Bullying in health care settings: time for a whole-of-system response

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Sadly, there is nothing new in reports of bullying in medical training and in health care settings. Reports and surveys over the years confirm as much, and many currently practising health care professionals will be able to relate their own experiences of bullying or harassment.[1] Two recent events have once again brought this issue to the nation's attention. The first event was triggered this year by an Australian doctor who revealed her experiences of sexual harassment within surgical training. The second event was the recent release of survey results on medical students' experiences of bullying. Both events are shocking. Shocking because they reflect an underlying reality that no-one is denying, and shocking because hospitals and other organisations involved in the delivery of health care have cultures that allow and sustain bullying and harassment.

Excuses can be made. The terms bullying and harassment are sometimes used loosely and not all behaviour that is labelled as such would really fit commonly used definitions. For example, an off-hand, one-off comment in a stressed situation can be interpreted by the recipient in a variety of ways. Hospitals and other health care settings are often highly pressured work environments with multiple staffing and financial stresses piling on top of inherently demanding and risky work. To survive in such environments, students and staff need to be tough and resilient, don't they? But excuses are just that. The underlying reality is that bullying and harassment contribute to negative working, learning and healing environments and are absolutely and categorically not acceptable.

We believe there may be a risk of a 'cycle of violence' as is seen in child-abuse. Many doctors teach in ways that they were taught: "a bit of ritual humiliation didn't do me any harm". The response should always be to support the 'victim', but we should not necessarily rush to condemn the 'perpetrator'—the behaviour is unacceptable, but the instigator may also need understanding and support. The mildest-mannered, well-intentioned person can act in regrettable ways when they are placed in stressful, unsupported environments.

We do not propose that we can achieve a utopian world where there are no disruptive or negative behaviours.[2] We do propose, however, that wide ranging system-level responses will improve the learning and working environment. How can universities, professional organisations, hospitals, general practices and other health care organisations contribute?

An honest appraisal of the problem of bullying and harassment

These longstanding problems need to be named and confronted. We commend the Royal Australasian College of Surgeons for owning and responding to these issues within surgical training, as it seeks to understand and address the underlying factors.[3]

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Encourage positive learning environments in health care settings

The literature confirms that bullying also occurs in other professions, such as nursing.[4] Bullying between professions also occurs. A multidisciplinary approach is needed that welcomes and supports student learning, encourages students to participate in clinical activities, and provides regular, constructive feedback. The University of Otago is currently initiating research into the creation of positive learning environments in health care settings.

Resilience and resistance training for staff and students

The quality of medical training contributes to students' future professional identity as a doctor.[5] To nurture resilience, health professional programmes need to encourage personal and professional development through small group work, reflective practice and mentoring.

There is considerable evidence that negative role modelling by senior staff is harmful to students.[6] Training of all health professional students should aim to provide students with knowledge about complex work places and human behaviour, provide strategies to use when they feel bullied or harassed, and encourage individual and bystander resistance. Both Otago and Auckland Medical Schools are exploring options for specific coaching to help equip students to respond to challenging interpersonal situations. Students are also trained how to provide support for peers and to work together within a team.

Encourage students to use the existing support mechanisms in universities and health care settings

At Otago Medical School, analysis of students' reflective writing shows that students recognise when they are affected by difficult interpersonal interactions. Mostly, they seek support appropriately through available channels: teachers and mentors, Associate Deans, staff/student committees, and student representatives. They also have opportunities to provide feedback via routine teaching evaluations.

Reporting mechanisms for staff and students

We cannot deal with a problem if we don't know it's happening. We cannot detect patterns if we do not collect information. We therefore need robust ways to track unacceptable behaviours. One major problem is victims may not feel safe to report such behaviours. They fear 'word will get around', they won't be offered jobs, won't be offered training positions, and will be regarded as difficult. Some even use the term 'career suicide'. There is clearly a power imbalance: the victims feel powerless, the perpetrators are seen as powerful. This imbalance needs correcting. Having independent advocates is an option, and these are already in place in universities and most workplaces.

Anonymous reporting might seem attractive, but there are pitfalls in this approach. Anonymous reports cannot be verified or queried and can be vindictive; also natural justice suggests the accused should have an opportunity to respond.

On the other hand, anonymous reporting may provide data for monitoring purposes. Several anonymous complaints about the same clinician may well indicate a pattern and can be used as a basis for confidential, respectful and timely feedback to colleagues; for example: "no attempt has been made to verify this information, but you should know that several students have anonymously reported feeling humiliated by your comments during ward rounds".

Confidential reporting that is not anonymous may be preferable. Complaints are made to an independent authority who protects the complainant's confidentiality. The process needs not only to be safe for the victim, but also to be seen to be safe.

Another option is to collect routine data on all staff. Many medical schools, including

Otago, now routinely collect data from staff on students' professional behaviours. Some medical schools, for example McGill University in Montreal, ask students to comment on staff professional behaviours.[7] Increasingly, reaccreditation procedures require practising doctors to collect information from co-workers on their professional behaviours—often through tools such as multisource feedback.

Top-down initiatives

Responsibility for the ethos of institutional and teaching environments for medical students is shared between District Health Boards and the two medical schools in New Zealand. While these institutions already have zero-tolerance policies, the current publicity about harassment and bullying may be an opportunity for a fresh approach to the working environment for students and junior staff. Initiatives could include workshops on teaching skills, anti-bullying campaigns led by well-respected senior staff, independent reporting and investigation systems, employing staff on the basis of teamwork and collegiality as well as on academic achievements, and staff training on sexual harassment, bullying and cultural sensitivity.

Conclusion

The problem of bullying and harassment in health care settings demands proactive, whole-of-system initiatives. Single, simple solutions will not be sufficient. Health care professionals should role model 'caring' in their interactions with colleagues and students—everyone will benefit.

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