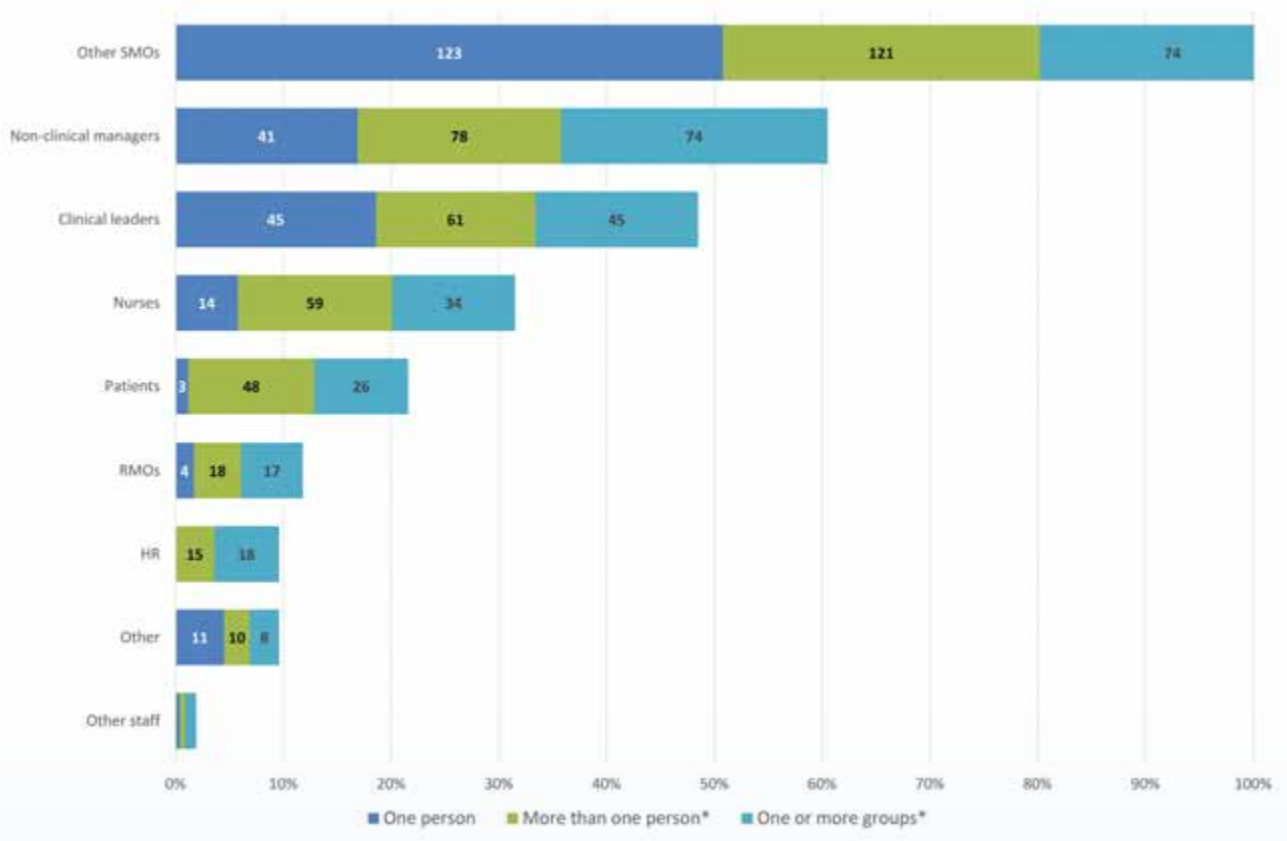


FIGURE 17: PERPETRATORS OF SELF-REPORTED BULLYING BY GROUP AND CATEGORY OF PERPETRATOR
***Respondents could select more than one perpetrator for these scenarios**

"The effect of 'bullying' patients is exhausting - they are likely trying to optimise their treatment but it comes across as combative and threatening which is emotionally draining when I am trying my best to provide a high standard of care routinely. I need to recall that such patients are the minority of those I treat..."

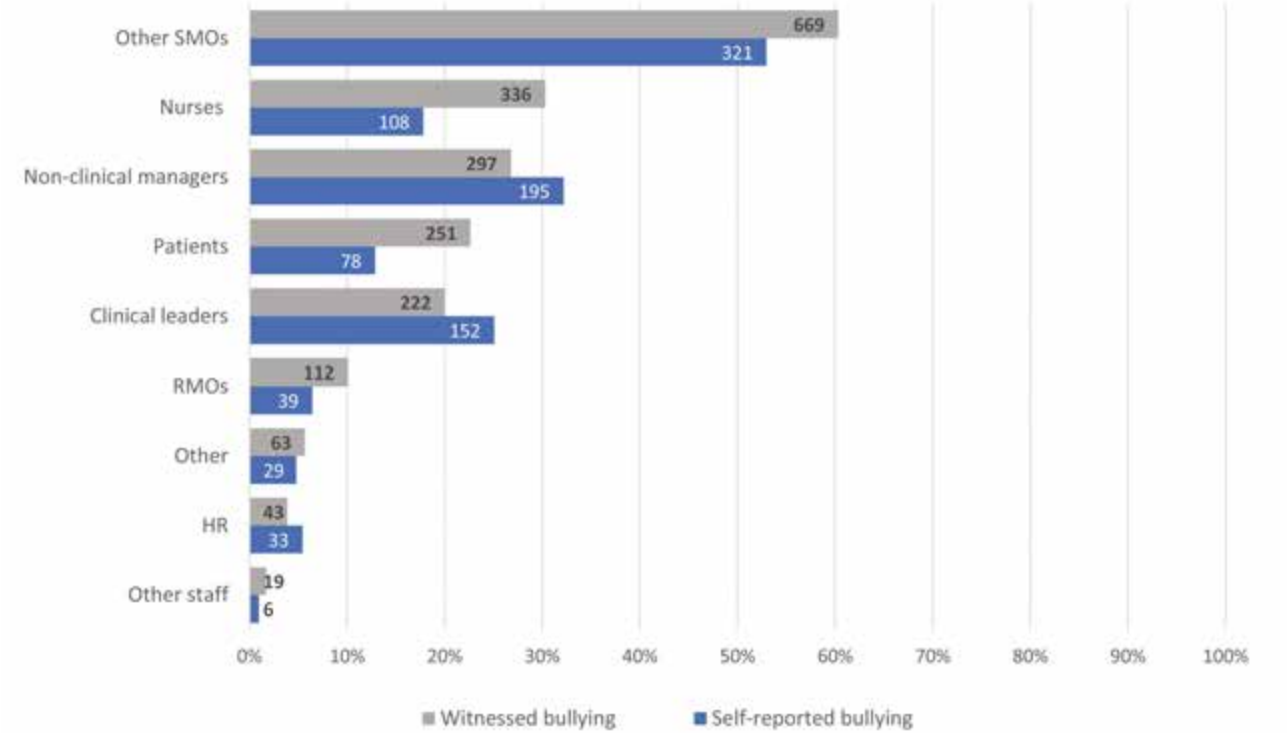


FIGURE 18: SUMMARY OF PERPETRATORS BY WITNESSED AND SELF-REPORTED BULLYING

Analysis of the qualitative data was helpful in fleshing out the effects of different perpetrators of bullying. As one respondent stated: "[My] non-clinical manager is a serial bully. This is widely known but senior management have not been prepared to deal with it." Others mentioned the fear this engendered where "there is a fear of speaking up as the hospital is [run] by cronies". Others commented on the negative consequences of witnessing bullying for wider morale as well as the feeling that some in management positions have a strong desire for compliance and control:

> *"I see non-medical staff being bullied by the same manager/[clinical director] as bullies me… It is actually worse in some ways to see it happening to other people. As an SMO, I feel it is my role to advocate and protect staff in my team. But this is what angers management the most. It is all about power and control. Managers want to control the whole clinical care. Patients would be terrified if they knew the truth – that managers have so much control over clinical matters, that they have minimal expertise in... Managers, in my experience, value compliance over competence. It is very depressing to see capable staff leaving, and less competent, but more politically-savvy staff, being promoted."*

These trends and comments confirm other research where bullying is frequently perpetrated by those in positions of responsibility or power. It is also possible that other senior medical or dental staff were frequently reported because they work most closely with other SMOs. While it is hard to examine these possible explanations further, these trends

suggest challenges for workplace morale as well as indicating potential difficulties in reporting negative behaviours (Blackstock, Harlos et al. 2015).

Rates and barriers to reporting bullying behaviour

Of those who self-reported as bullied, 30.4% (n=182) responded that they had formally reported the behaviour experienced. Of the 415 who did not report it, 407 provided reasons why. Figure 19 details the most common reasons for not reporting. Notably, 43.5% felt they would not be supported, and 42% felt that reporting would make the situation worse. Only 6.4% did not formally report bullying because the behaviour had resolved on its own.

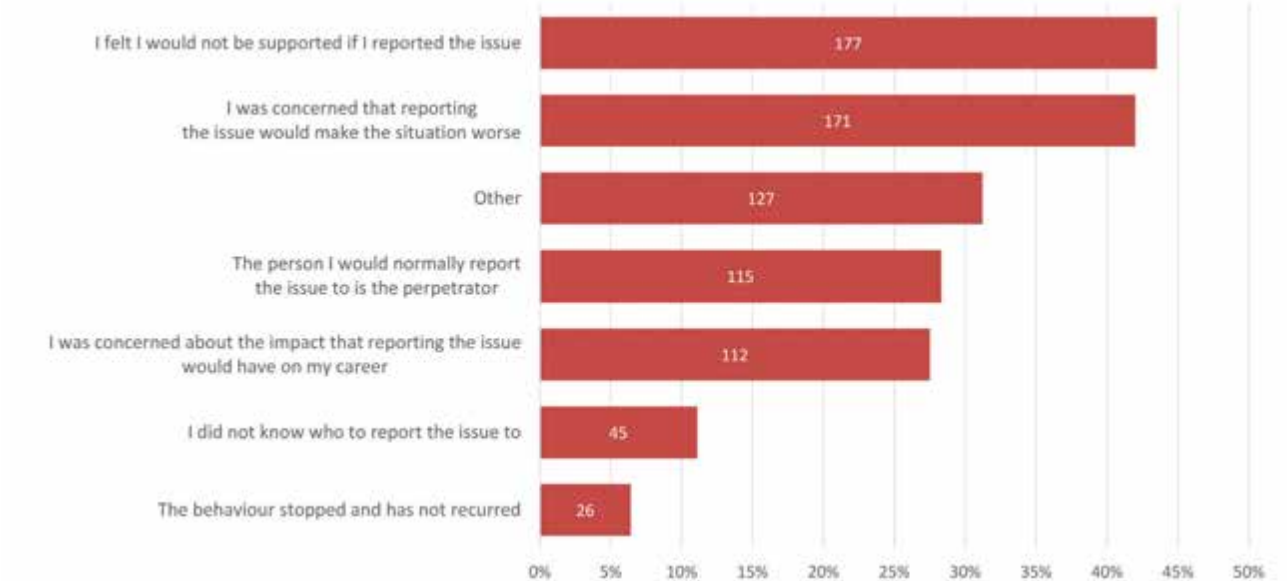


FIGURE 19: SUMMARY OF MAIN REASONS FOR NOT REPORTING
***Respondents could select more than one reason**

Explanations in the 'other' section expressed choosing not to report due to the behaviours being normalised:

> *"I have come to accept this as the culture of the institution I feel I cannot trust all the people (to whom) I could report."*

Others noted that the behaviour was something that they accepted as part of the job:

> *"Aggressive behaviour (shouting etc) from upset parents has always been part of my job. It makes me feel shaken and I generally would have a cup of tea with a colleague afterwards. Never considered a formal report."*

One respondent simply stated: "I have more important things to worry about."

Of the 182 (30.4%) who reported their bullying experience, 30.8% noted that the issue was not addressed and the behaviour continued, and 20.9% stated that the issue was addressed but not resolved and the behaviour continued. Only 23 respondents stated that the issue was resolved and the behaviours stopped after reporting. A summary of the main outcomes is provided in Figure 20.

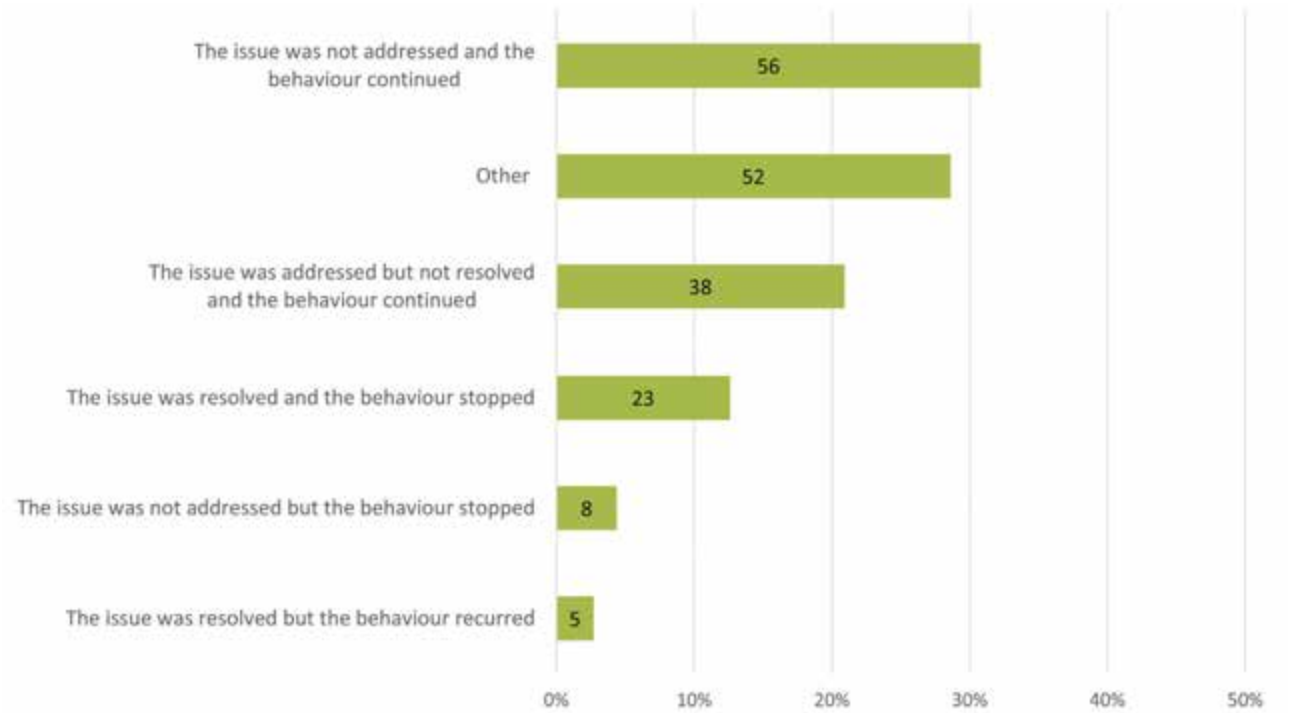


FIGURE 20: SUMMARY OF MAIN OUTCOMES OF REPORTING BULLYING BEHAVIOUR

'Other' outcomes (28.6%) included the issue being currently under review, dismissal of the reporting, and extreme consequences such as resigning or changing roles.

A respondent whose reporting was dismissed said:

> *"I mentioned to [head of department] and he said... yes they can be difficult sometimes. That's all. I am sure they will carry on."*

A respondent who experienced extreme consequences said:

> *"Eventually I resigned and moved to be as far away from possible from the person. Restructuring later occurred and that person has now left. The service has been traumatised and is still healing from his 2 years of reign."*

Consequences of bullying on professional and personal lives

The effects of bullying, as reported by those who self-identified as having been bullied (n=563), were many and varied, with 'moderate' consequences the most frequently reported. A total of 49 respondents noted that they felt the bullying they had experienced had limited impact on their lives, and three individuals reported dealing with the bullying personally. By contrast, 64 individuals described how the bullying had led to them either contemplating or making plans to leave medicine, and 58 comments said bullying had caused significant stress in their lives.

Twenty-one individuals reported coping with bullying by acquiescence, retreat or 'keeping their head down', and many referenced 'pulling back' from their work in order to cope. One respondent suggested that reprimand or lack of change could

further lead to tacit acceptance of bullying where people are encouraged to 'look away':

> *"[I] was told by the ops manager that [comforting a colleague] was being disrespectful and undermining her. That sums up what it is like working at [respondent's place of work] – if you show kindness to someone you get scolded for making the bully look bad. I work in a place where comforting someone sobbing receives rebuke and I detest what it is making me – someone who now averts their gaze from others in trouble as I don't want to get yelled at for being human."*

These issues were encapsulated in the following quote by a respondent who described the impact of bullying as follows:

> *"The experience of working in my DHB has been extraordinary in terms of witnessing the repetitive bullying from two senior medical officers towards other staff but particularly towards those with whom they have close personal working relationships. The individuals concerned are very senior, exhibit ingrained negative behavioural traits which have significant detrimental effects on the immediate working environment. This includes registrars having to change teams, and other SMOs on the verge of leaving. The issues have been raised on several occasions with head of department, nonclinical manager, chief medical officer and as far as I am aware there has never been any attempt to deal directly with the detrimental behaviour. Generally speaking, the dysfunctionality has been acknowledged readily but the advice has been to either ignore or learn strategies for dealing with the detrimental behaviour, and 'hold out until they retire'. Difficulty running a department has always been a feature and yet there's a strong sense that managers and other senior clinicians in management roles are not prepared to directly take the individuals to task because of their own fear of the individuals. The line managers in particular devolve dealing with them to other clinical colleagues resulting in a strong sense of lack of engagement. As the line managers and clinical managers don't have to work directly with these two individuals they can easily avoid dealing with the behaviours."*

In the main, respondents detailed feeling disillusioned, isolated, fearful and lacking in trust following experiences of bullying. Others described the significant personal and professional costs of bullying, including depressive episodes and feelings of burnout. Some reported feelings of distress and upset when their stress and frustration spilled over from work into their interactions with partners or children. Others described bullying as significantly circumscribing their ability to innovate or improve clinical service delivery (n=31) due to poor communication and a tendency to resort to defensive medical practice. Some felt that this ultimately affected the timeliness and quality of patient care:

> *"Aggressive behaviour from other [senior medical staff] makes you reluctant to engage a second time to discuss patient management. A delay in or wrong decision to discharge is then made. Over-monitoring by a non-clinical [manager] has you then working defensively. Then add abuse from patients for not meeting expectations and weekly passive aggressive reminders that targets are not being met..."*

A full summary of themes and illustrative comments is detailed in Table 5.

TABLE 5: SUMMARY OF THEMES AND ILLUSTRATIVE COMMENTS

CORE THEMES (NB: comments could reference multiple themes simultaneously)	Illustrative comments
Minor consequence/coping • Dealt with bully personally (n=3) • Coping by acquiescence, retreat, keeping head down (n=21) • Little effect or no significant impact (n=49)	"Recognise the behaviour and dismiss it and remain calm... Does not affect me and I do not try to defend against allegations made. Have had many years of practice."
Moderate consequences: • Defamation, character attacks, unfounded gossip or rumours (n=12) • Not wanting to go to work (n=20) • Undermining of abilities or professional standing (n=20) • Feeling unappreciated and/or unacknowledged (n=20) • Affected sleep (n=26) • Reduced hours and level of involvement (n=28) • Impeded ability to innovate or improve clinically (n=31) • Anger, irritation, frustration (n=42) • Loss of self-confidence and faith in abilities (n=42) • Affected personal life or home dynamic (n=49) • Compromised ability to work or perform to usual standards (n=51) • Negative work dynamic resulted (n=52) • Affected collegiality and willingness to collaborate (n=59) • Anxiety, loss of trust, faith in system, feeling isolated (n=66) • Disillusionment loss of enjoyment or love of job (n=76)	"For the first time in 19 years working as a doctor, I dislike coming to work. I am anxious and sleep poorly. I am struggling in my personal relationships because I feel like I should be able to cope but don't seem to be able to… I often feel unsafe now at work, and I worry that my experience here will have a negative impact on future positions I apply for. I am considering leaving the field of medicine because of my experience at this particular DHB." "As the person doesn't speak, communicate or interact with [me] and hasn't for 2.5 years, I am at a loss as to how to fulfil my role... [I'm] basically guessing what to do. Plus [I] have been undermined and humiliated and disenfranchised and the staff I give clinical guidance to know it. I have lost confidence in myself and in my professional abilities." "… Bullying wrecks a whole week. It leads to self-doubt and second guessing. It takes a long time to recover from. It is poorly recognised. It is difficult as an SMO to call out on bullying as it is a sign of weakness. Therefore, many of us put up with it especially in a system where we are overworked with unrealistic schedules and no hope of making an improvement." "You pull back and do the bare minimum to keep a service running. Bringing the behaviour to the attention of managers further up the pecking order has made no difference. Patient health is at risk." "Professionally it has affected my enjoyment of my job and I am considering moving to another DHB as I feel that I am so intimidated at times that I am unable to do my job to the best of my abilities. At times it is intolerable. The behaviour has caused me stress which has spilled over into my personal life too."
Significant consequences • Taken leave (n=7) • Burnout, mental health issues, depression (n=25) • Significant stress (n=58) • Contemplating leaving, early retirement, quitting medicine (n=64)	"I fear going to work. I feel as if I am being watched the whole time. I feel as though it doesn't matter how good my clinical work is, that my manager and [clinical director] will find a way to put a negative spin on it… I have lost confidence in myself as a doctor and a person. I feel disempowered... I am very anxious about work. This affects my sleep, which makes me worry more… I find it harder to trust people in general, and am more defensive… I am less patient with my children, as I feel so stressed. It feels like being trapped in an abusive relationship… I often dream of leaving. I often feel I have wasted my life, investing so much of myself in my work, when it is not valued by my seniors, even though patients value what I do. …I see patient care compromised, and the quality of the service being eroded. …I feel ethically compromised every day."

Discussion

This *Health Dialogue* reports the first multi-centre, multi-specialty study into the prevalence of workplace bullying in a senior medical workforce across an entire country, including the sources of such behaviour and rates of and barriers to reporting. It extends existing research into bullying prevalence by examining associations between bullying prevalence and perceptions of workload, peer support and managerial support. It also addresses the extensive methodological debate about how to measure workplace bullying (Cowie, Naylor et al. 2002), including both 'inside', or self-report measures, and 'outside', or peer report methods. The application of the NAQ-r enables an understanding of the types of behaviours most commonly experienced in this cohort as well as an objective assessment of bullying prevalence. Detailed analysis of the various behaviours and their prevalence serves to highlight specific behaviours and issues which are likely to require further consideration and action. The use of the standardised NAQ-r tool also provides for international comparisons with other studies applying this methodology. The combination of quantitative and qualitative data, with analysis of the latter describing personal and professional impacts of bullying, further adds to the strengths of this study, providing insight into the far-reaching and destructive consequences of this phenomenon.

The results from this study find over a third of this sample of senior doctors and dentists working in New Zealand's public health system are regularly exposed to a wide range of negative behaviours at work. Over a third of respondents self-reported as being bullied to some degree and over two-thirds reported witnessing bullying of colleagues to some degree. The results, overall, suggest that exposure to some degree of negative behaviour is ubiquitous in this senior medical workforce, with work-related bullying behaviours especially common. The strong linear associations between decreasing peer and managerial support, increasing workplace demands, and increasing frequencies of all measures of bullying are of note. These associations contribute to the literature that emphasises bullying as a phenomenon with multiple antecedents, including high workloads, stressful workplaces with poor organisational structures, and workplace cultures where bullying may be normalised as a coping strategy (Einarsen 2000, Salin 2003, Carter, Thompson et al. 2013). It is recognised in the wider literature that supportive work environments, broadly defined, can act as a buffer against work-stressors, including propensity for bullying (Quine 1999). Overall, these associations draw attention to the importance of fostering workplaces with strong collegial support networks. It also highlights the broader importance of high quality leaders who can nurture robust relationships with other staff.

Conversely, it is noted that work environments characterised by low work control (or high work strain) are strongly associated with higher rates of increased risk of stress and depressive symptoms (Madsen, Jorgensen et al. 2014). This is likely to be particularly relevant for the prevalence of work-related bullying, which was articulated by one respondent as follows:

> *"My understanding of bullying is that it includes placing unfair demands on people and can be constituted by an excessive workload as opposed to simply being 'traditional' bullying behaviour of physical/verbal/sexual intimidation etc. If this is the case then I would consider my current working conditions to constitute bullying even though I have not experienced 'traditional' bullying. The inherent implication that one is not managing one's workload due to inefficiencies, inability to change or adapt systems is wearing."*

As with the findings from the recent burnout and presenteeism surveys (Chambers, Frampton

et al. 2016, Chambers, Frampton et al. 2017), ensuring that workloads are manageable through appropriate levels of resourcing, including staffing, is likely to pay dividends in terms of reducing workplace demands and, in turn, the propensity for departments to resort to negative behaviours. As another respondent noted: "The problem is the workload which has increased [approximately] 40% in the last 5 years, but without any increase in staffing to manage it."

Importantly, Bradley, Liddle et al. (2015) emphasise that negative behaviours, including rudeness and incivility, are not always an inevitable consequence of being overworked and under-supported. They suggest that much can be learned from workplaces or departments with good behavioural cultures where staff, in the face of acute and stressful situations, do not resort to negative behaviours. Specialties and places of work with low bullying prevalence in the survey may provide exemplars from which lessons can be learned.

Demographic trends

The statistically significant differences in NAQ-r mean scores by age, medical specialty, place of work, and additionally for some of the sub-scale scores (gender, ethnicity, and country of medical training) are concerning. These results suggest that while bullying is experienced across the board, it is more common for certain groups of individuals. The trends for IMGs to report higher rates of person-related bullying are troubling and, given New Zealand's high reliance on IMGs, warrant further investigation and organisational action to ensure that these factors are not contributing to the high rate of IMG 'churn' experienced across the New Zealand public health workforce (Keene 2017). The age-related differences reflect statistically significant differences in the HSE sub-scale scores by age group; here it is notable that those aged 40–49 reported the highest level of workplace demands and the lowest level of non-clinical managerial support, and those aged 50–59 reported the lowest level of peer support. This appears to suggest that the higher prevalence of negative behaviours experienced by respondents in these age groups may reflect broader workforce pressures as well as the quality of relationships with peers and other colleagues. It is pleasing to note that there was no significant trend for the youngest age cohort of ASMS respondents to report higher prevalence of bullying.

The findings from this study confirm trends in the existing literature for certain medical specialties to experience higher prevalence of bullying than others. Of note are the high prevalence scores for specialists in emergency medicine, who had the highest overall NAQ-r score and the highest self-reported prevalence of bullying 'to some degree' (47.9%). These prevalence rates are, methodological differences notwithstanding, higher than the 34.5% bullying prevalence reported in a recent survey published by the Australasian College of Emergency Medicine, which surveyed all fellows of the college, and trainees (ACEM 2017). A possible contextual detail of relevance is that many emergency departments around the country at the time of the survey were reporting higher than usual demands on their services over the winter period (Gee 2017, Weber 2017). In light of broader workforce pressures, including poor resourcing, staffing shortages and high levels of burnout in the emergency medicine workforce (Chambers, Frampton et al. 2016), it is not hard to conceive that negative interpersonal interactions, particularly if they are already normalised in the workplace culture, may escalate as a way to 'get things done' in times of significant stress (Bentley, Catley et al. 2012).

"You develop a black sense of humour, but sometimes the aggression of patients within the emergency department is scary and I feel unsafe."

"I fear going to work. I feel as if I am being watched the whole time. I feel as though it doesn't matter how good my clinical work is, that my manager and CD will find a way to put a negative spin on it, eg, if I am thorough I will be seen as perfectionistic/too slow, if I am quicker I'll be seen as careless. If patients like me, I'll be seen as over-involved..."

This notion was referred to by one respondent who stated:

> *"Though not an excuse, much of the bullying type behaviour I have witnessed has to do with the chaotic and overwhelming environment which is the emergency department. As the pressures increase on EDs due to lack of funding, poor access to primary care and poverty and constantly increasing demand with limited increase in support, the stress of the ED will lead to poor behaviour due to patients and doctors loss of patience, fear, being overwhelmed and out of control."*

Further research is recommended to investigate how these issues pertaining to workloads, resourcing and broader growing demands on front-line services are intersecting with the high propensity for emergency medicine specialists to experience high rates of bullying, and what action needs to be taken to resolve this problem.

The high prevalence scores reported for specialists from general surgery and specialist surgery 'other' suggest that workplace bullying remains an issue of concern for surgical specialties but nevertheless provide a benchmark for the prevalence of bullying in senior surgical staff, progress of which will be important to assess in ongoing work such as 'Operating with Respect' (see www.surgeons.org/about-respect), among other initiatives.

The findings that certain workplaces have higher prevalence of overall NAQ-r scores as well as specific behaviours is also concerning. Despite no significant differences by place of work for witnessed or self-report scores, overall, the results suggest that problems with bullying are widespread across the places of work for ASMS members, but some places of work appear to have greater issues than others. For example, respondents from Tairawhiti DHB, which scored with the highest overall NAQ-r score as well as the highest prevalence of person-related bullying, also reported the lowest levels of peer support and the fifth lowest level of non-clinical managerial support. As with the age-trends, these correlations suggest that bullying prevalence may reflect broader workplace pressures and stressors as well as potentially reflecting issues with workplace culture at specific sites. Additional research will be required to understand these trends further.

Comparisons with other studies

Comparison of the results with other studies suggest that the overall NAQ-r prevalence findings are higher than the rates of bullying reported in Australasian studies applying the same methodology (Bentley, Catley et al. 2009, Ling, Young et al. 2016). The 38% NAQ-r and 37% self-reported bullying prevalence scores were also higher than other comparable international studies using the NAQ-r, such as Carter, Thompson et al. (2013).

The difference in the rates of self-reported (37%) and witnessed bullying rates (67.5%) is consistent with trends reported in other studies (Quine 1999, Steadman, Quine et al. 2009). This may result from individuals being reluctant to identify as 'victims' because of the negative connotations of doing so (Mikkelsen and Einarsen 2001), but it is also possible that some respondents may witness the same person either bullying or being bullied, thus potentially over-reporting bullying prevalence.

Perpetrators and reporting behaviour of workplace bullying

The results corroborate other studies in finding that other senior medical staff were the most commonly cited perpetrators for self-reported and witnessed bullying behaviour (52.5% overall).

This finding underscores the significant problem of peer-to-peer bullying in the senior medical workforce. Little research to date has revealed the extent to which other senior medical and dental staff bully each other, and this finding, while not entirely unexpected, is of great concern.

The reported perceived reluctance for those in leadership or human resources positions to actively address problems with individuals or departments reiterates the complex embedded and power-laden nature of the bullying problem. If those in managerial positions feel unwilling or unable to address negative behaviours, this can lead to the perpetuation of negative behaviours, which in turn can lead to a demoralised workforce and, at worst, increased intentions to leave the workforce (Matthiesen and Einarsen 2010). Recent research by ASMS also suggests a strong association between poor job satisfaction and increased intentions to leave the senior medical workforce (Chambers 2017).

The low rates of reporting revealed by the study, largely due to the fear of exacerbating the situation or not receiving support, suggests that considerable effort is still required to facilitate better reporting systems and improve procedures for handling complaints about bullying. As noted by Katrinli, Atabay et al. (2010), if bullying is 'normalised' or pervasive in a workplace, it may discourage people from reporting the behaviours because of the tacit view that little will change and it is something that they have to learn to deal with.

ASMS has put considerable effort into encouraging the widespread adoption of better systems to deal with bullying complaints and continues to recommend the approaches advocated by the Cognitive Institute. Overall, however, whatever system is adopted must be perceived to be safe for the victim of bullying – victims must be assured that they will not be disadvantaged in making a complaint, and moreover, that the principles of natural justice are adhered to so that everyone involved gets a fair hearing.

It is of further concern that for those who did formally report bullying behaviour, the majority reported that the issue was not addressed and the behaviour continued. Such statistics are unlikely to encourage others to report instances of bullying, particularly in light of the lack of enthusiasm for reporting in the first place. This suggests that despite the rhetoric, much work remains to be done to improve the experiences of those who do choose to report this behaviour. Given the finding that clinical managers, clinical directors and those in leadership positions were commonly cited as perpetrators of bullying behaviour, work remains to ensure that everyone is held to account for negative behaviours irrespective of their level of seniority. As articulated by one respondent, there was a feeling that while the problem was pervasive, there was hope for the future:

> *"Bullying is a cultural problem in medicine, made worse by high work pressure, under resourcing, lack of work life balance, and burnout. You are seen as weak if you can't sort yourself out. I think my colleagues do understand the issue, but are just trying to get by themselves and have little time/ energy to deal with the problem of a bullying culture. The virtual silence from the Medical Colleges says something about how we view one another. I think there is a generational problem; by and large younger consultants who have been subjected to bullying seem less likely to bully others, and more likely to be supportive. I feel many senior colleagues look down on us, and managers don't care so long as the bottom line is not affected. The answer is to change the culture in medicine by having the colleges to embed care/support of colleagues into their ethos."*

Conclusion

These findings have considerable relevance for those charged with improving the working conditions for this vital component of the medical workforce. Previous research has revealed a correlation with sickness absence, although the direction of causation is unclear (Kivimäki, Elovainio et al. 2000). A Finnish study found that those who experienced bullying were more likely to use sedatives and hypnotics, with potential consequences for their performance (Vartia 2001). The same study found greater levels of stress in those who were the victims of bullying and those who observed it, compared with those in workplaces without bullying. However, they also have implications for those concerned for the quality of patient care (Rosenstein and O'Daniel 2006). As explicated in grim detail in the qualitative data, bullying has far-reaching consequences which do not stop at the individual. Working in an environment where bullying is both witnessed and experienced has clear consequences for the manner in which medical teams are able to function (Roche, Diers et al. 2010, Shabazz, Parry-Smith et al. 2016) and deliver the services upon which public health systems depend (Wild, Ferguson et al. 2015, Paice and Smith 2009).

The results of this survey indicate a need for a comprehensive series of interventions not only to strengthen DHBs' existing low-level systems to prevent bullying and negative behaviours but also to address the broader implications of growing workloads, under-resourcing and under-staffing for the health and well-being of this medical workforce and their patients. These findings suggest that considerable work remains to be done to strengthen and address these broader workforce pressures, and equally suggest that such efforts are likely to pay dividends in assisting with efforts to reduce the prevalence of workplace bullying. The main aim must be to prevent bullying and negative behaviours by putting in place well-resourced education and training and non-punitive educative processes – for example, restorative practices, and strengthening existing programmes that appear to be working well.

The findings on low levels of reporting and positive outcomes following reporting suggest considerable work remains to be done on improving reporting and outcome data. DHB and medical college policies for bullying must be up to date with best practice, such as that provided through the Cognitive Institute programme. Good bullying and harassment policy must also be backed by best practice around how complaints might be made safely, without risk of career or other retribution and giving the alleged perpetrator every opportunity to change their behaviour – and for any workplace factors associated with the behaviour to also be addressed.

"I have lost confidence in myself as a doctor and a person. I feel disempowered, because all this happens behind my back, in a way I cannot address. I am very anxious about work. This affects my sleep, which makes me worry more, about whether I will be able to function at 100%. I find it harder to trust people in general, and am more defensive, feeling I need to protect myself, as I have come to expect surprise attacks without warning. I am less patient with my children, as I feel so stressed. It feels like being trapped in an abusive relationship."


EXIT

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Appendix 1

Introduction

The purpose of this survey is to provide ASMS with insight into the working conditions at your DHB or place of work including the prevalence of bullying. We are also interested in your perceptions of workloads and your relationships with management and your colleagues.

The survey is based on standardised, validated assessment tools; specifically the NAQ-R and sections from the HSE management standards indicator tool. There are no right or wrong answers.

The survey also requests demographic data for correlation analyses. Specifically and reflecting the aims of this research, this survey requests data about your place of work. Please be reassured that any reporting of the data from this survey will be done in such a way to protect and provide for anonymity.

Demographic data is collected and used for correlation analyses which are undertaken on an aggregated level. There is no line by line consideration of results. All raw data will be securely stored and will only be accessed by those conducting statistical analyses (Prof Chris Frampton) and by ASMS principal analyst (Dr Charlotte Chambers). If you have any concerns in this respect, please do not hesitate to contact Dr Chambers.

Your participation will help ASMS advocate for better working conditions for members, as well as informing our industrial activities more broadly. Results will be published and disseminated to the ASMS membership and in the form of academic peer-reviewed journal articles where appropriate. Material from this survey may also be used by ASMS to contribute to wider public discussions about the senior medical workforce and health care in New Zealand.

This survey will take approximately 8 minutes.

Please feel free to contact Dr Charlotte Chambers at the ASMS: cc@asms.nz if you have any questions.

Thank you for participating in this research.

1. Please consider the following statements in light of your experiences at work over the past six months:

	Never	Seldom	Sometimes	Often	Always
My colleagues are willing to listen to my work-related problems	☐	☐	☐	☐	☐
Different groups at work demand things from me that are hard to combine	☐	☐	☐	☐	☐
My non-clinical manager encourages me at work	☐	☐	☐	☐	☐
I have unachievable deadlines	☐	☐	☐	☐	☐
If work gets difficult, my colleagues will help me	☐	☐	☐	☐	☐

	Never	Seldom	Sometimes	Often	Always
I am given supportive feedback on the work I do	☐	☐	☐	☐	☐
I have to work very intensively	☐	☐	☐	☐	☐
I can rely on my non-clinical manager to help me out with a work problem	☐	☐	☐	☐	☐

Comments:

2. Please also consider the following statements in light of your experiences at work over the past six months:

	Never	Seldom	Sometimes	Often	Always
I have to neglect some tasks because I have too much to do	☐	☐	☐	☐	☐
I get the support I need from colleagues	☐	☐	☐	☐	☐
I am unable to take sufficient breaks	☐	☐	☐	☐	☐
I receive the respect at work I deserve from colleagues	☐	☐	☐	☐	☐
I am pressured to work long hours	☐	☐	☐	☐	☐
I can talk to my non-clinical manager about something that has upset or annoyed me at work	☐	☐	☐	☐	☐
I have to work very fast	☐	☐	☐	☐	☐
I have unrealistic time pressures	☐	☐	☐	☐	☐
I am supported through emotionally demanding work	☐	☐	☐	☐	☐

Comments:

3. Thinking back over the past six months, please consider how often you have experienced any of the following during the course of your work?

	Never	Seldom	Sometimes	Often	Always
Someone withholding information which affects your performance	☐	☐	☐	☐	☐
Being humiliated or ridiculed in connection with your work	☐	☐	☐	☐	☐
Being ordered to do work below your level of competence	☐	☐	☐	☐	☐
Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	☐	☐	☐	☐	☐

	Never	Seldom	Sometimes	Often	Always
Spreading of gossip and/or rumours about you	☐	☐	☐	☐	☐
Being ignored or excluded	☐	☐	☐	☐	☐
Having insulting or offensive remarks made about your person (ie. habits and background), your attitudes or your private life	☐	☐	☐	☐	☐
Being shouted at or being the target of spontaneous anger (or rage)	☐	☐	☐	☐	☐
Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	☐	☐	☐	☐	☐
Hints or signals from others that you should quit your job	☐	☐	☐	☐	☐
Repeated reminders of your errors or mistakes	☐	☐	☐	☐	☐
Being ignored or facing hostile reaction when you approach	☐	☐	☐	☐	☐

4. And also over the past six months, please consider how often you have experienced any of the following during the course of your work?

	Never	Seldom	Sometimes	Often	Always
Persistent criticism of your work and effort	☐	☐	☐	☐	☐
Having your opinions and views ignored	☐	☐	☐	☐	☐
Practical jokes carried out by people you don't get on with	☐	☐	☐	☐	☐
Being given tasks of unreasonable or impossible targets or deadlines	☐	☐	☐	☐	☐
Having allegations made against you	☐	☐	☐	☐	☐
Excessive monitoring of your work	☐	☐	☐	☐	☐
Pressure not to access or claim something which by right you are entitled (eg. sick leave, CME, annual leave, domestic leave, travel expenses)	☐	☐	☐	☐	☐
Being the subject of excessive teasing and sarcasm	☐	☐	☐	☐	☐
Being exposed to an unmanageable workload	☐	☐	☐	☐	☐
Threats of violence or physical abuse or actual abuse	☐	☐	☐	☐	☐

5. What is the best thing about working at your DHB/place of work?

6. Are there any specific initiatives at your DHB/place of work that have significantly improved your work-life balance or assisted with your abilitiy to work there?

7. Please consider the following definition of bullying at work:

"Bullying at work refers to situations where one or more persons feel subjected to negative and/or aggressive behavior from others in the workplace over a period of time and in a situation where they for different reasons are unable to defend themselves against these actions." (Adapted from Einarsen and Skogstad, 1996).

On the basis of this definition of bullying, during the course of your work over the past 6 months, do you think you have witnessed bullying of other staff or colleagues?

☐ No ☐ Yes, very rarely ☐ Yes, now and then ☐ Yes, several times a month

☐ Yes, several times a week ☐ Yes, almost daily

8. Who was the main perpetrator(s) of this witnessed bullying behaviour? Please select all that apply:

☐ Another senior medical or dental staff member

☐ A Resident Medical Officer (RMO)

☐ A nurse or other clinical staff member

☐ A patient (or member of patient's family and/or other hospital visitor)

☐ Someone from human resources (HR)

☐ A non-clinical manager

☐ A clinical leader

☐ Another member of hospital staff eg. cleaner, orderly

Other (please specify):

9. On the basis of the same definition of bullying (below), during the course of your work over the past 6 months, do you think you have been subjected to bullying?

"Bullying at work refers to situations where one or more persons feel subjected to negative and/or aggressive behavior from others in the workplace over a period of time and in a situation where they for different reasons are unable to defend themselves against these actions." (Adapted from Einarsen and Skogstad, 1996).

☐ No ☐ Yes, very rarely ☐ Yes, now and then ☐ Yes, several times a month

☐ Yes, several times a week ☐ Yes, almost daily

10. In the main, is this behaviour being carried out by one specific person, by more than one person or by specific group(s) of people?

☐ By one specific person ☐ By more than one person

☐ Be one or more specific group(s) of people

11. And is this person:

☐ Another senior medical or dental staff member

☐ A Resident Medical Officer (RMO)

☐ A nurse or other clinical staff member

☐ A patient (or member of patient's family and/or other hospital visitor)

☐ Someone from human resources (HR)

☐ A non-clinical manager

☐ A clinical leader

☐ Another member of hospital staff eg. cleaner, orderly

Other (please specify):

12. How has such behaviour affected your professional and personal life?

17. And are the people carrying out the bullying behaviour mostly:

☐ Male ☐ Female ☐ Equally male and female

18. Have you formally reported this behaviour?

☐ Yes ☐ No

Comment:

19. What was the outcome of this reporting?

- [ ] The issue was resolved and the behaviour stopped
- [ ] The issue was resolved but the behaviour recurred
- [ ] The issue was addressed but not resolved and the behaviour continued
- [ ] The issue was not addressed but the behaviour stopped
- [ ] The issue was not addressed and the behaviour continued

Other (please specify):

20. Why did you not report this behaviour?

- [ ] I was concerned that reporting the issue would make the situation worse
- [ ] I did not know who to report the issue to
- [ ] I felt I would not be supported if I reported the issue
- [ ] I was concerned about the impact that reporting the issue would have on my career
- [ ] The behaviour stopped and has not recurred
- [ ] The person I would normally report the issue to is the perpetrator

Other (please specify):

Please note that this information is vital for correlation analysis. Any potentially identifying information will be reported in such a way that the identity of the respondent is protected. All raw data will be securely stored and is confidential. Analyses are done on an aggregated level.

21. Please select your gender:

- [ ] Male
- [ ] Female
- [ ] Undisclosed

22. Please select your age bracket:

- [ ] <=24
- [ ] 25-29
- [ ] 30-34
- [ ] 35-39
- [ ] 40-44
- [ ] 45-49
- [ ] 55-59
- [ ] 60-64
- [ ] 65-69
- [ ] 70+

23. What specialty area are you currently working in?

24. Where is your main place of work?

- [ ] Non DHB national service (eg. ACC, Family Planning, NZ Blood Service)
- [ ] Hospice
- [ ] Union and community health care service
- [ ] Iwi health authority
- [ ] Non DHB rural hospital
- [ ] Northland DHB: Whangarei hospital
- [ ] Northland DHB: Other
- [ ] Waitemata DHB: North Shore hospital
- [ ] Waitemata DHB: Waitakere hospital
- [ ] Waitemata DHB: Other
- [ ] Auckland DHB: Auckland city hospital
- [ ] Auckland DHB: Other
- [ ] Counties Manukau DHB: Middlemore hospital
- [ ] Counties Manukau DHB: Other
- [ ] Waikato DHB: Waikato hospital
- [ ] Waikato DHB: Other
- [ ] Bay of Plenty DHB: Tauranga hospital
- [ ] Bay of Plenty DHB: Whakatane hospital
- [ ] Lakes DHB
- [ ] Tairawhiti DHB
- [ ] Taranaki DHB
- [ ] Hawke's Bay DHB
- [ ] Whanganui DHB
- [ ] Mid-Central DHB
- [ ] Wairarapa DHB
- [ ] Hutt Valley DHB
- [ ] Capital & Coast DHB
- [ ] Nelson-Marlborough DHB: Wairau hospital
- [ ] Nelson-Marlborough DHB: Nelson hospital
- [ ] West Coast DHB

- [ ] Canterbury DHB
- [ ] South Canterbury DHB
- [ ] Southern DHB: Dunedin hospital
- [ ] Southern DHB: Southland hospital
- [ ] Southern DHB: Other

Other (please specify):

25. Do you have dependent children for whom you are responsible and live in your household?

- [ ] Yes
- [ ] No

26. Do you have other dependents (eg. elderly) for whom you are responsible and live in your household?

- [ ] Yes
- [ ] No

27. What is your ethnicity?

28. In which country did you receive your primary medical qualification?

29. Do you have any other comments, questions or concerns?

Appendix 2

GROUPED SPECIALTIES	Specialties inclded:	n
Psychiatry	Addiction medicine	6
	Psychiatry	162
	Psychogeriatrics	10
Specialist surgery 'other'	Cardiothoracic surgery	5
	Neurosurgery	4
	Oral & maxillofacial surgery	3
	Paediatric surgery	4
	Plastic & reconstructive surgery	13
	Vascular surgery	10
	Urology	5
Other	Clinical genetics	3
	Medical administration	3
	Other incl. requests for anonymity	20
	Rehabilitation medicine	4
Specialist internal medicine 'other'	Dermatology	6
	Endocrinology	5
	Gastroenterology	12
	Haematology	15
	Immunology	2
	Infectious diseases medicine	5
	Neurology	12
	Obstetric medicine	4
	Rheumatology	11
Paediatrics	Developmental paediatrics	2
	Neonatology	10
	Paediatric other	15
	Paediatric oncology	6
	Paediatric haematology	1
	Paediatric cardiology	3
	Paediatrics	76
General practice	General practice	21
	Family planning & reproductive health	4
	Accident & medical practice	2
	Sexual health medicine	8
Oncology	Medical oncology	18
	Radiation oncology	10
Occupational and public health medicine	Occupational medicine	3
	Public health medicine	15

GROUPED SPECIALTIES	Specialties inclded:	n
Anaesthesia	Anaesthesia	191
	Pain medicine	8
Palliative medicine	Paediatric palliative care	1
	Palliative medicine	23

GROUPED NON-DHB EMPLOYERS:	n
Non-DHB national service (eg, ACC, Family Planning, NZ Blood Service)	12
Hospice	18
Union and community health care service	4
Iwi health authority	3
Non-DHB rural hospital	4

ASMS services to members

As a professional association, we promote:

- the right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

Other services

www.asms.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback because it is vital in maintaining the site's professional standard.

ASMS job vacancies online

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Substantial discounts are offered for bulk and continued advertising.

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"Tired, worn-out and uncertain" – Burnout in the New Zealand public hospital senior medical workforce.

Superheroes don't take sick leave – Presenteeism in the New Zealand senior medical workforce.

Proposed privatisation of hospital laboratories: weighing the risks of unintended consequences.

Reality Check: the myth of unsustainable health funding and what Treasury figures actually show.

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