Time to stop making things worse: an imperative focus for healthcare student bullying research

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ABSTRACT

Student bullying in clinical practice remains a concern, and evidence regarding what works to specifically help the student appears rather piecemeal. At the same time, emergent literature indicates that some bullying interventions can be ineffective for behaviour change, or even deleterious to the staff which they target. Considering the potentially sizeable financial and personal costs associated with continued bullying and undertaking an intervention, it would seem sensible that any selected intervention method avoids those shown to be potentially ineffective or deleterious. Such avoidance would likely help to move the student bullying research forward, prevent further suffering and reduce the waste of valuable taxpayer resources.

Having designed, implemented and evaluated an anti-bullying intervention for the clinical workplace over the last three years, we have come to better understand the current situation regarding student bullying in healthcare. This article reflects our understanding of the literature and what we have learned in practice.

Recent statistics and meta-analyses indicate that student bullying in the clinical workplace is an ongoing concern. Substantial media and academic attention has been paid to various aspects of student bullying, which both indicate that this issue remains a problem. One worldwide study shows that 59.4% of medical students will experience bullying during their training; in New Zealand, a similar level of bullying is at 54%. These levels of bullying have been described as an “unspoken emergency”, and similar concerns are expressed about students of nursing and the allied health professions. These concerns have now been played out in recent memoranda of understanding between several New Zealand district health boards (DHBs) and Australasian professional bodies, eg, the Royal Australasian College of Surgeons (RACS).

Empirical research into healthcare student bullying reveals several important facts: that the commonest perpetrator is the senior male staff member, and that the most frequent bullying acts are general harassment, verbal abuse, gender and racial discrimination. While any student can suffer bullying, those of a minority race, the female gender or who identify as LGBTQ+ are most likely to experience it. The consequences of bullying are reported to potentially comprise issues such as disengagement from learning and academic failure, acute and chronic mental health issues, to include self-harm and suicide. More broadly, bullying of students (and staff) can cause and contribute to team dysfunction, systemic medical error and avoidable adverse health outcomes. Therefore, any bullying in the clinical workplace can place our patients at risk.

Of importance to health systems more broadly is that the effects of bullying can have substantial negative financial implications. Because most of New Zealand’s DHBs already work against considerable resource constraints, student bullying can thus be understood to seriously impact an organisation’s bottom line and detract from many of its primary aims.
In the literature it has been established that policy about behaviour is necessary, but not sufficient to change behaviour.\textsuperscript{16} We also find that literature regarding bullying interventions implemented specifically to help the student is comparatively less informative than that aimed at clinical staff.\textsuperscript{17} What exists is also piecemeal, and unclear in terms of ‘what helps what’. This lack of apparent knowledge is in itself concerning, but also worrisome because students occupy a vulnerable position within the health workforce.\textsuperscript{14} This position is one in which a student is concomitantly subject to power differences, bullying that can occur specifically at the teacher-learner interface,\textsuperscript{17} and also likely to have limited or emergent resilience.

Mavis\textsuperscript{18} suggests the following definition of bullying/mistreatment, which acknowledges the unique position of a student within the clinical workplace:

“Mistreatment, either intentional or unintentional occurs when behaviour shows disrespect for the dignity of others and unreasonably interferes with the learning process. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender or sexual orientation; humiliation; psychological or physical punishment; and the use of grading and other forms of assessment in a punitive manner.”

While evidence from the literature suggests that there is no ‘magic bullet’ to solve the student bullying issue, some reports have begun to explain why some intervention attempts might fail to be wholly effective. For example, failure may be due to the potentially varied cause of each bullying act, which might emanate from a person’s beliefs, a personality conflict or catalysed by environmental influences in the workplace\textsuperscript{2,17,18} (eg, an unreasonable workload); underreporting of bullying also makes it difficult to understand what exactly is happening, and can create difficulties in understanding what might best be done to help. There are also concerns that bullying can be reluctantly or inexpertly addressed, the former being especially likely where an accused possesses clinical expertise which is desirable or rare.\textsuperscript{20} Because a bullying intervention might also compete financially with the provision of clinical services, it is also possible that a type of intervention is selected for perceived value-for-money rather than quality, relevance\textsuperscript{14} or efficacy, such as that required for staff to genuinely change or develop their values.\textsuperscript{29} An intervention might seem appropriate, but be incongruent with effective learning or what might actually help. In Table 1, we list some reasons why a bullying intervention may be ineffective.

While the fundamental effectiveness of a bullying intervention appears to be based on the successful negotiation of several complex factors, some emergent and potentially deleterious ‘side effects’ of bullying interventions give us more information about how to better implement an intervention, and thus now require consideration. For example, it is now noted that some methods of delivering interventions to staff may induce feelings of being ‘targeted’, ‘at fault’ and perhaps being bullied themselves, if content is ‘aimed’ at certain negative behaviours, say ‘anger management,’ or staff groups, say ‘the doctors’.\textsuperscript{20,21} It also seems that negative feelings (eg, anger, inadequacy) can be engendered by other delivery methods,

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\textbf{Table 1: Possible reasons why a bullying intervention might be ineffective.} \\
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\textbullet\ possibly complex or varied origins of bullying;\textsuperscript{2} \\
\textbullet\ environmental influences on workplace behaviour\textsuperscript{19,20} \\
\textbullet\ underreporting that prevents identification of origin or type of bullying;\textsuperscript{2} \\
\textbullet\ management reluctance to address bullying;\textsuperscript{20,21} \\
\textbullet\ lack of available expertise for handling complaints\textsuperscript{19,19} \\
\textbullet\ lack of available expertise for intervention delivery;\textsuperscript{19,20} \\
\textbullet\ selection of ineffective or inappropriate mode of intervention delivery or topic, eg, based on the preclusive costs or unavailability of another;\textsuperscript{14} \\
\textbullet\ learning challenges associated with the cultivation of values.\textsuperscript{20} \\
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such as the use of posters. At one New Zealand site, posters about appropriate and acceptable workplace behaviour were reportedly torn down by staff, apparently because of feelings of frustration. Most of these problems are reported to have a deleterious effect on staff engagement and how well they might ultimately learn from an intervention.20,21

Similarly, there are emergent findings about some reporting procedures, which rarely lead to positive behaviour change22–26 but have now also been shown to be potentially deleterious because aspects of the reporting procedures might themselves be experienced as bullying. For example, where an accused is ‘isolated’ from communicating about a complaint with other staff, which is usually undertaken to prevent others ‘taking sides’ or skewing information. While a laudable goal, such an act can be experienced as kind of marginalisation, in itself a harmful practice21 which is understood by some to indicate management’s complicity with bullying acts. We also understand that values education, where not done well (eg, by lecture), can cause a person to disengage from learning because it can imply ‘fault’ or ‘lack’ in a person.28,29 In summary, a growing body of literature about student bullying intervention now provides specific evidence that some might be harmful, as listed in Table 2.

**Table 2:** Possible reasons why a bullying intervention might be deleterious.

- a perpetrator feels personally targeted (eg, by professional group or behaviour);20,21
- marginalisation of an accused, imposed as part of an incident investigation;20
- ineffective or inappropriate methods of cultivating values.20,28,29

**Summary**

The focus of bullying interventions to help our students needs to change. We need a specific focus on interventions, with more in-depth and considered practices than has hitherto been the case, together with a significant amount of expert guidance and support for all who work and teach in the clinical workplace. While such options might be rare or financially prohibitive, without these, it might be that the values and behaviours required for better practice are not cultivated as we would wish.20 We need to undertake such a quest now: to ameliorate continued negative financial implications of bullying on our students, staff, patients and institutions.14 Some health providers (eg, DHBs in New Zealand) are now required, by law, to ensure that bullying is effectively tackled, as part of a duty of care to each student, staff, victim or protagonist.21,27 We are thus required both morally and legislatively to move from just ‘doing something,’ to ‘doing it right.’
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Nil.

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