Bullying and Harassment in Perioperative Settings

L'INTIMIDATION ET LE HARCÈLEMENT EN SITUATIONS PÉRIOPÉRATOIRES

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RÉSUMÉ
Cet article examine les concepts de l'intimidation et du harcèlement, offre une définition de ces termes et de leurs répercussions et explore ce qu'ils partagent et ce qui les diffère. Il analyse également la législation pertinente et identifie les stratégies qui visent la conscientisation ainsi que le développement d'un environnement périopératoire sans intimidation et sans harcèlement. L'intimidation et le harcèlement sur les lieux de travail était le sujet de cette présentation au congrès national de la *NATN* en 2002. Carrière et les comportements difficiles des patients constitue un sujet en soi.

BULLYING AND HARASSMENT IN PERIOPERATIVE SETTINGS

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ABSTRACT
This article explores the concepts of bullying and harassment, defines the terms and their implications, and explores similarities and differences between the two. It also examines pertinent legislation and identifies strategies to raise awareness and optimise a bullying and harassment-free perioperative environment. Bullying and harassment in the workplace was the focus of this presentation at NATN Congress 2002. Challenging behaviours involving patients and careers is another topic in itself.

BULLYING - FACT OR FICTION?

A survey by Rayner et al (2002) estimated that of 24 million employees in the UK, 10% have been bullied in the last six months. A Royal College of Nursing survey of 4,500 nurses revealed that one in six had been bullied in the last 12 months, one third of whom were intending to leave as a result (RCN 2002). Can we afford to let this carry on?

Many of you will have experienced the intimidating surgeon - the one who throws equipment across the floor, who shouts and criticises, constantly undermining staff. Many more will give examples of the theatre sister who expects 110% of her staff, but is never in theatre herself. But do we actually do anything about it? Do we constantly moan about their behaviour but inevitably accept and 'put up with it'?

It is not just managers who act like this; it may also be colleagues and peers. Should we tolerate a colleague's behaviour because they are good at their job or because, if we complain, we may create an environment of mistrust or animosity? Examples exist where theatre staff have

complained collectively about a member of staff's intimidating behaviour, resulting in that person leaving their post or being removed from the United Kingdom Central Council (UKCC) register (Castledine 2001).

Bullying may be seen as an umbrella term for behaviour such as intimidation, aggression, harassment and/or violence (Hadikin & O'Driscoll 2000). However, various definitions exist, resulting in a lack of clarity and therefore difficulty in tackling bullying effectively within the workplace. The definition of bullying is dependent on people's ideas and perceptions, and the workplace environment.

A manager may criticise your work and leave you feeling uncomfortable. However, to another person this might be a very negative and humiliating experience, particularly if the criticism occurred in front of colleagues (Hollinghurst 2000). Bullying is negative to the recipient, and is often persistent and long term in nature (Hadikin & O'Driscoll 2000, NATN 2002, Rayner et al 2002).

The Manufacturing, Scientific and Finance Union define bullying as 'Persistent, offensive, abusive, intimidating or insulting behaviour, abuse of power or unfair penal sanctions which makes the recipient feel upset, threatened, humiliated, or vulnerable, which undermines their self-confidence and which can cause them to suffer stress' (MSF 1994 cited by Rayner et al 2002). This is a strong definition, but one which clearly concentrates on the effects to the individual, recipient or victim.

WHO BULLIES WHOM? WHY AND HOW?

In nursing, a female-dominated profession, women are seen to bully more than men. Nationally there is no significant gender difference. Bullies are usually in a position of power, authority, responsibility or trust, and results of surveys echo this: 41% of nurses surveyed said they had been bullied by their manager. Surprisingly, in the same survey, 41% stated that their colleagues were bullying them (RCN 2002).

In the current climate, NHS managers are under pressure to achieve targets, and so may resort to bullying tactics to ensure that this happens. But what about colleagues? Changes within the NHS affect us all and may be uncomfortable for some. Colleagues may feel threatened or insecure, and alter their behaviour to deal with the situation. However, although this behaviour is understandable, if it results in bullying then it should be reported immediately. Such behaviour should not be ignored. It can be more harmful to colleagues and the work environment than abuse from patients.

Bullying manifests itself in many ways (see Hadikin & O'Driscoll 2000, Hollinghurst 2000, NATN 2002, Rayner et al 2002) and may include:

- overruling of decisions
- undervaluing or belittling of staff/colleagues
- lack of recognition for work done/taking credit for him/herself
- giving an unmanageable workload to an individual
- withholding information
- constant criticism
- impeding of progress/development
- lack of autonomy or giving authority to someone else.

Being bullied is unpleasant, yet many are unprepared for the experience as they have never encountered it before. Bullies often, but not exclusively, target those with low self-esteem, those who need to feel valued or who have high levels of dependence. Recipients of bullying may also be popular, committed, successful and competent. Bullies have little regard for their own behaviour and how it affects others; bullying is often seen as a symptom of the bully's own insecurity (Rayner et al 2002).

WHAT IS HARASSMENT?

Harassment, like bullying, is part of a wider issue, that of workplace occupational violence. It is outside the scope of this article to discuss all facets of occupational violence, but it is important to locate bullying and harassment within it.

Increasingly, the issue of occupational violence is being researched, acknowledged and addressed, usually via occupational health and safety legislation (Bowie 2002). Occupational violence research has been ongoing for two or three decades, but it is only in the last five to ten years that bullying and harassment have appeared in the literature and been the subject of research (Department of Health and Human Services 1994).

These challenging behaviours are increasingly being acknowledged as real issues in the workplace (Mayhew & Chappell 2001a&b, Howells-Johnson 2000, NATN 2002) and are significant issues for nurses (Michael & Jenkins 2001, Mayhew & Chappell 2001c). They are associated with wider social changes, such as economic rationalism and market-focused reform agendas (Hancock 1999), downsizing and job insecurity, and the increased use of casual labour. All of these have an acute impact on healthcare and nurses.

One of the frustrating aspects of examining harassment is the lack of clarity and consistency around the meaning of the word. There are similarities with and differences from bullying. The Australian Public Services Commission define workplace harassment as 'behaviour that is unwelcome, unsolicited, usually unreciprocated and usually (but not always) repeated. It makes the workplace or association with work unpleasant, humiliating or intimidating for the people or group targeted by this behaviour. It can make it difficult for effective work to be done' (APSC 1994). However, even this definition makes it difficult to distinguish bullying from harassment and in different cultures, the word harassment has different meanings. For example, in the Unites States of America, the word refers to bullying, just to cause further confusion!

This article explores the different types of harassment, and compares and contrasts it to bullying, but it is important to remember that the issue is not about an absolute or authoritative definition. It is about recognising and responding appropriately to unacceptable behaviours in the workplace.

Harassment can be verbal, physical or sexual and it can have a racial or disability overlay, that is the physically or mentally disabled or those of minority races (compared to the dominant culture) are targeted more than others. The different types of harassment will be explored in this article.

Why do we not hear more about the occurrence of challenging behaviours? Why do they continue to occur and why don't nurses, including perioperative nurses, complain more? There are a number of reasons for this.

Anecdotally, harassment, like bullying and horizontal violence, are prevalent in nursing, although they are under-reported and frequently surrounded by a culture of silence. This failure openly to acknowledge unacceptable behaviours is either because victims do not realise they are being bullied or harassed, do not know what to do about it, or believe that nothing can be done to improve the situation.

Previously, nurses were more obedient and tolerated it because 'that's how it is around here' or 'it's part of the job'. One colleague was told on entering the operating room 'if you can't stand the heat get out of the kitchen.' Additionally, nurses think they will not be believed or taken seriously, and they fear retaliation (Birman 1999) or, when they have complained, it has not been dealt with properly (NATN 2002).

A hierarchical organisational culture, which can be oppressive, can result in non-reporting of challenging behaviours (Mayhew 2002). Most hospitals are organised in this way. In times of economic restraint or downsizing (rightsizing!), or when an organisation is under pressure to improve its performance, bullying and harassment increase (Braverman 2002). As in other occupations, it is difficult to estimate their incidence or severity.

INCIDENCE IN PERIOPERATIVE SETTINGS

Some authors believe that bullying and harassment are prevalent within perioperative settings (Shibe 1991, Tyler & Ellison 1994, Kaye 1996), attributing this variously to the geographic isolation of the operating suite, the high stress experienced, the familiarity and bonding that develops between staff, and the persistent belief that nurses act only as handmaidens to surgeons and anaesthetists.

The issue of harassment of perioperative nurses is not new (Wry 1986, Cox 1987, Buchanan & Considine 2002, NATN 2002). Research over

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two decades has identified that perioperative nurses are bullied and harassed. Wry (1986), Cox (1987) and Tyler & Ellison (1994) describe a range of stressors experienced by perioperative nurses, including conflict, abuse, emotional manipulation, personality conflict and lack of support. When their results are examined more closely, it is evident that bullying and harassment are being described.

More recently, the work of Santamaria & O'Sullivan (1998) and Michael (2001a&b) in Australia have highlighted various stressors among perioperative nurses. Interpersonal conflict was identified as the leading stressor among the group of perioperative nurses they surveyed (Santamaria & O'Sullivan 1998). However, in exploring traumatic events experienced by perioperative nurses, abuse was the predominant finding, accounting for 45% of reported major types of trauma (Michael 2001a&b). This included verbal abuse, sexual harassment, sexual intimidation and physical assault. The main perpetrators were medical staff (78%). However, supervisors (11%) and colleagues (11%) were also implicated.

To put this into context, 69% of Michael's respondents had experienced workplace trauma. Of those, nearly three quarters had experienced more than one episode in the previous 12 months and more than 25% had experienced more than five episodes. The other major categories of traumatic events were: practice issues which affected the quality of care, such as perceived unsafe or inappropriate activities, due to lack of staff or being inexperienced conflict due to lack of communication or co-operation among team members death of a patient on the table.

Verbal abuse from doctors was the most frequently occurring event. Respondents were: humiliated or spoken to inappropriately, often in front of colleagues or awake patients made to suffer the temper tantrums of surgeons and anaesthetists, who yelled, intimidated, acted obnoxiously or made nurses feel inadequate or stupid.

One respondent revealed that surgeons constantly have the attitude that nurses are there to serve them, rather than to work as a team to provide the best care for patients. Another noted how sarcastic surgeons can be, and difficult to converse with, and how some do not remember your name even after months of working closely with them. Some respondents complained of experiencing various acts of physical abuse, such as having a dirty surgical gown thrown at them, surgeons throwing instruments, or being hit on the arm or chest. One nurse commented 'A registrar stapled my shoulder with a used skin staple gun'.

Cases of sexual harassment and intimidation highlighted that the perpetrators were mostly surgeons or anaesthetists. In other studies, other staff members perpetrate these behaviours. Behaviours include demeaning statements and sexually explicit jokes about other staff members, being slapped on the bottom, and a doctor exposing his genitals through an opening in his overalls whilst talking to a nurse.

One surgeon asked a nurse if she was there to get more exposure in theatre and then suggested she remove her clothes. One nurse complained of the arrogance of a surgeon because he was sexually harassing her. The surgeon was spoken to by management and subsequently he refused to work with the nurse, because he could not believe she had complained! Another nurse was scrubbed and assisting the registrar when the surgeon, who was supervising but not scrubbed, crawled around her feet and pulled her pants down. These are all examples from Rene Michael's research, which she published in 2001.

LEGISLATION

In Australia, there are various acts and policies at both state and federal level that aim to deal with all forms of harassment. For example, most states have occupational health and safety acts which note that all employers must provide a safe work environment, both physically and psychologically. There is also a Sexual Harassment Code of Practice (2001) produced by the Australian Human Rights and Equal Opportunity Commission, which applies nationally.

In the UK there are various pieces of legislation and the Department of Health (DoH) policy. While there is little specific law, the issues are dealt with under Sex Discrimination, Race Relations or Disability Discrimination Acts. The DoH has issued a policy statement advocating zero tolerance (DoH 1999).

DEALING WITH UNACCEPTABLE BEHAVIOURS

When being harassed or bullied, the recipient can suffer a range of symptoms described in Figure 2. The degree of suffering differs, depending on the recipient's awareness of the problem (Hadikin & O'Driscoll 2000, NATN 2002, Rayner et al 2002).

The Royal College of Nursing (RCN) acknowledges that nurses who report bullying by colleagues can experience symptoms similar to post-traumatic stress disorder. This could occur in as many as one in ten recipients (White 2002).

WHAT CAN BE DONE?

Many recipients of unacceptable behaviours may be unaware that there is a problem and try to correct their behaviour in response to the criticism. Others may recognise that they are being bullied but not have the confidence to override the criticism or behaviour directed towards them, particularly if they are being bullied by a senior colleague or manager. Some may even attempt to 'keep their head down' hoping that it will go away if they ignore it.

Another tactic adopted by the recipient may be to put a brave face on the situation, to carry on as if nothing is wrong, and to keep the situation to themselves even when colleagues ask them if there is a problem. However the recipient will gradually lose confidence to deal with the situation (Hadikin & O'Driscoll 2000, Hollinghurst 2000, NATN 2002, Rayner et al 2002).

In 1997, a Unison survey revealed that people who were being bullied took fewer actions than those who were not being bullied but imagined what they would do in the same situation (Rayner et al 2002). It is easy for someone outside to suggest plans of action, offer advice and counselling. But when you are the recipient, you question whether action would make things worse, or create a situation that you consider your fault, and alienate you from colleagues as you perhaps ask them to become involved as witnesses.

Bullying can wreck people's lives and careers, can affect job satisfaction, increase stress and anxiety. But it is important that recipients overcome those fears and tackle the problem. Why should we allow such behaviour to continue? If we do not do something then who will be their next victim - doing nothing will make it harder in the future, but 23% of the nurses responding to the RCN survey did nothing (RCN 2002). That means that a lot of bullying behaviour is being allowed to happen unchecked and unreported.

THE FORMAL OR INFORMAL ROUTE

If you are being bullied, you have a formal and informal route for taking action. Informally you should talk to colleagues - you may not be the only one that this is happening to. Keep a diary of events, times, places and witnesses, find out the local policies/ procedures and legislation, and try to avoid being alone with the bully.

Once you have the evidence, the hardest and most confrontational route is to confront the bully directly with support from colleagues or your manager. The RCN survey revealed that 51% were not satisfied with their employer's handling of the situation. This can be very demoralising, as employees deserve to be heard and positive action taken if their case is proved.

A more formal approach would be to approach your manager, personnel department or occupational health department directly. Some Trusts now have a bullying and harassment advice service. Such departments must ensure that the complaint is made without fear of reprisal, victimisation, further distress and embarrassment to the complainant. Organisations outside the NHS, such as the Andrea Adams Trust and many on the Internet, are available to offer advice, although they cannot take on individual cases.

Healthcare organisations can no longer afford to ignore the issues around bullying and harassment, as employers have a duty of care to their employees. Organisations need to assess the extent of the problem by first clearly defining 'workplace bullying' separately from

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'workplace harassment'. Bullying and harassment should be erased and disapproval of such behaviours made explicit. If proved, they should classify as gross misconduct offences.

Healthcare organisations need to foster a positive working environment, but they cannot do this alone. As managers, practitioners and colleagues we need to respect and listen to others, have time out with each other and foster a sense of belonging (Hadikin & O'Driscoll 2000). As practitioners we also owe a 'duty of care' to our colleagues, to work with them collaboratively and co-operatively in a reasonable manner (NMC 2002).

Bullying and harassment at work can damage employees' health and should be viewed and treated as a psychological hazard under the Health and Safety at Work Act 1974 (NATN 2002, Rayner et al 2002). People are healthcare organisations' prime asset and a healthy organisation has healthy assets.

Bullying and harassment is on the increase but together we can do something about it.

POSTSCRIPT

Incidences of bullying and harassment are reported in the nursing press on an almost monthly basis, and most of these reflect on the negative outcome from such behaviour on the recipient. As authors, we would like to hear from anyone who has been a recipient but has emerged with a positive outcome/result following their actions to address the issue. Please write to us via NATN HQ.

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Figure 1

How to distinguish bullying from harassment

BULLYING OR HARASSMENT?
There are similarities between bullying and harassment, but there are also differences:
Harassment can be a one-off event, whereas bullying tends to be repeated over time, often escalating in intensity.
Harassment can have a physical component or a sexual connotation; this includes sexual intimidation, sexual harassment or actual assault. Bullying is primarily psychological in nature, at least initially.
There is controversy over whether bullying is related to gender. Some are of the opinion that it occurs equally between men and women, however, the actual number of women victims is greater.
Women also experience greater rates of sexual harassment.
Harassment, particularly when associated with assault or sexual harassment, can have a criminal element; this tends not be the case with bullying.
Harassment and bullying are similar concepts - both are an abuse of power in the workplace.
There tends to be an aspect to both bullying and harassment which is linked with gender, with women being victims more often than men. However, women are also perpetrators of these unacceptable behaviours.
'Cyber violence' is being reported now, with people being harassed and/or bullied via telephone and email.

Figure 2

Some of the symptoms experienced by victims of bullying or harassment

SYMPTOMS EXPERIENCED	
Physical	**Psychological**
Disturbed sleep	Withdrawal/isolation
Loss of appetite	Tearfulness
Headaches	Loss of confidence
Sickness	Irritability
Inability to relax	Self doubt
Loss of libido	Depression

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