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HEALTH POLICY & OPINIONS

Tackling Workplace Bullying for Minority Ethnic Doctors

ABSTRACT

Workplace bullying, undermining and microaggressions are a reality for many, and although the prevalence may vary, there is no environment that is free of such hostile interactions. The healthcare workforce is focussed on empathy, kindness and caring, yet the daily experiences of many are in stark contrast to this. Although awareness of these issues exist, incidents of bullying are still grossly under-reported.

Bullying and undermining behaviours stem from a gradient of power and lack of appreciation of the societal advantages of diversity. In keeping with this, the experience of particular sub-populations are disproportionately worse, such as for women, minority ethnic groups, those with disability, LGBTQ+ and those from deprived backgrounds.

There have been campaigns and initiatives to change workplace behaviours, with mixed successes. A less explored role is that of organisations whose declared mission is to stand up for equality, represent the voice of the minorities and the under-represented, akin to self-help groups and advocacy.

This article explores workplace bullying from the perspective of the minority ethnic doctors and proposes the potential benefit of their representative organisations in helping to balance the inherent workplace disadvantages.

Keywords
Bullying, Harassment, Undermining, Minority Ethnic, Healthcare Workers

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Cite as: Chakravorty, T., Ross, N., George, C., Varadarajan, V. & Mehta, R. (2021) Tackling workplace bullying for minority ethnic doctors. Sushruta J Health Policy & Opin vol 15; Issue 1: ePub 3.12.2021 DOI: https://doi.org/10.38192/15.1.1

Article Information
Submitted 1.12.21
Pre-print 3.12.21

ISSN 2732-5164 (Online)
ISSN 2732-5156 (Print)

Background

Experiencing bullying, harassment and undermining in the workplace is not unique to healthcare, and is unfortunately only too common in many diverse workplaces and professions, including hospitality, arts as well as the uniformed forces.[1] Surprisingly white collar professions including medicine, legal and academic fields are not free of such toxic behaviours. Although healthcare self-selects people with an aptitude for caring and empathy, the evidence suggests that due to a multitude of factors, there is an environment that enables bullying and undermining (B&U).

Healthcare is a high stakes, hierarchical environment that depends heavily on teamwork and effective communication. Mistakes are usually catastrophic and often lives as well as careers are put at risk. Although many other professions (such as the air force or the army) also operate with a similar high pressure environment with life or death decision making, the healthcare profession is unique in the high rates of B&U reported, suggesting that there are other factors at play, aside from the nature of the job. These factors include the blame culture ingrained within the healthcare profession, isolation of minority groups (including ethnicity, gender and sexual orientation) and an ethos of underreporting due to fear of reprisals or being cast out. It is not surprising therefore, that the culture of extreme individual accountability within the healthcare profession may lead to negative behaviours.

In addition, gender as a social category is recognised as an important determinant of B&U. Importantly, gender interacts with other social categories such as race, creating unique experiences for different employee groups.[2]

In the United Kingdom, there are established surveys conducted by higher education institutions, the National Health Service (NHS), Health Education England (HEE), Care Quality Commission (CQC) and the regulators, such as the General Medical Council (GMC). Many of these surveys measure the proportion and frequency of B&U either experienced by individuals or observed being perpetrated on colleagues. Self-reported surveys also measure the power gradient by identifying the perpetrator or the origin of such behaviours. The results are made available to organisations and there is a voluntary expectation that appropriate corrective interventions are undertaken. Women, ethnic minority staff, migrants, nurses and healthcare assistants are most at risk of harassment.[3] This occurs within groups that are heavily dependent on the socialisation processes of acceptance, normalisation, indoctrination of professional standards and preservation of hierarchy such as the uniformed services and healthcare.[4]

B&U not only impacts people themselves, but may also have a much wider impact, including patients, families and colleagues. Workplace bullying is indeed a potent social stressor with consequences similar to, or even more severe than, the effects of other stressors frequently encountered within organisations. [5] For the affected individual, B&U leads to distress, burnout, increased rates of absenteeism, lower productivity, and intention to leave the job. The wide implications of B&U include poor patient outcomes and impaired teamwork, which ultimately leads to economic and social fallout. Asymmetric intergroup bullying is a mechanism through which intergroup hierarchy in the broader society corrupts management practice, employee interactions, and in turn exacerbates economic inequality. [6]

However, there are many barriers which lead to the underreporting of B&U. These include the perception that nothing would change, not wanting to be seen as a trouble-maker, the seniority of the bully and uncertainty over how bullying cases are managed. Data from qualitative interviews support these findings and identify workload pressures and organisational culture as factors contributing to workplace bullying.[7] Avoidance and doing nothing exacerbates the negative impact of bullying on psychological well-being and self-esteem. [8]

What constitutes B&U?

Bullying is defined as ‘persistent behaviour against an individual that is intimidating, degrading, offensive or malicious and undermines the confidence and self-esteem of the recipient’. Harassment is characterised as ‘unwanted behaviour that may be related to age, sex, race, disability, religion, sexuality or any personal characteristic of the individual’. Though these definitions are widely accepted, it can be challenging to define concepts such as bullying and undermining, as the experiences can be subjective and personal to the victim. However, within the workplace, there are several documented subtypes of bullying behaviours that pertain to specific aspects of working life.

Types of bullying

- Threat to professional status (e.g., belittling opinion, public professional humiliation, and accusation regarding lack of effort);
- Threat to personal standing (e.g., name-calling, insults, intimidation, and devaluing with reference to age);
- Isolation (e.g., preventing access to opportunities, physical or social isolation, and withholding of information);
- Overwork (e.g., undue pressure, unrealistic deadlines, and unnecessary disruptions)
- Destabilisation (e.g., failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, and setting up to fail);
- Indirect / reputational perpetrated by a third party (e.g., spreading rumors which lead to social manipulation); [9]
- Racially charged (minority ethnic employees report experiencing verbal abuse, being ignored, racist literature, name calling or mimicking, lack of access to training, arbitrary policies and unfair or excessive monitoring). [10]

B&U experience for minority ethnic doctors

Healthcare professionals from ethnic minority groups report a disproportionate amount of B&U. Several studies indicate that immigrants/migrants and ethnic minority members are more likely to report being exposed to bullying than the majority members, with some minority ethnic groups reporting more B&U than others. Experiences of bullying in the Medical Workforce Race Equality Standards (MWRES) indicate that whilst bullying from patients and relatives remain in equal proportions across all races (affecting a third of all doctors), minority ethnic doctors from all stages of training face significantly higher rates of bullying from colleagues, compared to their white peers (31% vs 22% for doctors in training and 33% vs 24% for other doctors). [11] There is evidence demonstrating how line managers use different tactics when bullying minority ethnic employees compared to white employees. Furthermore, when colleagues bully fellow colleagues, there are subtly different patterns of bullying behaviour towards white and minority ethnic victims.[12] This ethnic difference in B&U may be due to inequalities in both personal and social vulnerabilities among employees of different ethnicities that are intrinsic in certain cultures [13], and lack of knowledge or empowerment to report due to inherent discrimination. The quality of interethnic relations among employees is an important determinant based on the social identity, the concept of similarity-attraction, the influence of cultural distance and the paucity of social interactions. [13] Groups who are most culturally distant from the majority group tend to suffer the most B&U behaviours, including social exclusion. [14]

One of the greatest challenges facing B&U in healthcare is the systematic underreporting of bullying incidents. Unfortunately, healthcare professionals from minority ethnic groups tend to underreport incidents more than their white colleagues, which means that the racial differences in bullying may be greater than current data suggests.[15] There are several proposed reasons for the hesitancy amongst victims to report B&U incidents, including fears of ongoing bullying, reputational damage, career implications in cases involving perpetration by seniors and a lack of confidence that the organisation would investigate the issues.

A survey response from 348 doctors at a UK NHS hospital facilitated by the British Association of Physicians of Indian Origin (BAPIO), found that the majority of respondents (63%), had experienced harassment or bullying in the workplace. The

survey showed that the commonest group to be victims of bullying and harassment were trainee doctors, followed by line managers and senior medical managers. Race, religion and gender accounted for the vast majority of reported reasons for bullying. A significant number report the mental and physical consequences of bullying and harassment. Overall the majority feel the organisation was poor in the way it investigated and managed bullies. [16,17]

Other social characteristics impacting B&U

Staff with certain protected characteristics are more vulnerable to workplace bullying or harassment. The results of the NHS England Staff Survey show that disabled staff are the most likely to report bullying or harassment (32%), followed by LGBT staff (27-30%).[18]

Similarly, in terms of gender, significantly more female junior doctors report bullying behaviours than male junior doctors [2], this is often postulated as either a different gendered perception or that women are permitted narrower bands of acceptable behaviour, and deviations from traditional roles may submit them to negative evaluations and increase the risk of experiencing bullying.[19]

Hierarchy of B&U among doctors

Among healthcare workers, many cases of bullying experienced by doctors are perpetrated by colleagues based on hierarchy. Data from the Medical Workforce Race Equality Standard (MWRES) report shows that junior doctors and doctors not in formal training programs face the most B&U.[11] Traditional hierarchical structures of hospitals and medical training produce a culture in which bullying is not only unchallenged, but expected. Furthermore, even when the dysfunctional nature of the hierarchical system is recognised, it may be seen as a "functional educational tool" and therefore allowed to continue.[20]

Clearly hierarchy, silence, incognisance, fear, denial and legacy of abuse are key thematic causes of the pervasiveness of bullying among junior doctors. [21] These are all issues that need to be tackled at the ground level. However, senior doctors are also the victims of B&U. For example, in a UK Trust, several consultants from minority ethnic backgrounds requested protection from the Chief Executive Officer following unrelenting discrimination, bullying and harassment.[22]

Organisational factors

There are significant differences in negative interactions experienced according to clinical specialty, with higher mistreatment indices reported for those in medical rotation compared to paediatric or surgical rotations and in obstetrics. This suggests that there are differences in terms of job demands and resources and subsequent job strain between the clinical subspecialties, as well as hierarchical differences by seniority or between staff groups (such as between midwifery staff and obstetric doctors). Certain subspecialties demand more time and provide less emotionally and socially supportive working environments. [23]

There are significant costs for organisations from bullying and harassment, mainly arising from higher turnover of staff and increased absence due to sickness [24]. Lower productivity, potential costs of litigation and compensation, and loss of public goodwill and reputational damage also need to be considered. Autocratic management, hierarchy and work intensification fuel bullying culture. In recent years, there has been growing recognition of the role of organisational culture in encouraging and permitting bullying, which explains why some workplaces have higher levels than others. Among the factors identified as likely to lead to a bullying culture are: autocratic, target-driven management styles; poor job design; work intensification; and pressures arising from restructuring or organisational change, especially when radical and top-down.

Solutions to tackle B&U

Initiatives exist to tackle bullying and harassment in the NHS, but efforts to target racially charged B&U need to be embedded in these. [15] Formal anti-bullying policies and procedures may be insufficient. There have been very few formal evaluations of current interventions to stop bullying and harassment in the NHS or other healthcare settings. However, a recent evidence-based review of interventions to address workplace

bullying and harassment for the Advisory, Conciliation and Arbitration Service (ACAS) identified the limited effectiveness of the traditional approach of relying solely on formal anti-bullying policies and procedures.

The barriers to this succeeding include;

- Placing the onus on the bullied individual to formally report the problem when surveys and research show an unwillingness to;
- A reliance on formal complaints mechanisms prevents early resolution – a reluctance to impose formal sanctions on 'high value' individuals;
- A desire to avoid litigation or protracted formal proceedings which can result in pressure to find against the complainant or force them out; [25]
- The archaically hierarchical nature of medicine (especially hospital medicine), surgery, nursing and midwifery, which makes it hard for juniors to speak back or speak out;
- An abiding sense, even among some clinicians, that blame is an appropriate response to error;
- The legal perils and adversarial implications of being truthful;
- The pressures on management to be judged as 'well led' in the face of chronic staff shortages and financial pressures
- Multiplicity of different professions and professional pathways, each with its own silo mentality;
- Covert or inherit racism among some patients and relatives and even among NHS colleagues
- Gender preconceptions;
- Cultural differences (especially among first-generation migrant clinicians) such as different training approaches and language issues which give rise to misunderstandings or prejudice;
- Poor training of middle management in encouraging and rewarding candour;
- Resistance to change among senior clinicians;
- Multiplicity of organisations such as HEE, HEIs, medical Royal Colleges and NHS with different priorities;
- Tendencies by trusts and national agencies to tick boxes rather than ensure underlying cultural change.
- Minority ethnic people who have weaker ethnic identity or assimilation acculturation tend to experience more direct victimisation. [26]

It is recognised that comprehensive organisational approaches that focus on ensuring a cohesive culture of multi professional, collaborative team working, improved work-life balance, manageable workload, clarity of roles as well as responsibilities, blame-free learning environment, a concerted focus on well-being and investment in diversity and inclusion is essential for tackling inherent B&U.

Some good practice recommendations include:

- Developing behavioural standards in collaboration with employees and role-modelling through change laboratory methodology' [27]
- Demonstrating good behaviours by senior managers and staff;
- Accountability of senior leadership to robustly tackle cultural issues and negative behaviours an when behaviour is reticent to remove bullies from leadership roles;
- Early identification of bullying behaviours (e.g. through staff surveys, exit interviews);
- Acting on risk factors like poor management practices and excessive workloads;
- Empowering people to talk more openly about what is acceptable and unacceptable behaviour;
- Strong support structures for employees and managers (e.g. union representatives, bullying or fair treatment officers, occupational health);
- Encouraging informal resolution where appropriate, backed up by clear and accessible formal procedures for when early resolution does not work. [25]

How can minority ethnic organisations/ representation help

Arguably, the best way to tackle a culture of B&U within the healthcare system is from within. This requires the safety and mindset to foster a change laboratory with expert facilitation and extensive consultation. Occasionally, the environment is so toxic and the lack of trust so deep, that change laboratory suffers due to a lack of engagement and overwhelming fear of reprisals. Therefore when negative behaviours and perceptions of organisational inaction or tolerance of B&U are embedded in the psyche of the workforce, external and holistic solutions are needed.

One of the first interventions is to ensure psychological and physical safety for the victims. The Freedom to Speak-Up (FTSU) Guardian approach in hospitals is designed to provide a conduit for reporting bullying, and in some NHS trusts is used to support victims and press for satisfactory resolution. However, the NHS has not designed the FTSU system to intervene proactively, and some Guardians believe their role ends once their report has been passed on. Similarly, human resources (HR) should get involved to support victims, but HR staff sometimes see their role as administrative and managerial rather than in support of individual staff; or take what they regard as a balanced and neutral response to complaints of bullying, which can leave the complainant feeling exposed. Thus, many instances require the intervention of a truly external agency. These can take many forms, including formal agencies including HEE, GMC, CQC and the NHS England and NHS Improvement (NHSE/I). Most bullied individuals tend to voice their concerns through non-organisational support mechanisms, including trade unions, in preference to the systems created by employers to address bullying. Colleagues rarely offered overt support and union officials typically responded by providing indirect support to individual bullied members. Whilst unions may have limited power to alter managerially-derived solutions, there is some evidence that, where they engendered a collective response to allegations of bullying, perpetrators are more likely to be held accountable. [28]

The National Bullying Helpline is one such recognised advice centre, endorsed by several organisations founded in 2003 by employment law professionals to provide assistance to individuals struggling with bullying issues, whatever the nature of the abuse. It is essential that such organisations maintain the highest level of confidentiality while speaking out against systemic or individual abuse, including robust governance that ensures such standards. Third party interventions have a potential risk to individualise bullying allegations and may lead to a sense of impotence, injustice and lack of impartiality, serving to deflect bullying claims and exacerbate targets' suffering. [29]

However there is a role for independent organisations which represent specific groups of victims, such as women and ethnic minorities (Medical Women's Foundation, BAPIO and similar organisations). BAPIO has taken an active role previously in supporting its members in matters of employment dispute or victimisation through its arms length agency the Medical Defence Shield. More recently, it has taken on a proactive role in engaging with healthcare workforce in organisations struggling to improve their workplace behaviours. Such a collaborative intervention is likely to help those that are victimised to regain confidence and build trust. It is essential therefore that such employing organisations maintain a formal relationship with voluntary associations in addition to the trade union. This work needs to be collaborative and viewed as a tripartite alliance to tackle B&U, instead of being viewed as adversarial.

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