KEYWORDS BULLYING | AGGRESSION | INCIVILITY | NEGATIVE BEHAVIOURS

Looking beyond bullying to assess the impact of negative behaviours on healthcare staff

This study investigated the extent and type of negative behaviours between staff, and attempted to broaden the issue from focusing on bullying alone

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ABSTRACT Pope, R., Burnes, B. (2009) Looking beyond bullying to assess the impact of negative behaviours on healthcare staff. *Nursing Times;* 105: 39, 20-24.

Background Evidence suggests that bullying behaviours are common in the NHS. Various health organisations in the area studied had experienced problems with negative behaviours between staff and it was decided that research was needed.

Aim To assess and analyse negative behaviours experienced and/or witnessed by primary healthcare staff.

Method A mainly quantitative questionnaire was sent to random samples of staff in two primary care trusts, and a small "contact group" who had sought help because of negative behaviours.

Results In PCT A 63% and in PCT B 53% of respondents considered they had experienced and/or witnessed some level of negative behaviour in the previous 12 months. Most of the behaviour was described as incivility (67% in the random sample overall). Some of the incivility was also perceived as bullying but some was not. Regardless of perception, similar levels of negative effect were experienced.

Discussion Focusing on bullying alone and on frequency of behaviour misses part of the picture; what counts is the negative experience.

Conclusion Organisations need to take a broader view and prevent the full range of damaging negative behaviour between staff.

BACKGROUND

This research was carried out in two primary care trusts in 2005. These covered a large geographical area, with services comprising many different sized units, including five community hospitals.

Over the years, various health organisations in the area had experienced problems with negative behaviours between staff. It was decided that research was needed to assess the situation more fully.

LITERATURE REVIEW

Quine (1999) asked staff in an NHS community trust to indicate negative behaviours they had experienced at work; 38% had been subjected to one or more forms of bullying in the previous year and 42% had witnessed such behaviour. A further article (Quine, 2001) identified that 44% of nurses reported experiencing one or more types of bullying behaviour, compared with 35% of other staff, and 50% had witnessed it.

It is important to note that those affected may not have perceived the behaviours as bullying. The negative behaviours were, however, linked to lower levels of job satisfaction, higher levels of job induced stress, depression, anxiety and intention to leave their jobs.

The Amicus/CPHVA and Mental Health Nurses Association (2003) work involved health visitors, school and community nurses across the UK. It showed 45% considered they had been bullied under a given definition in their current workplace. Excessive supervision, criticism on minor matters, constant humiliation and belittling an individual's effort, often in front of others, were the most common complaints. Thirty-four per cent had taken time off due to illness and stress.

In 2000 and 2005 the RCN carried out surveys of 6,000 of it members across the UK. Most respondents (82%) worked in the NHS. Nurses were asked to state whether they had been "bullied/harassed by a member of staff in the last 12 months" (RCN, 2006), against two set definitions of these.

The most common behaviours were: intimidation/belittling (45%); verbal aggression (27%); professional judgement/role discredited (22%); and exclusion without support (15%) (RCN, 2006). Again, this negative behaviour was related to sickness levels and poor psychological health; it was also linked to an increased intention to leave, job related stress and reduced job satisfaction. The results showed a worrying increase in negative behaviour, up from 17% in 2000 to 23% in 2005.

The NHS staff surveys have also shown an increase in "harassment, bullying and abuse" for all staff, up from 18% in 2003 (11% from colleagues, 7% from managers) to 21% in 2007 (13% from colleagues, 8% from managers) (Healthcare Commission, 2008; Healthcare Commission and Aston Business School, 2004).

PRACTICE POINTS

On a day to day basis, the three most important ways of combating inappropriate behaviour are:

- Deal with problems quickly and, if possible, informally. One person behaving in a dysfunctional manner can destabilise a whole team and cause huge detrimental effects. If behaviours are tolerated, situations will only become worse and progressively more difficult to manage.
- Provide support to protect staff from some of the damaging effects of negative behaviour, such as dignity at work advisers, buddy systems, trained mediators and mentors. Trade union representatives, occupational health and personnel are also in a key position to offer support.
- Be proactive and focus on prevention. We all constantly have to assess our own behaviour. Dignity and respect has to be at the centre of all we do for patients and staff.

The very recent *NHS Health and Well-being Review Interim Report* showed that, out of over 11,000 respondents, 13% reported harassment from a manager/team leader and over 17% harassment from colleagues in the past 12 months (Boorman, 2009).

While most attention has been paid to behaviours termed bullying in Britain, Pearson et al (2001) have drawn attention to behaviour described as workplace incivility, with research conducted outside healthcare in the US: "Workplace incivility is low intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviours are characteristically rude and discourteous, displaying a lack of regard for others."

According to Pearson et al (2000), the consequences of incivility can be substantial. Words and deeds conveying disrespect can cause psychological harm, sometimes with a long term negative impact. The subtleties of incivility, the ambiguity of intent and the suspense about what may happen next can create feelings of confusion, fear or even a sense of panic.

Those affected avoided the instigator and more than one-third said they intentionally reduced their commitment to the organisation. They stopped helping newcomers and colleagues, reduced efforts to inspire innovation and took themselves off committees/taskforces. They "stopped doing their best" (Pearson et al, 2000). Five per cent retaliated by stealing property and 12% left the organisation. Consequently, incivility has negative effects for both individuals and organisations.

There is, therefore, a range of unacceptable workplace behaviour. Although most organisations tend to see bullying, harassment and aggression as unacceptable, the literature indicates that workplace incivility can be extremely damaging and should be considered equally unacceptable.

Raynor (2002) posed an important question: "Does someone need to label themselves as 'bullied' to be 'counted?'" She pointed out that only around half of those who experience negative behaviours at work label themselves as bullied but that both groups need to be considered. Hoel and Cooper (2000) found that people who experienced negative behaviour, but did not label themselves as bullied, reported similar effects as those who did.

Our research attempted to assess a broad range of negative behaviours and their effects (Burnes and Pope, 2007).

AIM

This study aimed to assess and analyse the prevalence, type, frequency, effect, response pathway and outcomes of negative behaviours experienced and/or witnessed by primary healthcare staff. It also aimed to categorise these as workplace incivility, aggression and/or bullying.

METHOD

A mainly quantitative questionnaire with some qualitative aspects was sent to random samples of staff in two PCTs.

PCT A had at that time approximately 585 employees and PCT B 1,250. Random samples (obtained electronically) were drawn from staff with substantive contracts, both full and part time, across all grades. GPs with clinical assistant contracts, bank only staff, trainees, board members and any staff who had contracts with the PCTs but were managed by another organisation were excluded.

Questionnaires were sent to 100 people in PCT A (18% of employed staff after exclusions) and 120 in PCT B (10%). In PCT B the final figure was 116 for analysis purposes, as four people in the sample had left. Of these, 73% of the PCT A sample and 50% of PCT B were nursing staff at various grades.

The samples were stratified to provide a representative sample of both manager/team leader groups and non-manager groups. No other personal information was requested to maximise the response to a sensitive questionnaire. Before it was sent out, it was piloted with individuals and discussed with a group of staff drawn from both PCTs.

A questionnaire was also sent to a contact group of 16 people who had sought help from personnel managers, trade union representatives and occupational health staff in both PCTs because of negative behaviours.

Definitions of behaviour

For the purpose of the research, negative behaviour was defined as: any behaviour that is disrespectful and undermines/violates the value/dignity of an individual; it is behaviour that harms individuals and organisations.

This was divided into three categories and defined as follows:

- **Workplace incivility:** Rude, insensitive or disrespectful behaviour towards others in the workplace with ambiguous/unclear intent to harm;
- **Aggression:** Aggressive behaviour with the unambiguous, clear intent of causing harm to a person;
- **Bullying:** "Offensive, abusive, intimidating, malicious or insulting behaviour or abuse of power, which makes the recipient feel upset, threatened, humiliated or vulnerable, undermines their self-confidence and may cause them stress" (Chartered Society of Physiotherapy, 1997).

The definitions for workplace incivility and aggression were based on the descriptions and definitions of Pearson et al (2001). The bullying definition was the one most commonly chosen, from a sample of 223 PCT staff, as being the one from a selection of seven that best described their experience, perceptions and understanding of bullying. However, this definition does not include any references to intent, frequency, persistency or exclusions of one-off incidents. A number of staff made comments about disliking such references. These findings are reflected in a recent much larger study (Saunders et al, 2007).

The questionnaire asked respondents about the behaviours they had experienced and/or witnessed and their frequency, and whether the perpetrator was a manager/team leader, colleague or person on a lower level in the organisational hierarchy. They were also asked about the stressful effect and how the experience had affected them in terms of: sickness absence; physically avoiding the perpetrator; avoiding communication; reduced job satisfaction, motivation and cooperation; reduced commitment to the department/organisation; whether they had changed their job or considered doing so; and whether they had retaliated.

Respondents were also asked to indicate whether they considered the behaviour to be incivility or aggression, using the definitions above, and whether it was perceived as bullying, using the Chartered Society of Physiotherapy (CSP) (1997) definition.

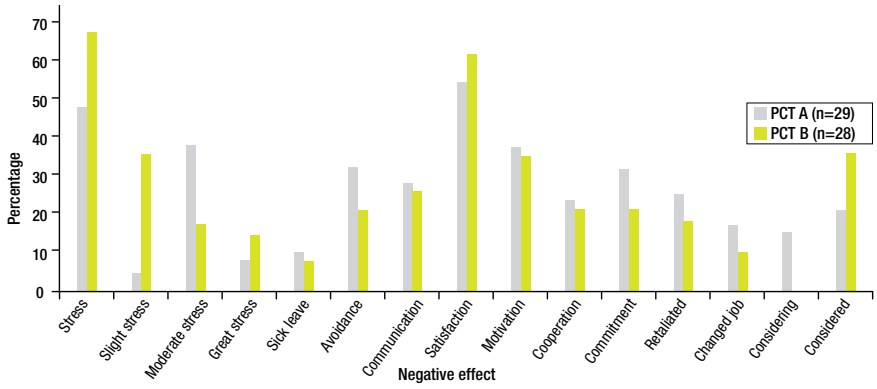
Ethical considerations

We gained permission from the PCTs and the NHS ethics committee before the research was carried out. To prevent identification, no personal information was requested, except whether a person was a manager or team leader.

RESULTS

In PCT A, the response rate was 46% (n=46), of whom 63% (n=29) perceived they had experienced and/or witnessed some level of negative behaviour. In PCT B, the response rate was 46% (n=53), of whom 53% (n=28) perceived they had experienced and/or witnessed this.

FIG 1. EFFECTS OF NEGATIVE BEHAVIOURS IN PCT A AND PCT B



Combining the figures, most respondents considered they had been negatively affected in some way (74%). The perpetrators were colleagues (54%), managers/team leaders (47%) and people on lower levels in the hierarchy (9%); 10% of respondents received negative behaviour from two sources.

There was a negative impact on job satisfaction, motivation, commitment and cooperation. Those affected also avoided communication and direct contact with perpetrators. Some admitted to retaliating (21%) and some moved jobs within their organisation (14%). As Fig 1 shows, a significant percentage experienced increased stress levels (58%).

Most of the behaviour in the random sample group was defined as incivility (67%). Of this group, 52% described the behaviour as incivility and bullying; 37% as incivility and not bullying; 9% as incivility, aggression and bullying; and 2% as incivility with no response regarding the perception of bullying.

An extremely important finding was that incivility that was not perceived as bullying had very similar levels and patterns of effect as incivility also classed as bullying (Fig 2).

The majority of the negative behaviour was at "now and then" frequency (51%). Another key finding was that this low frequency behaviour had similar levels of negative effect as more frequent behaviour. Isolated incidents appeared not to affect people, although there were exceptions. One person in the contact group experienced only one negative event, but this resulted in them having three months away from work and changing their job.

Witnesses also experienced negative effects, although to a lesser extent. Managers/team leaders were as likely to suffer negative behaviour (70%) as non-managerial staff and at similar levels of effect, indicating a widespread problem. Those who had contacted personnel, trade union representatives and occupational health (the contact group) clearly identified greater levels of negative effect.

Aggression was present in the two organisations, but at a much lower incidence than incivility and was always classed as bullying, as was behaviour reported by the contact group. Aggression correlated with much higher levels of negative effect.

In the random sample group the most common negative behaviours identified from a list of 27 were:

- Claiming credit for someone else's work;
- Setting out to make a member of staff appear incompetent and/or make their lives miserable through persistent criticism;
- Deliberately withholding information/providing incorrect information;
- Isolating/deliberately ignoring/excluding someone from activities.

In contrast, the most common negative behaviour experienced/witnessed by contact group respondents (n=11) was: "Putting someone's physical, emotional or psychological health at risk by making them upset, frightened and/or ridiculed." Four of these 11 had changed jobs within their PCT and another two had left their trust. Five identified the presence of aggression.

The random sample comments identified that the experiences had deeply affected people. There were feelings of isolation, insecurity, fear, worthlessness and lack of value. People felt undermined, powerless and vulnerable:

"Completely incapacitated/ineffective at both work and in my private life. Suicidal";

"Stupid, lonely and vulnerable";

"Powerless, small, embarrassed";

"Demoralised, low, unhappy to attend work".

People experienced similar feelings on witnessing negative behaviour but, in contrast, many also felt angry and frustrated. They felt helpless and unable to help or unsure of what to do. Many expressed concern for those who were the target of negative behaviours.

The contact group's comments indicated a much greater intensity of negative effect and emotional turmoil than the random sample group. They reported feelings of great anxiety, extreme anger, of being let down and frustration at their situation, using words such as "destroyed", "paranoid", "hopeless", "worthless" and "hostile".

FIG 2. NEGATIVE EFFECT OF WORKPLACE INCIVILITY COMPARED WITH INCIVILITY ALSO DEFINED AS BULLYING

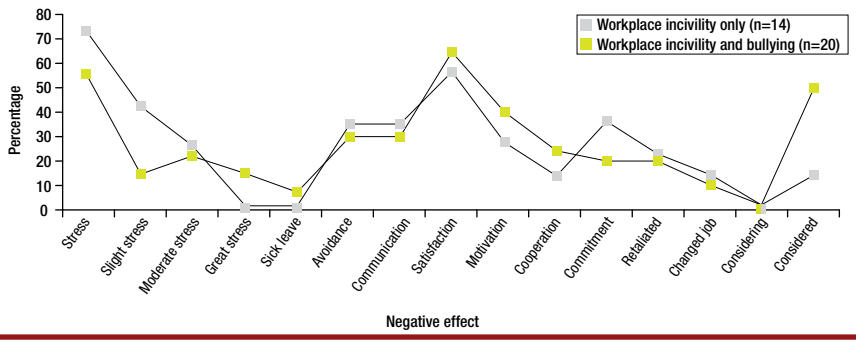
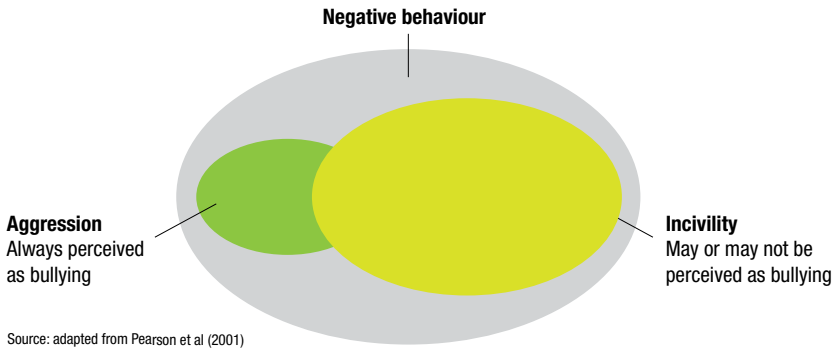


FIG 3. NEGATIVE BEHAVIOUR IN THE WORKPLACE



Source: adapted from Pearson et al (2001)

Regarding questions about prevention and more effective responses to problems, both groups gave a clear message of the need for zero tolerance, quick and effective action and the importance of prevention.

Limitations

We recognise that the groups assessed were quite small and that the findings of any one study should be viewed with caution. However, in light of previous research and other literature, organisations should take the findings seriously.

DISCUSSION

The literature review and these results indicate that many healthcare staff experience and/or observe unacceptable levels of negative behaviour, with definite negative effects. It is imperative, particularly in light of increased reporting of negative behaviours in the NHS, that organisations view these problems more seriously, taking action to prevent and address problems.

This study clearly identifies that all negative behaviour causes damage to both individuals and organisations. There is an obvious greater effect when it is perceived as aggression, which is behaviour where there is clear intent to harm. Aggression was always classed as bullying, using the CSP (1997) definition. However, the more common, perhaps more subtle and ambiguous incivility, is still extremely damaging, as is lower frequency behaviour.

Incivility that is not classed as bullying has very similar levels of effect as incivility that is perceived as bullying. All negative behaviours should be considered when attempting to address problems of dysfunctional workplace behaviour and be acknowledged in organisational policy.

Ignoring incivility, which is not classed as bullying, misses an important and extremely damaging part of the picture.

Fig 3 identifies the balance of incivility and aggression and the perception, or not, of bullying within the overall term of negative behaviour, while Fig 4 reflects the relationship between incivility, aggression and bullying and increasing levels of negative effect.

CONCLUSION

In these PCTs, high levels of negative behaviour were experienced and/or witnessed, with damaging effects.

Most of the behaviour was considered to be incivility and most was at a low frequency.

One key finding was that incivility not classed as bullying had similar levels of effect as incivility also perceived as bullying.

Another was that "now and then" behaviour had similar levels of effect as more frequent behaviour. Aggression caused greater effect and was always classed as bullying.

It is clear from the findings that focusing on bullying alone misses part of the picture and focusing on high frequency negative behaviour only also distracts from dealing with the full range of damaging behaviours.

We also conclude that definitions for bullying should not include references to intent, frequency, persistency or exclusions of one-off incidents.

The perception of bullying is perhaps irrelevant; what actually counts is the negative experience. Even tolerating low levels of incivility can cause problems and leave teams and organisations dysfunctional with implications for quality of patient care. The focus needs to be on preventing the full range of negative behaviour – of workplace incivility, aggression and bullying.

RECOMMENDATIONS

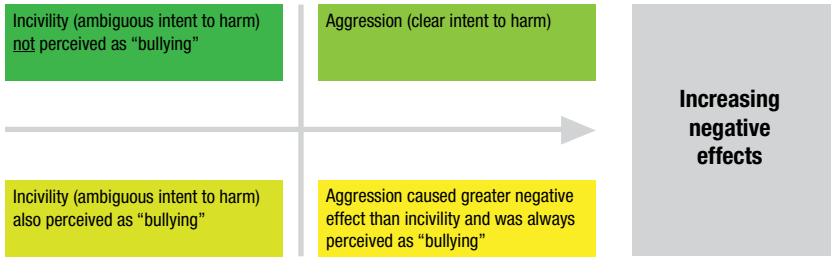
To tackle negative behaviour effectively, organisations need to take action in three key areas of leadership, policy and practice (see Practice Points box for the last, p20).

Leadership

Leadership behaviour influences and impacts on the whole organisation. Ensuring staff health and wellbeing must be seen as a priority at board level. Leaders and managers need proactively to develop a culture that does not tolerate negative behaviour. While this is the responsibility of all managers, there must be a clear message from the top of the organisation that negative behaviours are unacceptable. Without this there will be no change in the NHS.

The most effective leaders/managers are those who show a genuine concern for others' wellbeing, as well as modelling key positive qualities, including: the ability to communicate and inspire; empowering

FIG 4. THE RELATIONSHIP BETWEEN WORKPLACE INCIVILITY, AGGRESSION, BULLYING AND INCREASING LEVELS OF NEGATIVE EFFECT



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others; transparency (integrity, honesty and consistency); and accessibility, approachability and flexibility (Alimo-Metcalfe and Alban-Metcalfe, 2000).

Alimo-Metcalfe and Alban-Metcalfe (2003) said: "The single biggest leadership determinant of staff satisfaction – 'showing genuine concern' – is a weakness for NHS managers."

These findings need to be incorporated in management programmes. Managers need to assess themselves against these standards constantly.

Policy

Organisations need to develop a dignity at work policy (prevention and management of negative behaviour), which encompasses the full range of negative behaviours, including incivility.

Any definition of bullying should not include any references to intent, frequency, persistency or exclusion of one-off incidents.

This policy should be linked to an effective preventing and managing stress policy. A staff charter should also identify and protect staff from the full range of unacceptable behaviours, including incivility.

Overall, organisations need to establish a risk assessment cycle, which includes regular monitoring/reporting to the board and other committees. Consideration should be given to having feedback from peers and those on lower levels of the organisation regarding behaviour (Pearson et al, 2000) in appraisal systems, at all levels.

Negative behaviour should be dealt with as quickly, effectively and informally as possible – informal supervision guidelines may be helpful in achieving this. The emphasis should be on prevention, and promoting positive behaviour and communication (RCN, 2005; Chartered Institute of Personnel and Development, 2004; Raynor, 2002), perhaps in the form of a code of positive conduct. There should be a clear expectation of acceptable positive behaviour, with an emphasis on treating all staff with dignity and respect.

Trade unions also need to take a proactive role (Ironside and Seifert, 2003) by encouraging honest assessment and effective action, underpinned by good policy in organisations to ensure that steps are taken to address the problems of all negative behaviour. ●

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