Bullying in Nursing: Trapped in History

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Finally, I want to thank the participants who contributed to this study. During a very difficult period in your lives, you all gave your time to speak your truth and, in doing so, will help so many more.

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Abstract

Workplace bullying is not a new phenomenon and the nursing profession in particular has experienced this form of incivility as a persistent problem. The continued prevalence of bullying in nursing has implications for the profession in terms of staff retention and burnout. Despite increasing awareness of the problem, there has been little shift in the pervasive culture of bullying in nursing. While much attention has been given to the presence and effect of bullying in the profession, little is known about how and why the phenomenon has evolved and persisted over time. This research aimed to investigate how bullying evolved over four decades in the nursing profession in Australia, and why it continues to exist. A historical approach was used, employing the testimony method of data collection. Testimonials from 70 registered nurses across Australia were collected online and by interview. Data were analysed using a three-dimensional analysis technique developed by the researcher. The findings are presented as a historiography to capture the collective meaning of all participants across dimensions of breadth, depth and time. The analysis identified four major categories: *antecedents to bullying*, *manifestations of bullying*, *responses to bullying* and *impacts of bullying*. While bullying is a complex problem that cannot be understood in isolation, the findings serve as a significant reminder of its oppressive, pernicious nature and ever-changing presence in Australia's nursing profession. Over the past four decades, and likely many decades prior, exposure to bullying has come to be normalised for registered nurses. The findings shed light on the significant role of nurse managers in preventing and managing bullying, yet they are often inexperienced and ill-equipped to recognise and respond to this significant problem. Bullying in nursing may be trapped in history, but an understanding of the changing antecedents, manifestations, responses and impact can provide an explicit roadmap for reform and emancipation.

Recommendations from this study address the dynamic and evolving factors that allow bullying to continue, and offer ways in which to address the problem of bullying in the nursing profession into the future.

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List of Abbreviations and Acronyms

CN	Clinical Nurse
GP	General Practitioner
EN	Enrolled Nurse
HR	Human Resources
HREC	Human Research Ethics Committee
JCU	James Cook University
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NUM	Nurse Unit Manager
RN	Registered Nurse

List of Key Terms and Definitions

In the table below, key terms and definitions applicable to this study and used in this thesis are clarified to ensure congruence between the writer and reader in context and understanding.

Term	Definition
Enrolled nurse (EN)	An individual who has completed the required education and clinical placement and is qualified to practise as an EN in Australia under national legislation (NMBA, 2016).
Nurse manager (NM)	The nurse manager oversees all aspects of the provision of nursing care within the health service.
Registered nurse (RN)	An individual who has completed the required education and clinical placement and is qualified to practise as an RN in Australia under the *National Law of the Health Practitioner Regulation* (ANMAC, 2012).

Table of Notations Used in the Thesis

Within this thesis, notations are used to promote readability. These are explained in the table below.

Notations	Definition	Use
T	Testimony	At the end of the participant quotations, these notations will be found and represent the data collection method.
I	Interview	
1–70		At the end of participant quotations, these notations are used to indicate the number assigned to identify the participant.
M	Male	At the end of participant quotations, these notations are used to identify and represent the gender of the participant.
F	Female	
[ ]	Square bracket	Inserted by the researcher within a quotation to explain details.

Prologue

Tracey (pseudonym) is a registered nurse who recently changed positions to my ward to broaden her experience. Unfortunately, the experience she gained was not limited to clinical practice. On this particular morning, Tracey was once again ridiculed for her handover. 'Why does she speak to me like that?' she asked. 'Why does it have to be like this? I can't take it anymore!', she uttered with a quivering voice. I take a deep breath. Very few people can survive working in an environment that is hostile and confrontational. People do not usually stay under those circumstances; they want to go somewhere they feel valued, can thrive and can make a difference.

The idea that nurses often aggressively bully each other probably shocks anyone not in healthcare. Unfortunately, it feels all too familiar to those of us who are. Nurses are acutely aware of the problem, but do not understand how or why the behaviour is set in motion, what keeps it moving or what can be done to stop it. Safe nursing practice is something that is instilled in every nurse. Yet, from my own experience, bullying creates an environment that is anything but safe for nurses.

In nursing, bullying has long existed; it was the ugly truth no one wanted to talk about. I am optimistic that this study will help change the conversation, and that we will increase our efforts in developing workplaces that inspire collegiality and respect. I hope that we commit to understanding this problem and start calling it what it is. The phenomenon has a pervasive nature and multidimensional complexity, which requires a thorough and evidence-based approach to eliminate it from the profession.

I do not want to minimise what happened with Tracey. I want Tracey to truly see and understand the forces that create and maintain this problem. It would be as much of a disservice to Tracey as it would be to nursing not to answer the questions she posed thoroughly and honestly. I believe there is an important story to be told. Bullying in

nursing is the dark side of the caring profession, and we desperately need to find another way.

Tracey's situation, in part, became the impetus for this thesis. Her experience, and the unique stories shared by study participants, are poignant reminders of our individual and collective need to remain vigilant for any form of bullying in our workplaces. I trust this thesis will assist with that process.

Chapter 1: Introduction

1.1 Introduction

‘Something needs to be done, urgently’ [T32F].

A silent epidemic, a rite of passage, secret turmoil—these are just a few of the evocative ways in which bullying in nursing has been described. Bullying by and between nurses in the clinical environment is widely acknowledged. It is unconscionable that, in the nursing profession today, the spectre of bullying remains. No nurse should have to accept or even tolerate a workplace where bullying happens. An understanding of how and why the problem exists is necessary if the profession is to develop effective strategies to address and prevent bullying in nursing. The purpose of this chapter is to outline the research described in this thesis. The chapter introduces the problem and research question to be explored, and discusses the significance of this study with background information relevant to bullying in the nursing profession in Australia. The rationale for selecting a historical approach as an appropriate methodology is provided, followed by an overview of the study design. The chapter concludes with an outline of the chapters that comprise this thesis.

1.2 Background and Significance

Bullying is a term usually associated with school playgrounds. However, the incidence of bullying in the workplace is growing and the effect, especially in the healthcare industry, is significant (Arnetz et al., 2019; Baillien et al., 2014; Butler et al., 2018; Hallberg & Strandmark, 2006). Several studies have shown that there are toxic conditions in many healthcare workplaces that encourage bullying (Renee, 2011; Skogstad et al., 2007; Tracy et al., 2006). A study by Kim et al. (2019) reported that bullying is a significant yet avoidable cause of stress at work, costing the Australian economy AU$10.11 billion per year (SafeWork Australia, 2013). The cost to the

organisation comes in the form of absenteeism; turnover; and reduction in morale, work and dedication to the organisation (Livne & Goussinsky, 2018; Oh et al., 2016; Rodwell et al., 2012).

Bullying is frequently characterised as verbal violence or criticism that is repeated, yet can present in covert behaviour, such as manipulation or talking behind the back of another (Hutchinson, Vickers et al., 2010; Laschinger et al., 2010). Regardless of the action, bullying is a deliberate and extreme form of mistreatment in the workplace. Bullying in the workplace appears to be nuanced and incorporates degrees of psychological cruelty (Franklin & Chadwick, 2013). Although the context may be different, bullying in healthcare is congruent with bullying generally. Bullying in healthcare is widely acknowledged, yet rarely admitted (Carter et al., 2013). It is also apparent in the literature that bullying in healthcare is treated as if it were a private matter (Berry et al., 2012; Gaffney et al., 2012).

Bullying has long existed in healthcare, and a focal point of research has been the nursing profession. Edmonson and Allard (2013) observed that most bullying in nursing is nurse to nurse, either between nurses horizontally or between nurses and supervisors vertically. Various degrees of bullying exist and represent a continuum of behaviours, with some extreme examples contributing to violent acts. Birks et al. (2017), for example, described how nursing students experienced sexual violence while on clinical placement. Clearly, bullying is harmful to the nurse, the profession and the organisation. The prevalence of workplace bullying is troubling, even more so because many such incidents are typically underreported (Hegney et al., 2010; Hutchinson, Vickers, et al., 2010; Hutchinson, Wilkes, et al., 2010). A lack of confidence in management and fear of retribution are the most common reasons for underreporting (Budden et al., 2017; Castronovo et al., 2016; Gaffney et al., 2012). Unfortunately, the

most common coping strategy—that of sharing the bullying experiences with relatives, friends or other colleagues—was described in a study by Hampton et al. (2019) as a mechanism that further leads to underreporting.

In Australia, nurses comprise the largest group of healthcare professionals (AIHW, 2016). In 2019, there were 265,335 registered nurses, according to the Department of Health (2014). Nurses play an essential role in ensuring the delivery of safe and efficient patient care. Workforce planning projections indicate that there will be a shortfall of approximately 25,000 nurses in Australia by 2025 (Health Workforce Australia, 2014). Thus, healthcare organisations need to eliminate components that negatively influence the recruitment, retention and work satisfaction of nurses, as well as nurses' mental and physical health, to ensure that nurses remain within the workforce and are able to perform at their optimum level. To build and sustain a high-performing, compassionate, healthy nursing workforce, eliminating bullying within the workplace is crucial.

The prevalence of bullying in the nursing profession is gaining increasing recognition internationally, with incident rates ranging from 17% to 76% (Spector et al., 2014; Vessey et al., 2010; Yildirim, 2009). An Australian study by Farrell and Shafiei (2012) found that 52% of nursing staff had experienced varying types of bullying behaviour. It seems that bullying has taken on a life of its own. In Australia, it has been reported that over 50% of nursing students experience bullying during their clinical placements (Budden et al., 2017; Curtis et al., 2007; Hopkins et al., 2014). Research has also indicated that bullying in nursing is so ingrained that nursing students often display the same behaviour as part of their professional integration into the role (Randle, 2003), contributing to the insidious and intransigent nature of the problem. For nursing students who are typically eager and willing to learn new ways of practice and thinking,

this is just another learnt activity. As is established in the following chapter, the empirical evidence demonstrating the prevalence of bullying in nursing is overwhelming and deeply troubling, and the profession can ill afford to tolerate it any longer.

While there is an important body of current research on the incidence and prevalence of bullying in nursing that has significantly contributed to understanding the effects of the phenomenon, bullying within the profession remains a persistent and pernicious problem. There is little substantive knowledge from Australian nurses on the factors that lead to or encourage a culture of bullying to continue. Still less is known about the detection, development and use of effective initiatives to counteract it. Therefore, this study aims to enable nursing leaders, educators and policymakers to better understand bullying in the Australian healthcare workforce. The findings will help inform strategies to address the problem in respect of policy, education and practice, and provide direction for future research. The background to the problem, laying further foundation to its significance, is explored in Chapter 2.

1.3 Methodology

To understand and make sense of the phenomenon of bullying in the nursing profession, this research is set within the qualitative paradigm. Research so located considers, explores, describes and clarifies the participants' subjective experience (Morrow & Smith, 2000). In this study, the qualitative approach provided the avenue by which to retell participants' experiences in a meaningful way by using narratives, rather than statistics, thereby making it possible to focus upon the socially constructed elements that shape bullying in the nursing profession.

A critical lens was used in this research because it draws attention to power imbalances and oppression within the healthcare environment (Kincheloe & McLaren,

2000). The strength of critical theory lies in its capacity to identify power differences within the population studied (Rosenberg, 1988). Critical theory research extends beyond describing 'what is' and towards describing 'what could be' (Kincheloe, 2000). Critical theory provides a basis from which to further unpack the dominant notion of bullying in this research by identifying social, political, cultural and economic factors that may be expressions of an underlying cause (Dahms, 2017).

The need for representation of participants' accounts of bullying lends itself to the use of a historical research methodology. Kerlinger and Lee (2000) defined historical research as a critical investigation of the ways in which the past shapes the future. Historical research seeks to discover new knowledge about what has happened in times past in relation to specific portions of time. Historical research—sometimes referred to as historiography—involves investigation of elements from history (Brink et al., 2006). Yuginovich (2000) suggested that history 'is probably a stronger force than language in the moulding of social consciousness' (p. 73) and that it is connected with power and political systems. The use of a historical research methodology in this study facilitated the elicitation of critical narratives that depicted bullying in nursing over time.

This study extends beyond the description and explanatory analysis that many previous studies provide. It offers a critical analysis of the factors that influence the actions of nurses, and the consequences of those actions, within the context of the nursing profession. It is an exploration of the history of contributing factors that have shaped a climate and culture where bullying is able to continue to flourish. The methodology guiding this study is discussed in detail in Chapter 3.

1.4 Study Design

This research explored the phenomenon of bullying in the nursing profession in Australia. Using a historical methodology, this research explored how bullying in the nursing profession in Australia evolved over four decades and describes the factors that have ensured its persistence. It will show how these factors varied according to context and over time, and why bullying has been enabled to continue. This study will demonstrate that the factors that contribute to the emergence and development of this phenomenon have varied according to context and over time. The findings highlight the importance of understanding the factors that contribute to the emergence and development of this phenomenon as key to implementing effective solutions.

Historical researchers suggest that a broad and vague research question can lead to a study that lacks direction and impact. Instead, they advocate for a research question that has boundaries and limits (Willis et al., 2016). When formulating the research question, Horsford and D'Amico (2015) suggested that a good historical question must be phrased in such a way that it does not predetermine the answer. Yin (2014) described the basic categorisation scheme for the types of research question as who, what, where, how and why. 'Why' questions lend themselves to historical research methods, as they are more explanatory in nature. The question that guided this research was: why does bullying continue to flourish in the nursing profession in Australia? Thus, the aim of this study was to determine the factors that contribute to bullying and allow it to persist in the various settings in which nurses are employed.

The study participants included current registered nurses in Australia who agreed to describe their experiences of bullying while working as a nurse. The Australian College of Nursing distributed the opportunity to participate in the study through their various networks and events. In this research, data collection was in the

form of testimony. Testimony is common in historical research. Wang et al. (2014) suggested that, as a method, testimony can be a powerful because it enables the researcher to discover, investigate and assess a phenomenon. Testimony, described as first-hand authentication of a fact (Goodman & Kruger, 1988), recognises a constantly changing perception of social reality as an evolving property of each person (Bryman, 2001).

Following approval from the James Cook University (JCU) Human Research Ethics Committee (HREC), participants were invited to present their testimony during an interview or alternatively online or via postal submission. Giving participants different options for telling their story ensured they were able to do so in the least threatening context. Questions were used to provide structure for the testimony—a strategy suggested by Morgan and Guevara (2008). Questions sought to encapsulate the experiences of bullying faced by nurses and to describe the wider context. Questions were drawn from the themes identified from the integrative review presented in Chapter 2. Demographic information was also collected (gender, age, location) with the testimony to inform the process of analysis. A total of 70 participants consented to participate in the study, and these are described in Chapter 5.

In this study, the challenge was to bridge the gap between analysed patterns of bullying and changes over time. In the spirit of a critical approach, it was of fundamental importance to this study to choose a method that would enhance the potential for change and encourage reform. A three-dimensional approach to analysis was conceived by the researcher as a means of achieving the thick description needed to fully capture the complex phenomenon of bullying, as reported by participants. This innovative approach offered a step-by-step process that generated highly organised results from the summarised data. The three-dimensional analysis was helpful to

manage the large amount of data and achieve a detailed, concise description of the entire dataset, without losing connection to the broader context. The three-dimensional analysis enabled a higher level of theoretical and analytical rigour, while also ensuring a degree of consistency. A detailed discussion of the study design is presented in Chapter 4.

1.5 Research Outcomes

In this study, findings are discussed as a historiography. Historiography provides a unique opportunity to capture the collective meaning of all participants across the dimensions of breadth, depth and time. The historiography developed from the analysis of the findings is significant because it identified factors that have contributed to bullying in the nursing profession over time and allowed it to flourish. This broader framework for understanding uncovered power relations within political, historical and ideological contexts that gave rise to the nursing environment in which these bullying experiences occurred. This analytical historiography is summarised in a published articled included in this thesis, with subsequent chapters exploring the major categories in detail. The findings are explored in Chapters 5 to 9 of this thesis.

The findings of this study are comprehensively considered in a discussion chapter that explores the evolution of bullying in the nursing profession. Historical factors linked to oppressive forces and behaviours reflect a context where nurse managers are often found to be unable to deal effectively with the persistent bullying problem. Often lacking the requisite personal and organisational resources, nurse managers are charged with handling the highly complex bullying epidemic, while experiencing significant performance-based pressure. Nurse managers have scope within their roles to proactively address bullying within the workplace, yet when they

fail to do so, they become part of the problem. A detailed discussion of the findings is presented in Chapter 10.

The findings described in this thesis have significant implications for the nursing profession. These implications give rise to recommendations that will inform future policy, practice, education and research to address the issue of bullying in the nursing profession. Implications and recommendations arising from this thesis are described and proposed in Chapter 11.

1.6 Thesis Overview

This thesis is organised into 11 chapters. An outline of each chapter is provided below.

Chapter 1: Introduction. This chapter has introduced the topic to be discussed and the study question to be addressed. It has presented an overview of the history of current knowledge in Australia that is important to bullying in the nursing profession, followed by an introduction to the methodology, study design and research outcomes.

Chapter 2: Background. The next chapter builds on the background for the study established in Chapter 1 and sets the scene for the subsequent analysis. The published articles contained in this chapter include an integrative review conducted to investigate bullying in the nursing profession in Australia and a scoping review discussing the definitions of bullying in Australia in the nursing profession.

Chapter 3: Methodology—Critical Historical Research. The ontological, epistemological and axiological perspectives that inform this study are explored in this chapter. Philosophical considerations that are important, including the use of critical theory as a philosophical lens, are described. With the aim of further validating its relevance to this study, the fundamentals of a historical approach are then presented.

Chapter 4: Study Design. This chapter further clarifies and justifies the design of this study, including the methods used in the analysis. A thorough explanation of data collection and analysis, followed by the ethical considerations in the conduct of this study, are presented. The chapter ends with a summary of how the study findings will be disseminated.

Chapter 5: Findings. A summary of the findings is presented in this chapter as an advanced organiser for the chapters that follow. Participant demographics are presented alongside the published historiography. This overview of findings is then examined in detail in subsequent chapters, with each reporting one of the four major categories of findings. In this way, reporting of findings offers a detailed, systematic understanding of the factors that have allowed the persistence of bullying in the nursing profession.

Chapter 6: Antecedents to Bullying. This chapter presents *Category 1: antecedents to bullying* and describes the contributing factors that have allowed bullying to persist over four decades.

Chapter 7: Manifestations of Bullying. This chapter presents *Category 2: manifestations of bullying* and maps how the face of bullying has changed over time.

Chapter 8: Responses to Bullying. This chapter presents *Category 3: responses to bullying*, describing the action taken in response to the bullying experience from both the participant and the organisational perspective.

Chapter 9: Impacts of Bullying. This chapter presents *Category 4: impacts of bullying* and exposes the extensive and enduring impact of bullying in the nursing profession.

Chapter 10: Discussion. In the context of established literature, this penultimate chapter considers the findings and situates them within the wider field of

knowledge. To consider the historical context in which bullying occurs, a chronological approach is used. The theory of oppression is then discussed and applied to the bullying epidemic in the nursing profession. The use of this framework helps to understand the changing and sustained nature of bullying within the nursing profession in Australia.

Chapter 11: Implications, Recommendations and Conclusions. The final chapter revisits the aim of this study and the methods used to address the research question. An evaluation of the study is provided to reassure the reader of the quality of the findings. Implications and related recommendations arising from the findings of this study are presented and discussed.

1.7 Conclusion

Bullying in nursing that is 'trapped in history' poses a significant threat to the profession today—a threat that must be overcome. This chapter has provided an introduction to this study by presenting the aim of the research and describing the background, which explained the context and significance of this research. The design of the study and the underlying philosophical framework have been outlined, and will be discussed later in this thesis. By expanding on the background, the following chapter will establish a detailed context for the research and provide an in-depth exploration of bullying in the Australian nursing profession.

Chapter 2: Background

2.1 Introduction

Chapter 1 introduced the significance of the study, along with the research aim, question and study design. This chapter explores the background of the existing knowledge about bullying in the nursing profession in Australia. In doing so, this chapter builds on the information outlined in Chapter 1 and is divided into two sections: integrative review and scoping review. An integrative review undertaken to examine bullying in the nursing profession in Australia is included as a published article. A published scoping review undertaken to explore the definitions of bullying in the nursing profession in Australia is then presented.

2.2 Integrative Review of Bullying in the Nursing Profession in Australia

Hartin, P., Birks, M., & Lindsay, D. (2018). Bullying and the nursing profession in Australia: An integrative review of the literature. *Collegian*, *25*(6), 613–619.

With reports of the incidence of bullying in the nursing workforce rising, bullying in nursing remains unacceptable. This article discusses the current state of awareness about bullying in the nursing profession in Australia. The approach by Whittemore and Knafl (2005) informed the analysis of bullying in the nursing profession in Australia. The results highlight the various ways in which the nursing profession's history of bullying are demonstrated and the effect on nurses and the profession. For nurses, educators and policy makers, the history, prevalence and effect of bullying discussed in this paper raises concerns. The contributing factors that enable the problem to continue must first be investigated to establish effective strategies for both nurses and organisations to address the problem of bullying in nursing in Australia.

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Bullying and the nursing profession in Australia: An integrative review of the literature

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ABSTRACT

Background: Bullying in nursing remains unacceptable with reports of bullying and harassment increasing.
Aim: This article discusses the current state of knowledge about bullying in the nursing profession in Australia.
Methods: The review was informed by the approach described by Whittemore and Knafl. A literature search was conducted using thefollowing search terms: 'nurse OR nursing OR nurses' AND 'bullying OR bully OR violence OR harassment' AND 'Australia'.
Findings: The findings highlight the many ways in which the experience of bullying in the nursing profession can be manifested and the implications for the profession as a whole.
Discussion: The culture, prevalence and impact of bullying described in this paper raises concerns for practitioners, educators and policy makers.
Conclusion: In order to develop effective strategies for both nurses and organisations to address the problem of bullying in nursing in Australia, the contributing factors that allow the problem to persist must first be examined.

1. Introduction

Workplace bullying is not a recent phenomenon, yet for the nursing profession it is a problem of increasing concern. As far back as 1987, Cox warned of the damaging nature of verbal abuse in nursing in the USA (Cox, 1987). Now 30 years on, the problem has clearly not diminished. Anecdotally, some nurses have compared their clinical setting to that of a battlefield and describe the environment in which they work as a place of professional turmoil. The insidious nature of the problem has seen it overlooked as a threat to the nursing profession and reduced to a belief that bullying is a 'rite of passage' (Birks, Budden, Biedermann, Park, & Chapman, 2018).

The prevalence of workplace bullying in the nursing profession is troubling (Allen, Holland, & Reynolds, 2015; Hegney, Eley, Plank, Buikstra, & Parker, 2006; Levett-Jones, Pitt, Courtney-Pratt, Harbrow, & Rossiter, 2015; Magin et al., 2011; Rodwell, Demir, Parris, Steane, & Noblet, 2012). International research indicates that bullying is widespread with 65% of nursing professionals in the US reporting frequently observing lateral violence among co-workers (Stanley, Martin, Michel, Welton, & Nemeth, 2007). Research in Turkey by Yildirim (2009) revealed that 21% of nurses had been exposed to bullying in the preceding 12 months. Further, in a survey of 3000 nurses in the United Kingdom, nearly 25% of respondents reported being bullied or harassed at work in 2005 (Lipley, 2006). Laschinger, Grau, Finegan, and Wilk, (2010) found that 33% of Canadian new graduate nurses had experienced workplace bullying in hospital work settings. These studies indicate the level of international concern about the magnitude of bullying in the nursing profession.

In the Australian context, a survey of registered nurses and midwives in Victoria found that 52% of nursing staff had witnessed some type of bullying behaviour (Farrell & Shafiei, 2012). The increasing presence of bullying in Australia is reflected in recent national and Nursing and Midwifery Board of Australia policies. On the 27th June 2013 Australia's federal parliament passed amendments to the Fair Work Act setting out new standards and specific provisions on workplace bullying (Australian Government, 2013). The Nursing and Midwifery Board of Australia has published a new Code of Conduct for Nurses, effective from 1st March 2018. This Code has a specific section on bullying, clearly stating a

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Summary of relevance
Problem or issue
Bullying is a recognised phenomenon in nursing. Some attempt has been made to examine the nature and extent of bullying in nursing, however it is important to integrate findings for greater awareness and understanding of bullying as a complex phenomenon in nursing.
What is already known
The statistics and prevalence of bullying in the nursing workforce is widely reported in the nursing literature.
What this paper adds
By synthesizing current research about bullying in the nursing profession in Australia this integrative review identifies gaps in the literature to focus future research.

zero-tolerance approach (Nursing & Midwifery Board of Australia, 2018).

Some attempt has been made to examine the nature and extent of bullying in nursing, as reflected in a number of empirical studies and reviews (see, for example, Farrell & Shafiei, 2012; Hutchinson & Jackson, 2015). Although this research has advanced our understanding of the incidence and prevalence of bullying in nursing, it is important to integrate these findings to better understand this complex phenomenon. Such understanding can inform the development of strategies to address the problem. To that end, this integrative review synthesizes current research about bullying in the nursing profession in Australia and identifies gaps in the literature to focus future research (Whittemore & Knafl, 2005).

2. Method

An integrative review was conducted to identify, appraise and examine literature exploring the problem of nurse to nurse bullying in Australia. An integrative review provides an avenue to systematically explore both experimental and non-experimental studies in order to describe the overall state of the evidence (Whittemore & Knafl, 2005). The integrative review framework, informed by Whittemore and Knafl (2005), was implemented because it enhances rigour when reviewing a combination of primary studies with various methodologies.

Search terms relating to bullying in nursing were reviewed and the following terms developed: 'nurse OR nursing OR nurses' AND 'bullying OR bully OR violence OR harassment' AND 'Australia'. The parameters for the search term were determined based on the definition provided by the Australian Human Rights Commission of workplace violence, harassment and bullying (Australian Human Rights Commission, 2011). Searches were conducted using the following electronic databases: (i) Medline, (ii) Cumulative Index to Nursing and Allied Health Literature (CINAHL) and (iii) Scopus (Fig. 1). The time period was limited to between January 1991 and December 2016. This timeframe was chosen as it represents when the search terms were first indexed. Inclusion and exclusion criteria are summarised in Box 1. Social and cultural context can influence the problem of bullying (Ariza-Montes, Muniz, Montero-Simó, & Araque-Padilla, 2013), therefore this review is limited to the situation in Australia. The potential confounding impact of numerous variables that define the profession internationally is reduced by containing the search to this specific jurisdiction.

2.1. Search outcomes and synthesis

In the initial search a total of 255 articles were identified. Each abstract was reviewed to determine if the publication met the inclusion/exclusion criteria. Articles retrieved from the initial search were hand-searched to limit bias and maximize the number of relevant studies identified (Whittemore & Knafl, 2005).

Box 1: Inclusion and exclusion criteria.
Inclusion
Published after 1991
Topic addressed nurse to nurse bullying
Primary research
Study location was Australia
Published in English language
Exclusion
Published after 2016
Topic did not address nurse to nurse bullying
Article other than primary research
Study location outside of Australia
Published in language other than English

Fig. 1 provides an overview of the identification, screening, eligibility and final inclusion of papers and follows the Preferred Reporting Items for Systemic Reviews and Meta-Analysis (PRISMA) schema. The final sample for analysis was 23 publications. From the 23 publications that met the inclusion criteria, data were extracted and organised according to year, author, study design (as identified by the authors), description of study sample and summary of key findings (Table 1). Whittemore and Knafl (2005) assert that there is no gold standard for appraising quality in research, with the use of a formal quality appraisal tool being more conducive to reviews in which the sampling frame and research design is identical. Owing to the heterogeneity of studies, quality was not evaluated comparatively. A modified version of the criteria suggested by Birks et al. (2014) was used to conduct a prima facie evaluation of papers that met the inclusion criteria, thus ensuring they were of a standard to justify their use. None were excluded as a result of this assessment.

The goal of data analysis is grouping the data into themes to identify patterns (Whittemore & Knafl, 2005). Qualitative data analysis software (NVivo) was used to manage the data and facilitate coding to identify these themes and patterns. The N7 + 1 pedagogy to write a literature review (O'Neill, Booth, & Lamb, 2018) and Domain and Taxonomic Coding (Saldaña, 2013) was used to construct a detailed index of major themes and commonalities identified across the articles, which were noted and categorised to capture important recurring concepts. The recurring concepts were then used to determine patterns within the data which informed the current thematic findings.

3. Results

A total of 23 papers were included in this review. These papers described 22 separate studies. Of these, 10 were descriptive, qualitative designs that employed various methods including surveys, interview, focus group and narrative analysis. 11 were quantitative. The remaining two studies used mixed methods. Where it was not explicitly stated, the study design has been interpreted. Results have been placed in chronological order to provide a trajectory of bullying research in Australia and facilitate interpretation of the results. The themes to which the studies relate are indicated in this table and presented graphically in Fig. 2.

3.1. Workplace culture

Bullying is so ingrained in the nursing profession that it now exists as *workplace culture*. Workplace culture refers to the social contexts that influence the way people behave and the social norms that are accepted. The nursing culture in Australia has been described as toxic, hostile and harmful (Hutchinson, Jackson,

Table 1
List of included studies.

	Data analysis matrix				
Author (year)	Study Design	Data Collection	Sample Description	Key Findings	Theme
Farrell (1999)	Quantitative	Questionnaire	270 nurses in Tasmania	Nurses from both the public and private sector were more worried about colleague aggression than aggression from other sources	Pervasive nature of bullying
Chaboyer et al. (2001)	Quantitative	Survey	555 Registered Nurses in three large territory Australian hospital	The item rated least positive was 'staff can be really bitchy towards each other' for both Level I and II/III nurses	Workplace culture
Deans (2004a)	Qualitative	Phenomenological approach	33 nurses in Victoria	The feeling of professional incompetency, the expectation to cope and emotional confusion	Impact
Deans (2004b)	Quantitative	Survey	380 nurses in Victoria	Perception nurse managers not interested	Impact
Hutchinson et al. (2005)	Mixed methods	In-depth, semi-structured interviews	16 interviews	Bullies could co-opt organizational processes with the intentional outcome of harming targets	Impact
Farrell et al. (2006)	Quantitative	Questionnaire	2407 nurses in Tasmania	Majority of respondents experienced bullying, influence on desire to stay and their productivity and potential for errors yet were reluctant to make their complaints official	Impact
Hegney et al. (2006)	Quantitative	Survey	1349 Queensland nurses	Increasing reports of workplace violence	Pervasive nature of bullying
Hutchinson et al. (2006)	Qualitative	In-depth, semi-structured interviews	26 nurses recruited from two Australian organizations: a rural and a metropolitan health service	Relationships between bullies were embedded within informal organisational alliances, enabling bullies to control work teams and means of enforcing rules of work	Workplace culture
Eagar et al. (2010)	Qualitative	Focus groups	30 Registered nurses and Enrolled nurses in New South Wales	Nurses reported that confusion surrounding scope of practice particularly in the areas of medication administration, patient allocation and workload result in situations whereby nurses feel bullied, stressed and harassed.	Workplace culture
Hegney et al. (2010)	Quantitative	Cross-sectional survey	1192 Queensland nurses	Existence of workplace policy did not decrease levels of workplace violence	Pervasive nature of bullying
Hutchinson, Vickers, Wilkes, and Jackson, (2010)	Qualitative	In-depth, semi-structured interviews	26 nurses from two Australian area health services	The typology of behaviours provides detailed insights into the complexity of bullying experienced by nurses	Pervasive nature of bullying
Hutchinson, Wilkes et al. (2010)	Mixed methods	Survey	370 across Australia	Organisational characteristics were confirmed to be critical antecedents of bullying	Pervasive nature of bullying
Jackson et al. (2010)	Qualitative	Narrative inquiry	18 nurses	Reported the need to facilitate a climate in which it is safe for nurses to raise concerns	Impact
Opie et al. (2010)	Quantitative	Cross sectional questionnaire	349 nurses	Increasing incidence of violence in the workplace	Pervasive nature of bullying
Demir and Rodwell (2012)	Quantitative	Cross-sectional survey design	207 nurses and midwives from a large Australian hospital	High frequencies of reported exposure to workplace bullying and internal and external emotional abuse violence types. In terms of antecedents, bullying was linked to high negative affectivity (NA), as well as low supervisor support and coworker support	Impact
Farrell and Shafiei (2012)	Qualitative	Questionnaire	1495 nurses in Victoria	32% experienced bullying from colleagues	Workplace culture
Rodwell and Demir (2012a)	Quantitative	Cross sectional survey	273 nurses at 1 Australian hospital	Psychological distress was noted as an impact of bullying	Workplace culture
Rodwell and Demir (2012b)	Quantitative	Cross sectional questionnaire	233 hospital nurses and 208 aged care nurses	High levels of bullying and concerning levels of emotional abuse	Impact
Rodwell et al. (2014)	Quantitative	Cross sectional survey	250 nurses across 5 Australian hospitals	Abusive supervision impacted nurse outcomes	Impact
Hutchinson and Jackson (2015)	Qualitative	Cross-sectional survey	3345 respondents in one state of Australia	Tension between workplace policy and embedded institutional practices; chronic from the top level down	Workplace culture
Terry et al. (2015)	Qualitative	Phenomenology narrative inquiry	15 community nurses 13 health facilities in Tasmania	Vertical violence identified as the biggest issue that impacts on health	Workplace culture
Hurley et al. (2016)	Qualitative	Cross-sectional study	3345 respondents in one state of Australia	Palpable mental distress and illness stemming from exposure to workplace bullying	Workplace culture

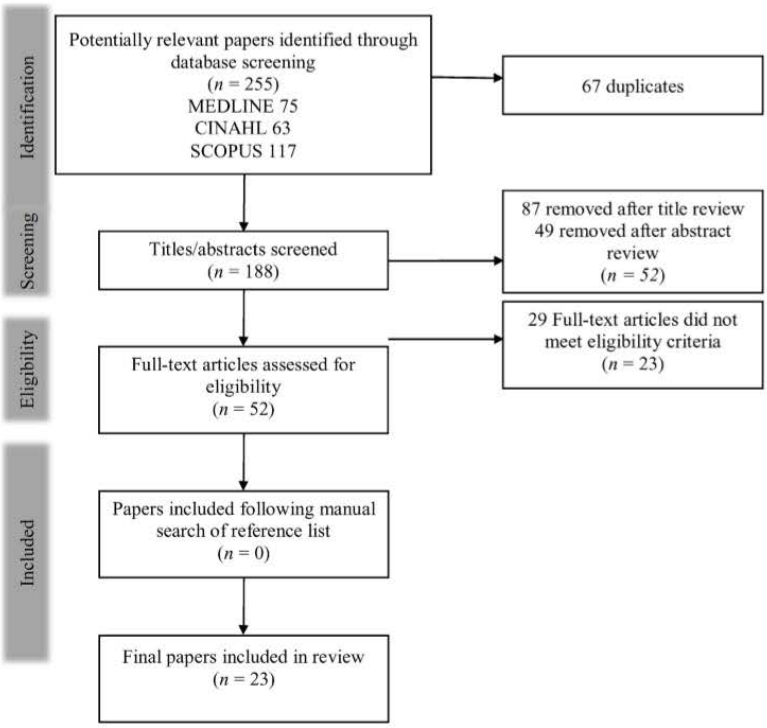

Fig. 1. PRISMA flow chart summarising search and outcomes.

Fig. 2. Themes derived from the literature.

Wilkes, & Vickers, 2008; Rodwell & Demir, 2012a), and fueled by cliques of power, inflated personalities and displaced aggression towards one another. Differentials of power between nurses has been suggested as a contributor to a workplace culture of bullying among nurses. Hurley, Hutchinson, Bradbury, and Browne, (2016) describe power as a central mechanism for bullying behaviour. However, the differentials of power are evident not only between the novice nurse and senior nurse but also within groups of nurses who hold equal positions (Chaboyer, Najman, & Dunn, 2001). Hutchinson, Vickers, Jackson, and Wilkes, (2006) study provides a fascinating insight into the power relations of nurses, including how bullying behaviour is often a function of peer group formation. Farrell and Shafiei (2012) later reported that a perpetrator's own personality is a key contributing factor to the bullying culture in nursing. In addition, Hutchinson and Jackson (2015) revealed a nursing culture that sustained a power dynamic of distortion, fueled by competing truth claims and silencing.

Displaced aggression and stress towards one another is often the result of the workload required of nurses (Terry, Le, Nguyen, & Hoang, 2015). Bullying occurs because nurses either overtly or covertly redirect their dissatisfaction towards each other. Rodwell and Demir (2012a) found there was a positive relationship between the work schedule of morning shift and bullying, with morning shift workers more inclined to experience this behaviour. Variations in work distribution across these shifts may feed the problem, as Eagar, Cowin, Gregory, and Firtko, (2010) found that perceived inequities in the distribution of the day-to-day workloads was a contributing factor in bullying.

3.2. *Pervasive nature of bullying*

The *pervasive nature of bullying* in the nursing profession in Australia is a matter of significant concern. The increasing preva-

lence and experience of bullying in the nursing profession is the most prevalent theme in the literature. Opie et al. (2010) reported a statistically significant increase in the incidence of bullying between 1995 and 2008 and Farrell (1999) found nurse-to-nurse aggression as the most distressing type of bullying to deal with. Hegney et al. (2006) reported significant evidence from 2001 to 2004 of the percentage of nurses citing other nurses or nursing management as a source of bullying incidents. Allen et al. (2015) set out to explore the relationship between bullying and burnout with 61% of respondents reporting they had experienced bullying within the last 12 months. When read as a single discourse, these studies reinforce the pervasive nature of bullying and the notion that many nurses work within a culture that features bullying. Most agree that these statistics are likely to be underreported (Hegney, Tuckett, Parker, & Eley, 2010; Hutchinson et al., 2010; Hutchinson, Wilkes, Jackson, & Vickers, 2010). The experience of bullying by nurses includes threats, personal attacks or attack through work roles (Hutchinson, Vickers, Jackson, & Wilkes, 2005; Hutchinson, Vickers, et al., 2010).

3.3. Impact

The workplace culture and pervasive nature of bullying has a significant negative *impact* on the nurse, profession and organisation. For the nurse, bullying effects each dimension of the individual: psychological, physical, emotional and social. Bullying increases the prevalence of psychological distress and depression (Rodwell & Demir, 2012b) resulting in significantly higher levels of burnout. The aggressive and destructive nature of bullying can undermine the professional confidence of the nurse and decrease self-worth (Deans, 2004a, 2004b). In addition, it can create powerlessness, decrease motivation and damage the nurse's work ethic.

Professionally, bullying decreases job satisfaction with the intent to quit among nurses significantly impacted as a result of these experiences (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014). Hutchinson et al. (2005) reported many nurses considered leaving their current position or reducing workload hours as a result of bullying. In their study on workplace aggression among nurses, Farrell, Bobrowski, and Bobrowski (2006) reported 24% of respondents had considered resigning during the preceding four working weeks. Bullying in nursing compromises the standards of care. Farrell, Bobrowski, and Bobrowski, (2006), for example, reported that bullying frequently contributed to the potential to make errors and a decrease in productivity.

In such an environment of decreased job satisfaction and decreased productivity, the impact of bullying also permeates the organisation. Organisations suffer when such a culture creates a hostile workplace (Jackson et al., 2011) and higher turnover of staff. Furthermore, from a functional perspective, organisations have to deal with increased absenteeism (Farrell et al., 2006; Terry et al., 2015), decreased productivity (Hegney et al., 2010) and recruitment and retention difficulties (Farrell et al., 2006; Hegney et al., 2006; Hutchinson et al., 2005).

4. Discussion

As can be seen from Fig. 2, a workplace culture of bullying increases the pervasive nature of this hostility and impacts negatively on the individual, the profession and the organisation. As Daiski (2004) identified, bullying is fuelled by a lack of respect, poor intra-professional relationships and mutual non-supportiveness. Even nursing students begin to adopt bullying into their own practice. Research suggests that bullying in nursing is so culturally integrated into the workplace that nursing students can quickly learn to become bullies as well (Randle, 2003). For nursing students who are typically eager and willing to learn new ways of practice and thinking, it becomes one more learned behaviour.

In today's healthcare environment, in which professional autonomy and independence are crucial, nurses are gaining increased momentum in authority. This shift results in power struggles (Hutchinson & Jackson, 2015), hierarchy differentials (Eagar et al., 2010) and differing attitudes (Demir & Rodwell, 2012) where team cohesion gets destroyed and a bullying culture rears its ugly head. Power imbalances can then occur when groups of nurses in a workplace unconsciously (and also consciously) adopt inflated feelings and attitudes of superiority, even when performing the same or similar role. Bullying in nursing is rarely one-to-one; evidence indicates that there are usually many nurses involved in a bullying incident (Hutchinson et al., 2006, 2008; Lewis & Orford, 2005). Without such a cultural milieu a bully would find it difficult to maintain their bullying behaviour without the support of peers.

This review reinforces the many ways in which the experience of bullying in the nursing profession can be manifested. Bullying can be expressed in an overt, blatant fashion or covertly in a more insidious, subtle manner in forms of silencing and exclusion (Jackson et al., 2011). Regardless of how it is manifested, the impact of bullying upon those bullied can be linked to low self-esteem, anxiety, increased sick leave, impaired concentration, changed work environment, resignation from a position, leaving nursing completely or worse still, depression and even suicide. Each individual incident of workplace bullying may seem inconsequential, but over a period of time, it can erode the self-confidence and self-esteem of the employee. Workplace bullying can also create physiological symptoms such as hypertension, cardiac palpitations and irritable bowel syndrome (Hallberg & Strandmark, 2006).

The trajectory of bullying in Table 1 reveals that the pervasive nature of bullying in nursing is gaining increased recognition. The nursing profession is subject to the growing prevalence of bullying and its resultant contagious effects. The literature examined in this review suggests that the phenomenon has no boundaries or affinity for any particular nursing workplace or location. This literature is part of a significant international body of work that has greatly contributed to our understanding of this complex phenomenon, yet bullying remains a major concern for the profession as the consequences are widespread.

Job satisfaction among nurses drops significantly as a result of bullying and this has an impact on career directions, which also shapes the public's perception of the nursing profession. Given the critical shortage and maldistribution of the nursing workforce internationally (Guo et al., 2018), this is concerning. Issues in relation to recruitment and retention of nurses in the workforce, particularly in rural and remote areas, have been a major concern for professional organizations, policy makers and Governments, both within Australia and internationally (Hayward, 2016; O'Brien-Pallas, 2006). Major flow-on effects from the turnover of staff include the financial costs associated with employing and orientating new staff, and the potentially de-stabilizing impact that a changing staff mix has upon an organization. Importantly, unless the bully is reported they are unlikely to be the one leaving the organization.

Ultimately, the impact of bullying on the person, profession and organisation jeopardises patient safety and care. Laschinger (2014) found that workplace mistreatment can have detrimental effects on patient safety. It is challenging to deliver compassionate, quality care if nurses are working in an environment of intimidation, humiliation and power imbalance. In such an environment, teamwork, collaboration, and communication are impaired. This culture can influence communication between nurses which ultimately threatens patient safety (Embree & White, 2010).

The culture, prevalence and impact of bullying described in this paper raises concerns for practitioners, educators and policy mak-

ers. Although anti-bullying policies do exist, research indicates that nurses feel unsupported and rarely utilise the policies in place. In the UK, Carter et al. (2013) found that of the staff who experienced bullying, only between 2.7% and 14.3% reported it.

5. Recommendations and limitations

Many of the studies examined in this review used terms relating to bullying that were poorly defined. The lack of a clear definition prevents a full understanding of this construct and makes drawing comparisons between studies difficult. Of those studies that have presented definitions of bullying, some have used global definitions taken from workplace policies; others have tried to make the definition specific to the healthcare environment and still others have included specific definitions of direct and indirect bullying. Although this review has confirmed that bullying in nursing is pervasive, the definition of bullying varies among researchers and the construct of bullying has yet to be consistently defined.

Future research on bullying should seek to identify trends in the broader population regarding how and why bullying occurs and how these relate to the problem in nursing. Such research could also establish what Australian nurses themselves conceptualise as bullying behaviours. Researchers should consider asking how factors such as the cultural foundations of the nursing profession in Australia have allowed bullying to continue. Only then can the profession identify strategies for the prevention of bullying and effective interventions to address the problem when it occurs.

6. Conclusion

Bullying in the nursing profession continues to be a problem resulting in negative impacts on the individual, profession, organization and, most importantly, patients. Determining the true extent of bullying among the nursing profession is difficult and is largely dependent on how bullying has been measured and the definition that has been used in existing work in this area. It is clear, however, that the problem exists to such an extent that there is a risk of it being normalized in the profession. The pervasive bullying culture in nursing can destroy nurses, the profession and ultimately place patients at risk. The review of empirical research presented in this paper can enhance our understanding of the nature and extent of bullying in the nursing profession in Australia. There is little substantive data from Australian nurses on why bullying is allowed to continue and the identification, development, and use of practices to counter it. If nurse leaders, educators and policymakers aim to develop effective strategies to address the problem, they first must understand bullying in the Australian nursing workforce and the contributing factors that allow the problem to persist.

Conflict of interest

The authors declare no conflict of interest in this study.

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2.3 Scoping Review of the Definition of Bullying in the Nursing Profession in Australia

Hartin, P., Birks, M., & Lindsay, D. (2019). Bullying in nursing: Is it in the eye of the beholder? *Policy, Politics, & Nursing Practice*, *20*(2), 82–91.

Through a scoping review of definitions provided in the literature published until 2018, this article offers a detailed overview of the phenomenon of bullying in the nursing profession in Australia. The research questions used to guide the search were as follows: How in the literature is the definition of bullying in nursing in Australia conceptualised? How do the definitions vary with these concepts of bullying? How has the concept of bullying grown over time, as used in literature? Arksey and O'Malley's (2005) approach was used to identify clear definitions of bullying as found in the nursing literature. The results indicate that, over time, the conceptualisation of bullying has become more dynamic in the nursing profession. However, a shared and cohesive distillation of the essence of bullying in the nursing profession was not expressed in the literature examined.

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Bullying in Nursing: Is it in the Eye of the Beholder?

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Abstract

The nursing profession is presented with numerous definitions of workplace bullying. This study provides an in-depth analysis of the concept of bullying in the nursing profession in Australia through a scoping review of definitions presented in literature published up until 2018. The research questions used to guide the search were as follows: How has the definition of bullying in nursing in Australia been conceptualized in the literature? How do these definitions of bullying differ? How has the definition of bullying, as used in the literature, evolved over time? The review was informed by the approach of Arksey and O'Malley, containing explicit definitions of bullying in nursing literature. The findings reveal that the literature does not reflect a shared and integrated vision of the exact nature of bullying in the nursing profession. The conceptualization of bullying in the nursing profession has become more dynamic over time. The myriad ways in which bullying in nursing is defined in Australia has important implications for research, practice, education, and policy.

Keywords

bullying, nursing, Australia, policy, workplace

Research on bullying in the nursing profession has increased substantially since the early 2000s. The focus of research has primarily been on identifying the forms that bullying can take (Cleary, Hunt, & Horsfall, 2010; Hutchinson, Vickers, Wilkes, & Jackson, 2010; Rodwell & Demir, 2012), measuring the prevalence of bullying (Birks et al., 2017; Evans, 2017; Hegney, Eley, Plank, Buikstra, & Parker, 2006), and reporting on the consequences of the phenomenon (Ariza-Montes, Muniz, Montero-Simó, & Araque-Padilla, 2013; Franklin & Chadwick, 2013; Speedy, 2006; Yildirim, 2009). Some researchers have explored the organizational precursors or workplace antecedents of bullying (Baillien, Bollen, Euwema, & De Witte, 2014; Skogstad, Matthiesen, & Einarsen, 2007), and more recently, others have studied nursing students' experiences of bullying during their clinical placements (Budden, Birks, Cant, Bagley, & Park, 2017; Hogan, Orr, Fox, Cummins, & Foureur, 2018). The Nursing and Midwifery Board of Australia (NMBA) Code of Conduct for Nurses (2018) has a specific section on bullying, clearly recognizing the presence of the problem in Australia. Bullying is one of the most serious threats to the nursing profession as it has the potential to jeopardize patient safety (Hartin, Birks, & Lindsay, 2018), yet it continues, at times, to be dismissed as a rite of passage (Birks, Budden, Biedermann, Park, & Chapman, 2018). Despite substantial advances in the knowledge of bullying, one of the most challenging issues facing researchers is the development of an accepted definition (Galperin, 2014).

Lack of a clear definition prevents the clear and consistent conceptualization of the phenomenon of bullying in nursing, thereby complicating potential collaboration among researchers and practitioners, and contributing to an inconsistency in findings across studies (Hartin et al., 2018). Definitions that exist are often vague and contradictory—reflecting the complexity of bullying in the

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workplace and the diverse meanings of bullying to those who witness or experience it. The difficulties in defining bullying behaviors, precursors, and effects highlight the complexity of the phenomenon. Furthermore, lack of a clear definition of bullying raises considerable challenges when attempting to identify the nature and measure the prevalence of the problem. Prevalence rates of bullying in the Australian nursing workforce show that the proportions can vary from 21% (Yildirim, 2009) to 82% (Dumont, Meisinger, Whitacre, & Corbin, 2012) depending on the definition used and the workplaces involved (Chatziioannidis, Bascialla, Chatzivalsama, Vouzas, & Mitsiakos, 2018). In addition, the lack of a clear national definition reduces the ability to effectively synthesize findings from studies.

Definitional ambiguity in relation to bullying has implications for identifying and addressing factors that contribute to the problem in the nursing profession. Lutgen-Sandvik and Tracy (2012) suggest that bullying is in a state of denotative hesitancy, referring to the initial difficulty in naming experiences when there is no widely agreed language from which to draw.

Given the reported prevalence of bullying, and increase in national attention being paid to the health and well-being of the nursing workforce more broadly, this scoping review of published definitions is timely. In this review, we aim to acknowledge and illustrate the wide range of conceptualizations of bullying in the nursing profession in Australia, describe the differences and similarities of the multiple perspectives, clarify the dimensions of the concept, and highlight the evolution of this phenomenon. The review is confined to the Australian literature to reduce the potential for variables specific to this location (e.g., duration of training) to impact the interpretation of the finding.

Methods

The method we employed for this scoping review utilized the five-stage process described by Arksey and O'Malley (2005). A scoping review is an effective way to rapidly map the key concepts underpinning a research area and identify gaps and innovative approaches (Levac, Colquhoun, & O'Brien, 2010). Arksey and O'Malley (2005) presented a clearly defined approach to conducting scoping reviews. Undertaking a scoping review is not a linear process; rather, it employs a recursive approach that requires the reviewer to move back and forth between early work and new insights. This approach ensures clarity and consistency when reporting thematic analysis results. Arksey and O'Malley (2005) stress that a scoping review does not involve an assessment of the quality of the primary studies. We used five stages of the Arksey and O'Malley's (2005) framework to scope the definition of bullying as evidenced in nursing literature in Australia published up until the end of 2017. The five stages are (a) identifying the initial research questions; (b) identifying relevant studies; (c) study selection; (d) charting the data; and (e) collating, summarizing, and reporting the results.

Identifying the Initial Research Questions

The research questions used to guide the search were as follows: How has the definition of bullying in nursing been conceptualized in the Australian literature? How do these definitions of bullying differ? How has the definition of bullying, as defined in the literature, evolved over time?

Identifying Relevant Studies

Search terms relating to the definition of bullying in nursing were reviewed and the following terms developed in conjunction with a librarian: *nurse* OR *nursing* OR *nurses* OR *nursing staff* AND *bullying* OR *bully* OR *violence* OR *harassment* AND *Australia* AND *definition* OR *define*. We searched four electronic databases: (a) Medline (OVID), (b) Informit Databases, (c) Scopus, and (d) Google Scholar (Figure 1). In being as comprehensive as possible in the identification of definitions, inclusion and exclusion criteria were developed and are outlined in Table 1.

Study Selection

Using the key search descriptors, 120 literature citations were identified. Of these, 17 were duplicate articles across the four databases. Guided by the inclusion criteria, 84 articles were identified as being relevant to the topic. Full-text versions of these were obtained and reviewed, providing an opportunity to identify any additional relevant literature from a review of the references lists (ancestry approach). The process of literature selection followed the Preferred Reporting of Items for Systematic Reviews and MetaAnalyses Statement (Moher, Liberati, Tetzlaff, Altman, & Group, 2009; Figure 1). During the process of literature selection, several articles were excluded, specifically, those that used the same definition as the Australian Government Fair Work Act (Australian College of Nursing, 2016; Farrell & Shafiei, 2012; Potter, Dollard, & Tuckey, 2016). The first author reviewed the articles, and the analysis was overseen by the other authors who had more experience in the scoping process.

Charting the Data

The fourth stage of Arksey and O'Malley's (2005) scoping review framework involves the charting of selected literature.

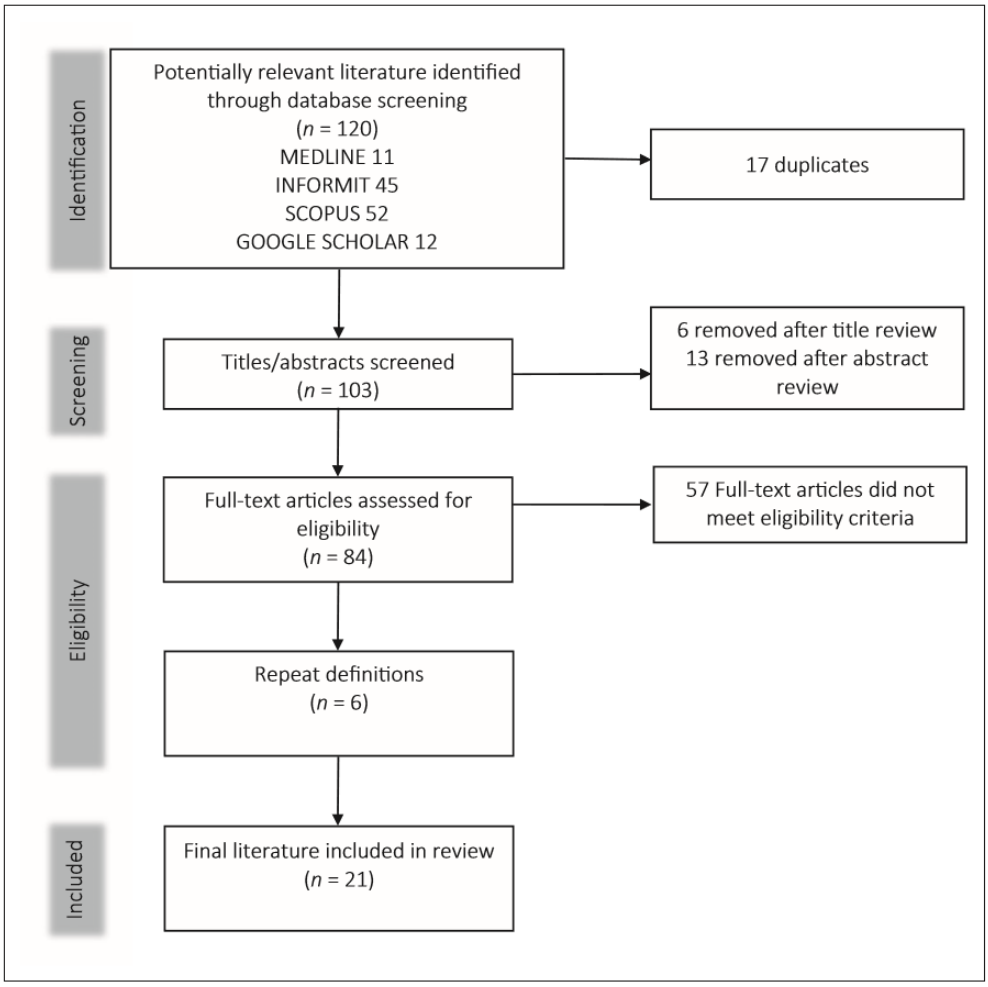

Figure 1. Preferred Reporting of Items for Systematic Reviews and MetaAnalyses (PRISMA) flow chart summarizing article selection process (Moher, Liberati, Tetzlaff, Altman, & Group, 2009).

Table 1. Criteria for Inclusion of Literature in Scoping Review.

Criteria	Inclusion
Type of document	Original research, policy, book
Language	English
Bullying definition	Provided in literature
Location	Published in Australia

The general characteristics of literature included in this study are reported in Table 2. The year 2000 was the earliest publication date of any article that met the inclusion criteria. All included literature was published between 2000 and 2018, with 66.7% (14/21) published after 2010. Journal articles (76.2%; 16/21) comprised the majority of literature included in the review. Other sources included organizational policy documents (14.2%; 3/16), government policy documents (4.8%; 1/21), and books (4.8%; 1/21). An overview of the definitions obtained from the literature is presented in Table 3.

Collating, Summarizing, and Reporting the Results

The fifth and final stage of Arksey and O'Malley's (2005) scoping review framework summarizes and reports results. Results of this scoping review are described in the following section.

Table 2. Scoping Review Results Through March 2018 by Year and Type of Publication (Number and Percentage).

Characteristic	Number	Percentage
Publication year		
<2000	0	0.0
2000–2004	2	9.5
2005–2009	5	23.8
2010–2014	9	42.9
2015–March 2018	5	23.8
Publication type		
Journal article	16	76.2
Government policy	1	4.8
Organizational policy	3	14.2
Book	1	4.8

Findings

This review revealed no universally accepted definition of bullying in the nursing literature for research conducted in Australia. Many authors emphasized the myriad meanings of the term with no single, accepted definition. Few definitions were broadly recognized and integrated into the reviewed literature. Of the published definitions, only the one in the Australian Government Fair Work Act (2009), "repeated and unreasonable behaviour directed toward a worker or a group of workers that creates a risk to health and safety," was cited more than once, appearing in 25.9% of the literature analyzed.

Despite the lack of a universally accepted Australian definition, there were three common themes underpinning how authors characterized bullying. Table 4 displays the three key themes of action, temporality, and outcome identified in the 21 original definitions of bullying in the literature relating to the nursing profession in Australia.

The *action* theme includes the types of behavior that are characterized as bullying (experience, behaviors, and perceptions). As shown in Table 4, all of the definitions in the reviewed literature made reference to some type of action. These studies described several specific workplace behaviors that were seen to typify bullying among nurses. Earlier studies (prior to 2009) largely referred to offensive language and public humiliation, while by contrast, more recent literature included a greater focus on psychological bullying.

The *temporality* theme describes the frequency and duration of bullying, for example, whether it was daily, often, persistent, gradual, constant, cumulative, prolonged, or repetitive. Many definitions of bullying require it to be a repeated phenomenon (Allen, Holland, & Reynolds, 2015; Australian Nursing and Midwifery Federation, 2011; Eagar, Cowin, Gregory, & Firtko, 2010; Australian Government, 2009; Hutchinson & Jackson, 2015; New South Wales Government, 2011; NMBA, 2018). Prior to the Australian Fair Work Act (2009) definition outlining a repeated behavior, the term *repeated* was not included in definitions reviewed for this study.

The *outcome* theme considers the result of the action on those being bullied. Regardless of the behavior perpetrated, the outcome can result in a host of problems including, but certainly not limited to, humiliation, distress, and feeling intimidated, all of which might be harmful to a person's safety and well-being. Similar to the action theme, over time the literature tended to include a greater focus on psychological distress (Australian Nursing and Midwifery Federation, 2011; Birks et al., 2018; Cleary, Walter, Horsfall, & Jackson, 2013; Evans, 2017).

Discussion

This is the first known scoping review to examine definitions of bullying among nurses in Australia as described in the literature. The lack of a universally accepted Australian definition of bullying in nursing is problematic for several reasons. First, the use of varying definitions limits the opportunity to compare findings of studies or to draw conclusions. The evolving nature of the phenomenon and associated definitional opacity has contributed to these difficulties. Second, the inconsistency of definition creates confusion when attempting to assess cases of bullying. D'Souza, Forsyth, Tappin, and Catley (2018) claim that the ability of managers to deal with such cases is flawed by the complexity of definitions of bullying within the nursing context. Finally, the variations in definition also contribute to difficulties in recognizing and describing instances of bullying with any clarity and certainty.

Three key themes that characterize definitions of bullying were identified in this review. Despite these thematic similarities, there remains no universally accepted way of defining bullying in the nursing profession in Australia, nor indeed of evaluating its impact. The conceptual framework presented in Figure 2 is a tool that begins to integrate the dimensions of bullying in the nursing profession.

Action

One feature common to all definitions of bullying within the reviewed literature was the experience of negative actions, consisting of a diverse array of negative behaviors, ranging from overt to subtle. Two modes and four types of bullying were identified in the scoped literature. The two modes of bullying were direct (Douglas, 2014) and indirect (Hutchinson,Vickers, Jackson, & Wilkes, 2006;

Table 3. Results of Scoping Review by Author, Year of Publication, and Bullying Definitions.

Author (Year)	Definition
Hockley (2000)	Less-favorable treatment of a person by another in a workplace, beyond that which may be considered reasonable and appropriate workplace practice.
Bray (2001)	Form of harassment which involves persistent, intimidating behavior, usually by a supervisor toward an employee.
Hutchinson, Vickers, Jackson, and Wilkes (2006)	Deliberate and ongoing array of often subtle and masked negative behaviors and actions that accumulate over time. Bullying in the workplace has been characterized as a gradual, often invisible, and an intensely individualized and harmful experience.
Speedy (2006)	Persistent criticism and personal abuse which humiliates and demeans the individual, gradually eroding their sense of self.
Hutchinson, Wilkes, Vickers, and Jackson (2008)	A range of behaviors that are often hidden and difficult to prove. Perpetrators aim to harm their target through a relentless barrage of behaviors that may escalate over time and include being harassed, tormented, ignored, sabotaged, put down, insulted, ganged-up on, humiliated, and daily work life made difficult.
Fair Work Act (2009)	Repeated and unreasonable behavior directed toward a worker or a group of workers that creates a risk to health and safety.
Hutchinson (2009)	Bullying takes three main forms: erosion of professional competence and reputation, personal attack, and attack through work roles and tasks.
Dietsch, Shackleton, Davies, McLeod, and Alston (2010)	Behavior that is perceived as uncaring, cold, callous, threatening, abusive, and aggressive.
Eagar, Cowin, Gregory, and Firtko (2010)	Repeated, abusive, intimidating, or insulting behaviors; abuse of power or unfair sanctions that make recipients feel humiliated, vulnerable, or threatened.
Field (2010)	Workplace bullying involves the repetitive, prolonged abuse of power. Unwelcome, unreasonable, escalating behaviors are aggressively directed at one or more workers and cause humiliation, offence, intimidation, and distress.
Australian Nursing and Midwifery Federation (2011)	Bullying is repeated unreasonable behavior directed toward an employee or group of employees that creates a risk to the psychological or physical health or safety of the employee(s).
New South Wales Government (2011)	Workplace bullying means behavior which is offensive, intimidating, intended to humiliate, or threatening and is directed at a staff member or a group of staff members, and occurring in the course of or related to work. Workplace bullying will generally meet the following criteria: 1. It is repeated and systematic (although a serious single incident can also constitute bullying) 2. It is unwelcome and unsolicited 3. The recipient considers the behavior to be offensive, intimidating, intended to humiliate, or threatening 4. A reasonable person would consider the behavior to be offensive, intimidating, intended to humiliate, or threatening.
Rodwell and Demir (2012)	An individual's perception of receiving and having difficulty defending, the negative actions from one or several others that is persistent over a period of time.
Cleary, Walter, Horsfall, and Jackson (2013)	Bullying acts involve unwanted and persistent psychological or physical abuse directed at one person, generally across a timeframe of 6 or more months.
Douglas (2014)	Deliberate behavior that is meant to humiliate and distress.
Rush, Adamack, Gordon, and Janke (2014)	Perceived negative and hurtful acts.
Allen, Holland, and Reynolds (2015)	Threatening, intimidating, degrading, belittling, harassing, or offending behavior directed at an individual or group of individuals. Bullying also includes behavior that seeks to socially exclude an individual or negatively affect his or her work tasks. The negative behaviors need to be repeated over time with isolated or "one off" instances of negative behavior not generally classified as bullying.
Hutchinson and Jackson (2015)	Repeated and cumulative harmful interpersonal behaviors, which are often subtle and embedded in workplace relations and processes.
Evans (2017)	Rude or disruptive behaviors which often result in psychological or physiological distress for the people involved and if left unaddressed, may progress into threatening situations.

(continued)

Table 3. Continued.

Author (Year)	Definition
Birks et al. (2018)	Verbal, physical, social or psychological abuse by your employer (or manager), another person or group of people at work.
Nursing and Midwifery Board of Australia (2018)	When people repeatedly and intentionally use words or actions against someone or a group of people, it causes distress and risks their well-being.

Table 4. Summary of the Conceptualization of the Themes.

Author (Year)	Action	Temporality	Outcome
Hockley (2000)	x		
Bray (2001)	x	x	x
Hutchinson et al. (2006)	x	x	x
Speedy (2006)	x	x	x
Hutchinson et al. (2008)	x	x	x
Fair Work Act (2009)	x	x	x
Hutchinson (2009)	x		
Dietsch et al. (2010)	x		x
Eagar et al. (2010)	x	x	x
Field (2010)	x	x	x
Australian Nursing and Midwifery Federation (2011)	x	x	x
New South Wales Government (2011)	x	x	x
Rodwell and Demir (2012)	x	x	
Cleary et al. (2013)	x	x	
Douglas (2014)	x		x
Rush et al. (2014)	x		x
Allen et al. (2015)	x	x	x
Hutchinson and Jackson (2015)	x	x	
Evans (2017)	x		x
Birks et al. (2018)	x		
Nursing and Midwifery Board of Australia (2018)	x	x	x

Hutchinson,Wilkes, Vickers, & Jackson, 2008). The four types of bullying included physical (Field, 2010), verbal (Birks et al., 2018), social (Allen et al., 2015), and psychological (Evans, 2017). When specific types of actions were not mentioned, the term "unreasonable" was used. However, determining whether an action at work is reasonable requires an objective assessment of the action in the context of the circumstances at the time.

Temporality

There are variations among definitions as to the temporality with which a nurse must be subjected to a negative action before the experience qualifies as bullying. Even if a single serious episode may be regarded as bullying, most definitions emphasize the term "repeated." These definitions do not account for isolated experiences of bullying, raising a number of questions in relation to the current definitions, for example: Can a registered nurse be bullied on their first day of work? Would a registered nurse recognize the experience as bullying, and if so are they likely to report it? Is it reasonable to expect a registered nurse to wait until the negative action is repeated to report it as bullying?

Olweus (1993) argued that repetition is necessary in the definition of bullying, in order to exclude occasional acts of aggression directed at different people at different times. While not focused on nursing, Guerin and Hennessy (2002) in their study of children found that more than 50% of the sample did not consider the frequency of occurrence to be important, with more than 40% of those believing that an act that occurred once could still be bullying. Furthermore, if it is assumed that

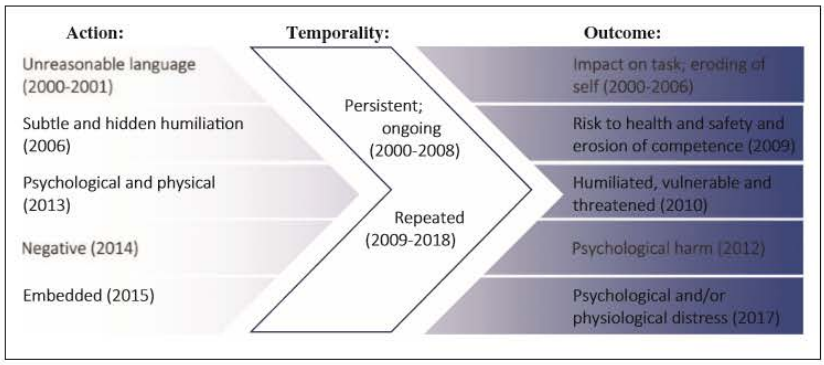

Figure 2. Conceptual framework of the evolution of the construct of bullying as it pertains to nursing in Australia (2000–2018).

all types of action are equal in terms of outcome to the person who is bullied, then it follows that actions should not need to be repeated to inflict harm. This strengthens the argument that the current definitions of bullying may not be as relevant to nursing in Australia, as this is a system-wide problem (Hutchinson, Wilkes, Jackson, & Vickers, 2010; Wright & Khatri, 2015).

The term "embedded" was mentioned in 2015 (Hutchinson & Jackson, 2015), giving insight to the conceptualization of a bullying culture that has become normalized within the nursing profession, and therefore the evolution and embodiment of the profession as "the bully." We argue therefore that repetition in nursing is especially problematic. While repetition is clear when a perpetrator acts, it is not so clear if the victim has received this type of behavior from another perpetrator from the same profession. The danger in definitions that rely on temporality is that this may result in excusing bullying behaviors by the individuals who make up the profession. This raises a further question: Is it considered repeated when the profession is perceived as the bully?

Outcome

The criterion that a person who is bullied must experience some form of harm as an outcome of the action is a definitional component about which there is unequivocal consensus (Australian Government, 2009; Australian Nursing and Midwifery Federation, 2011; Eagar et al., 2010; Field, 2010; Hutchinson et al., 2006, 2008; New South Wales Government, 2011; NMBA, 2018). The types of harm experienced are also diverse, ranging from decreased self-esteem (Randle, 2003) to suicide (Castronovo, Pullizzi, & Evans, 2016). Some definitions pinpoint the adverse negative outcome this behavior may have on the person or nurse bullied. The negative outcome is an essential component of all definitions of bullying. Researchers and practitioners generally agree that a negative action can only be defined as bullying if the outcome is harmful. A substantial amount of research has focused on documenting the harmful outcome that bullying can have (Berry, Gillespie, Gates, & Schafer, 2012; Felblinger, 2009; Houshmand, O'Reilly, Robinson, & Wolff, 2012; Sauer & McCoy, 2016). There is also research focusing on children and youth that has documented the negative impact on bystanders who witness bullying. The National Academies of Sciences, Engineering, and Medicine conducted a consensus study in which the committee examined the risk factors for bullying, its impact, and ways to prevent it (Rivara & LeMenestrel, 2016). This study reported on work undertaken by Salmivalli (2010, 2014) on the adverse effects on bystanders, with reports of anxiety and insecurity. Ultimately, in the clinical environment such outcomes would impact patient care. Hutchinson and Jackson (2013) and Laschinger (2014) both report on mistreatment in the workplace having detrimental effects on patient safety.

Implications for Practice, Policy, and Research

The results of this scoping review indicate that bullying is a theoretical and subjective concept that is in the eye of the beholder. Bullying can no longer merely be described as a repeated event eliciting a response, but rather as a complex phenomenon involving a multitude of antecedent factors, organizational, and interpersonal power-oriented dynamics that may result in potentially fatal outcomes (Noronha, 2018). The results of this review make a compelling case for a more unified and accepted definition of bullying in the nursing profession in Australia.

Further research on bullying among nurses needs to proffer a definition of bullying that works for the profession. Such a definition would allow nurses and nurse

researchers to bring clarity to an otherwise complex and unacceptable problem. This has strong implications for improving knowledge about the factors that contribute to the development, maintenance, or reduction of a bullying culture within the nursing profession.

Future research could also consider a historical perspective of bullying in the nursing profession, thereby recognizing the significance of the health care context in which it occurs and the changes to the definition over time. Bullying is a response-related behavior attributable to complex intra- and interpersonal organizational dynamics within the workplace, and robust research is urgently needed to identify and explicate the nature of these dynamics.

Conclusion

This review has enhanced understanding of bullying in the nursing profession in Australia. The review identifies gaps in current definitions and calls for a radical new look at how bullying is conceptualized and therefore managed in the Australian nursing workforce. It is a sad indictment of the nursing profession (and Australian society more broadly) that there are so many definitions that reflect the extent of the bullying problem within a profession built upon caring. Bullying conceptualizations range from the more specific to the most comprehensive as they focus on one or several of its multiple dimensions. These multiple and sometimes diverging perspectives might be partially attributed to the complexity of bullying itself. Further research is needed to explore the concept of bullying in the nursing profession. Such research is paramount given that the term bullying is being more widely used in research, educational, policy, and workplace contexts.

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Melanie Birks, RN, BN, MEd, PhD, FACN, professional goal is to enhance the quality and experience of tertiary education for students and educators through leadership, research and innovation. Her track record in publication, grant success and consultancies demonstrate her determination to advance scholarship in health professional education. Professor Birks' professional goal grew out of her own experience of the power that education has in promoting and enhancing personal and professional opportunities for practitioners and educators in the health sciences. Professor Birks' publications include 7 textbooks, most notably Grounded Theory – a practical guide (2011, 2015), and Qualitative Methodology – a practical guide (2014), along with around 100 peer reviewed publications and book chapters. Professor Birks has extensive experience and expertise in educational administration, teaching and curriculum design and development in local, international, military and civilian environments, and has worked in Malaysia, Singapore, Papua New Guinea, Hong Kong and Australia. She is active on numerous expert advisory panels and is also a recipient of the Australian Defence Medal.

David Lindsay, RN, BN, MEd, PhD, FACN, is a Registered Nurse and an experienced nurse academic and researcher within Nursing & Midwifery at James Cook University, Townsville. He has a longstanding interest and involvement in rural nursing and rural nurse education in Australia, and nursing education and practice in low resource settings across the Western Pacific, particularly Nurse Practitioner/Advanced practice roles. His current research interests include long-term condition self-management by health professionals, bullying within nursing, and quality improvement in low resource settings in the Western Pacific.

2.4 Conclusion

This chapter has provided a context for the study described in this thesis. The integrative review and scoping review established the need for further research to identify the factors that have allowed bullying to continue in the nursing profession, recognising the context in which it occurs and the changes of the phenomenon over time. The next chapter presents a detailed exploration of the methodology employed in this study and justifies its use to explore the factors that have allowed bullying to flourish in the nursing profession in Australia.

Chapter 3: Methodology—Critical Historical Research

3.1 Introduction

Having presented the aim, context and background of the study in the previous chapters, it is important to now discuss the philosophical and methodological foundations that underpin the research. This chapter will discuss the ontological, epistemological and axiological perspectives that inform this study, justifying the aim and foundational concepts of the research. The chapter begins with a brief overview of the philosophical considerations that are necessary before designing a research study. This overview is followed by a discussion of the use of critical theory as a philosophical lens. The fundamentals of a historical methodology are then presented with the intention of further validating its application to this research.

3.2 Overview of Philosophical Concepts

The overarching term ‘philosophy’ relates to knowledge creation and the essence of how knowledge is acquired (Birks, 2014; Brinkmann, 2018; Petty et al., 2012). An exploration of philosophy provides a framework for understanding positions and assumptions about the ways in which the world is viewed. These assumptions underpin and shape the research endeavour and the methods chosen to answer a research question (Creswell & Creswell, 2018; Nicholls, 2009). Assumptions about the nature of the world that shape research are philosophical paradigms that help sharpen the focus on a phenomenon of study (Birks, 2014). According to Creswell and Creswell (2018), a philosophical paradigm describes a set of questions relating to axiology, ontology and epistemology (see Table 3.1: Philosophical Questions).

Table 3.1

Philosophical Questions

Axiology	Ontology	Epistemology
Questions the role of values in the research process	Questions the nature of reality and its characteristics	Questions how knowledge can be created, acquired and communicated

The four major philosophical paradigms are positivism, post-positivism, critical theory and constructivism (Lincoln et al., 2011).

3.2.1 Philosophical paradigms. A positivist paradigm lends itself to an experimental approach focused solely on what can be observed (Denzin & Lincoln, 2011) and therefore does not allow values to influence the research process. This paradigm starts with the premise that there is an objective reality distinct from subjective human experience and that an objective reality can be understood by a scientific investigation process (Nicholls, 2009; Ormston et al., 2014). Positivists believe in cause and effect, meaning one event leads to another. The positivist researcher will most likely use a methodology and methods that can facilitate replication (Birks, 2014). The emphasis will be on quantifiable observations and quantitative data that lend themselves to statistical analysis (Denzin & Lincoln, 2011). Therefore, in the positivist paradigm, axiology is seen to be value-free. Its ontology is naïve realism (accepts there is only one reality) and its epistemology is objectivist (Lincoln et al., 2011).

The post-positivist paradigm has similar ontological and epistemological beliefs as positivism; however, there are some differences. Post-positivism recognises the impossibility of total objectivity (Cruickshank, 2012). Lincoln et al. (2011) described post-positivism as a paradigm that appreciates the impediments to knowing reality with absolute assurance and therefore seeks probabilistic evidence. Post-positivism does not

aim to disprove the scientific elements of positivism in the research; rather, it emphasises an understanding from multi-dimensions and multi-method perspectives (Lincoln et al., 2011).

The critical paradigm is ontologically based on the belief that reality is virtual, meaning it is constructed from social interactions and historical social imbalances (Bleiker et al., 2019; Petty et al., 2012). Critical theory holds that truth is shaped by social factors that develop over time; however, in common with positivism and post-positivism, it still holds that there is truth to be discovered (Bleiker et al., 2019; Guba & Lincoln, 2005). Ontologically, it represents a continued step away from the naïve realism of positivism. Therefore, the critical paradigm assumes an axiology that respects cultural norms, an ontology of historical realism (especially as it relates to oppression) and a transactional epistemology (in which the researcher interacts with the participants) (Lincoln et al., 2011).

Constructivism holds that people construct what is possible through their social knowledge and experiences (Ormston et al., 2014; Petty et al., 2012). This approach privileges subjectivity over objectivity and explores multiple experiences among groups of people and shared meanings (Ponterotto, 2005). Constructivism must be faithful to the subject in context, as no ultimate truths exist (Denzin & Lincoln, 2011). This approach asserts that people experience and interpret the social world differently, even though they experience the same event (Braun & Clarke, 2013). Constructivism seeks clarification within the context of human consciousness and subjectivity, within the participant's frame of reference, as opposed to the observer of practice (Ormston et al., 2014). Therefore, constructivism assumes a balanced axiology (seeking to provide a balanced interpretation of the data), a relativist ontology (many realities that all can be

examined) and a subjectivist epistemology (in which the researcher, by their own thinking, makes sense of the data) (Lincoln et al., 2011).

3.3 Philosophical Lens: Critical

Emerging from the Frankfurt School in 1920s Germany, critical theory can be traced back to the works of Immanuel Kant, Georg Wilhelm Friedrich Hegel and Karl Marx. These origins embraced critical theory as enabling philosophies that look below the surface of existing knowledge to reveal exploitative and distorted societies (Miller & Brewer, 2003). According to Kincheloe and McLaren (2000), all three philosophers had common emancipation and power concerns, even though Kant and Hegel's use of critical theory was epistemological, while Marx's use was more sociological in intent.

A second wave of critical theorists, led by Jürgen Habermas (Emden & Midgley, 2013), brought the epistemology of critical theory to a new level. Habermas proposed that critical knowledge was knowledge developed through analytic and hermeneutic approaches (Outhwaite, 1994). French philosopher and sociologist Pierre Bourdieu (2003) proposed that critical theory is concerned with revealing new understanding, employing ways of generating enlightenment and emancipation, the rejection of economic determinism and the critique of power and domination. Bourdieu (2003) explained that a critical approach to research is based on a range of basic assumptions. These assumptions include the view that research should explicitly seek to emancipate the participants from historical and social power imbalances, that some groups in society are privileged, and that the oppressed often contribute to their own situation through the belief that their lack of status is unchangeable (Bourdieu, 1998, 2003). Roper (2005) referred to this view as 'hegemony'. Hegemony is an understanding that the maintenance of dominance by ideological or cultural means is typically achieved through social structures that allow those in power to strongly influence the worldview

of the rest of society (Gregory & Halff, 2013). Epistemologically, critical theory aims to generate change to the dominant worldview or produce theory that supports emancipatory outcomes (Roper, 2005; Kincheloe & Steinberg, 2008). The relationship between the researcher and participants forces the ontological and epistemological components to overlap (Guba & Lincoln, 2005). The subjective experience of participants is valued, such that data that represent experience and attitude are favoured (Creswell, 2009).

Critical theory perspectives are about empowering people to overcome the limitations placed on them by society (Emden & Midgley, 2013). It is important for researchers to recognise their own influence and participate in dialogues to explain or shed light on social action (Madison, 2005). The main topics to be discussed by a critical researcher include the empirical examination and evolution of social institutions leading to the creation of new possibilities (Madison, 2005; Morrow & Brown, 1994). The critical researcher could design a study to incorporate changes in the thinking of people, encourage interaction, create networks, become an advocate, generate action-oriented organisations, and assist others to examine their society (Emden & Midgley, 2013; Kincheloe & MacLaren, 2000 Madison, 2005).

Critical theory research is about encouraging progress and inspiring people by objectively analysing the social structure that places constraints on them (Outhwaite, 1994). The epistemology of critical theory is motivated by reform and the liberation of excluded or silenced groups from the established social structures being examined. Critical theorists, such as Habermas (1984) and Bourdieu (1998), emphasised that conventional empirical research contributes to the invisible, or at best opaque, nature of power relations and thus further roots these relations in what is perceived to be reality. It follows that the strength of critical theory lies in its capacity to expose differences in

power relations in context and among the population studied at a variety of levels where power is exercised (Emden & Midgley, 2013; Madison, 2005; Miller & Brewer, 2003). This has been recognised as a strength in raising the potential for enlightenment by both Habermas's and Bourdieu's methods and was instrumental in further developing critical theory (Morrow & Brown, 1994).

Critical theory has been adopted by many disciplines (Kincheloe, 2015) and creates an opportunity to frame, identify and understand complex phenomena within a complex social context. Critical theory is a useful lens through which to explore and describe issues of equity in healthcare because it draws attention to power imbalances and oppression within the environment. In particular, the work of Bourdieu is increasingly appealing to nursing and the study of nursing practice (Rischel et al., 2008). The conceptualisation of the culture and practice of nursing work has contributed to Bourdieu's concepts of field, capital and habitus (Rhynas, 2005) and his theories have appealed to researchers conceptualising healthcare practice (Angus et al., 2005; Lumme-Sandt & Virtanen, 2002). These concepts provide new insights into the dynamics of nursing and healthcare practices and the influence on the profession (Williams et al., 2016). Cultivating the nurse's voice is one strategy for realising some of the goals of critical theory (Polman & Pea, 2001). Nurses need to be respected and their stories heard so they can feel motivated and build counterbalanced improvements over the limitations placed on them by the profession. To reveal new understandings related to power relations and the influence this may have on bullying in nursing, this study has embraced qualitative approaches to research.

3.4 Research Approach: Qualitative

Qualitative approaches to research are considered the most appropriate to use when endeavouring to understand social behaviour and the underlying explanations of

that behaviour (Creswell, 2009). Lincoln et al. (2011) supported this view, describing qualitative research as an interpretive, naturalistic approach to the subject to capture the meaning given and understood by individuals.

To understand and make sense of a phenomenon, qualitative approaches focus on the perspectives of those who experience it. Qualitative researchers are also interested in the contexts of people's experiences (Birks, 2014; Merriam, 2009). Thus, the purpose of research undertaken in the qualitative paradigm is to understand and explain the experience of the participants (Morrow & Smith, 2000). More precisely, Creswell (2009) described qualitative research as a process centred on various methodological research traditions that examine a social or human problem. The researcher conducts the study in a natural setting to produce a dynamic, holistic picture, which enables the elicitation of detailed data from participants (Birks, 2014; Bleiker et al., 2019; Ponterotto, 2005).

Qualitative approaches are fundamental to studies of people in their social world. Qualitative research enables the socially formed nature of reality to be emphasised (Creswell, 2018; Denzin & Lincoln, 2008). It has been argued that reality is not anything different from human experience, and that reality is constructed through repetitive social discourses (Petty et al., 2012). Qualitative research requires a close relationship between the researcher and participant and takes into account the role of context in shaping the individual's perception of reality. Gaining understanding through interaction with the research participants was at the heart of this research approach from the outset (Birks, 2014; Creswell, 2018). The researcher's role was to interpret, filter and grasp the meanings of the participants' stories as expressed in their testimonies.

Qualitative research differs from quantitative approaches, as the latter gathers evidence that is objectively obtained, rather than reflective of personal beliefs

(Barnham, 2015; Creswell & Creswell, 2018). According to Creswell (2014), quantitative research in the positivist paradigm is conducted systematically, using formal instruments to collect data, which are then subjected to formal analysis using statistical procedures. The degree to which findings can be generalised is a commonly used criterion for evaluating the quality and importance of a quantitative study (Landrum & Garza, 2015). Conversely, qualitative research seeks to describe and understand participants' experiences, alongside attitudes, opinions and social interactions (Aspers & Corte, 2019; Denzin & Lincoln, 2008). Importantly, it is also conducted systematically, yet draws upon a wide variety of approaches and designs. This study was not intended to pursue or identify an ultimate truth; rather, the goal was to discover meaning as defined from the participants' perspective (Birks, 2014; Glesne, 2016). For this reason, questions were not amenable to objective measurement. This research was conducted in the qualitative domain through a critical lens using a historical approach.

3.5 Research Methodology: Historical

Historical research has been described as the systematic and objective assessment of evidence to uncover facts and draw conclusions about past events, enabling a critical investigation of the ways in which the past shapes the future (Andrews, 2008; Kincheloe, 2015). It is a reconstruction of previous events that is designed to achieve an authentic representation. Reconstruction suggests a systemic approach in that the inquiry process of historical research seeks to accept and then clarify the past in a context that places a major focus upon social, cultural and economic factors (Andrews, 2008; Brink et al., 2006). A useful feature of historical research principles, as categorised by Hill and Kerber (1967) (see Table 3.2), is the connection that the past may have with the present, and indeed with the future.

Table 3.2

Principles in Historical Research

• Allows for the search for solutions to current problems in the past. • Places present and future trends in perspective. • Stresses the relative importance and consequences of experiences found within all cultures. • Allows the reassessment of evidence that supports the identified assumptions, theories and generalisations currently held about the past.

Historical research, therefore, enables the past to inform the future, while using the present to explain the past, providing dual and unique qualities that make the outcomes of the research especially useful (Kincheloe, 2015). Zeichner (1999) argued that a significant benefit is the analytical conception that historical research brings to a field of knowledge. In this current study, the need for representation of participants' accounts of bullying lends itself to a historical research methodology. Historical research seeks to discover new knowledge about what has happened in times past in relation to specific portions of time. It is a specific type of scientific research work and a common approach used in qualitative research. Yuginovich (2000) argued that history is undoubtedly a greater moulding factor in social consciousness than language, and is linked to power and political structures.

3.5.1 Critical historical method. Critical historical research is that which seeks to destabilise the dominant ideology of the object of its critical gaze (Firouzkouhi & Zargham-Boroujeni, 2015). Conducting historical research using a critical lens enables a rich and meaningful exchange, leading to new understandings. The underlying concepts of critical historical research are criticality, affirmative presentism, bricolage and multilogicality (Kincheloe, 2015; Villaverde et al., 2006).

Criticality refers to the view that historical discourses can be influenced by power and privilege between individuals and societal structures—that is, history is not a

process through predetermined incidents with definite triggers (Villaverde et al., 2006). Popkewitz (1999) referred to the idea of criticality as a strategy by which to view change in current trends as social ruptures, rather than as a progression of events that may appear unavoidable or theoretically progressive. By extending it to accommodate simultaneous and overlapping interactions, the linear, one-dimensional concept of time is challenged by criticality (Novoa & Yariv-Mashal, 2003). Indeed, past, current and future relationships are dynamic with a constructive presentism. The present is seen as a transition cycle from past to future, not simply a static timeframe (Villaverde et al., 2006). For this research, this viewpoint is fundamental, as it attempts to uncover the evolution of bullying over four decades.

Affirmative presentism is the assertion that a good narrative does not make assumptions about the past using existing concepts and understandings (Villaverde et al., 2006). Affirmative presentism accepts that existing beliefs and understandings form how we draw on our past transmissions. The qualitative researcher should therefore acknowledge subjectivity (Janesick, 2010), as the value of this recognition is to give greater integrity to the researcher's analysis (Villaverde et al., 2006).

The third concept of critical historiography, bricolage, applies to making something by using a number of different available tools (Kincheloe, 2015). In the context of this critical historical study, bricolage may include making comparisons or connections between seemingly unrelated ideas (Villaverde et al., 2006). This principle supports the analysis of data from multiple dimensions, drawing on varying data analysis methods, which are described in more detail in the following chapter.

The fourth and final concept, multilogicality refers to the appreciation of various viewpoints (Novoa & Yariv-Mashal, 2003; Villaverde et al., 2006), particularly of those who have been silenced or under-represented through oppression. One way to analyse

under-represented viewpoints is to select primary sources of data produced by oppressed individuals (Janesick, 2010. This principle was supported in this study through the use of testimonies as a first-hand authentication of a fact.

3.6 Application to This Research

An important consideration in this study was the researcher's own theoretical sensitivity, personal bias and positioning within the research (Birks & Mills, 2015; Ralph, 2013). In the context of this study, the researcher found that he was driven by transition and change while challenging his own philosophical position. As stated earlier, researchers within the critical paradigm seek to change the status quo (Emden & Midgley, 2013), and this resonated with the researcher's desire to not only examine the phenomenon of bullying, but also consider ways to do something to change it. In the critical paradigm, this ongoing process of critical (self-) reflection is applied through all stages—from designing the study to collecting and analysing the data, through to reporting the findings. The use of critical theory in this study was therefore intended to be a vehicle by which issues of emancipation, empowerment and social change would be a major focus, in the context of the phenomenon of bullying in the nursing profession.

The researcher used a critical lens in this research because it draws attention to power imbalances and oppression within the healthcare environment (Kincheloe & McLaren, 2000). Critical theory research extends beyond describing what is, and towards describing what could be (Emden & Midgley, 2013). The ontology of critical theory provides a basis from which to further unpack the dominant notion of bullying in this study by identifying social, political, cultural and economic factors that may be expressions of an underlying reality.

The research described in this thesis aimed to uncover factors that have allowed bullying to flourish in the nursing profession in Australia and was therefore set in the qualitative tradition, which was suitable for developing the necessary thorough understanding of the experiences of the participants (Birks & Mills, 2015). In-depth interpretation occurs in qualitative research through listening, analysing and retelling accounts of the participants in a meaningful manner (Denzin & Lincoln, 2008; Glesne, 2016). Qualitative research provides the versatility required to retell participants' stories in a meaningful way by using narratives, rather than statistics, thereby allowing a structured approach to gathering empirical evidence (Denzin & Lincoln, 2008). Therefore, the researcher used a qualitative approach in this study because it provided a means to understand bullying in the nursing profession through exploring and analysing the personal testimonies of the participant.

The epistemological position in regard to historical research also requires a focus on the reflexivity of the researcher or interviewer within the study process. The goal of reflexivity focuses not on the individual, but on the profession that forms the respective field of inquiry. Ultimately, the use of a critical historical methodology enabled the researcher to explore and describe issues of oppression, disempowerment and social change within the context of bullying in nursing over time. This study is an attempt to extend beyond the descriptive and explanatory analysis that many previous studies have rendered. It offers a critical analysis of the factors that influence the actions of nurses and the consequences of those actions. It also highlights the importance of understanding the factors that contribute to the emergence and evolution of this phenomenon as key to implementing effective solutions.

3.7 Conclusion

This chapter has provided an overview of the way critical theory informed the methodology and methods used within this study. The case was made that a critical historical approach was an appropriate methodology to address the aim of the study. This approach enabled the generation of emancipatory knowledge capable of liberating the nursing profession from bullying by uncovering oppressive historical, cultural, social and political influences. This discussion of critical historical research will be expanded in the next chapter, where the specific methods used in this study are described.

Chapter 4: Study Design

4.1 Introduction

The previous chapter discussed the philosophical and methodological foundations that underpin the design of this study. Study design refers to the procedures and techniques used for the compilation, production and analysis of data in a study (Birks & Mills, 2015). In historical research, the researcher systematically investigates and analyses documents and other sources of facts about an experience or event in the past. This process reveals how history influenced current practice, can predict future trends and can suggest ways in which current practices should be modified in light of the events of history. The design of this study, including the methods used in the research, will be explained and justified in this chapter. The chapter will begin with a detailed description of data collection and analysis, followed by the ethical considerations in the conduct of this study. The chapter will conclude with an overview of the way the outcomes of the research will be disseminated.

4.2 Research Question

The research question for this study was: why does bullying continue to flourish in the nursing profession in Australia? Yin (2014) described the basic categorisation scheme for the types of research question as who, what, where, how and why. As stated in the previous chapter, how and why questions are more exploratory in nature and lend themselves to qualitative research methods.

4.3 Data Collection

4.3.1 Inclusion/Exclusion criteria. To be eligible for the study, participants had to be a current or retired registered nurse in Australia who were able to describe their experience of bullying while working as a registered nurse.

4.3.2 Participant recruitment. The Australian College of Nursing distributed the opportunity to participate in the study through their various networks and events from January to February 2019. The Australian Nursing and Midwifery Federation was identified as an additional potential recruitment avenue, however this was not needed. A total of 70 participants consented to participate in the study, with bullying experiences ranging from 1981 to 2019. These will be described in the following chapter.

4.3.3 Data sources. Two types of data sources are able to be used in historical research: primary and secondary (Salevouris & Furay, 2015). Primary sources are individuals who were present at an event (Mages & Fairman, 2008). The more informed and competent the primary sources were at the time of the event, the more reliable and valuable these sources are to the historical research study. Secondary sources are individuals who were not present at the event, yet report what other people relayed to them (Salevouris & Furay, 2015).

To understand the context that contributes to bullying in the nursing profession in Australia, primary sources were used to obtain data in the form of testimony. Testimonies are common in historical research. Testimony is a source of human knowledge that creates understanding and awareness of past events (Miller-Rosser et al., 2009). The use of testimony as a method enabled personal bullying experiences over four decades to be captured for use in this study. Wang et al. (2014) suggested that testimony as a method can be a powerful instrument to discover, explore and evaluate. Testimony is defined as the first-hand authentication of a fact (Goodman & Kruger, 1988), and recognises a view of social reality that continues to shift and is the emerging property of each individual (Bryman, 2001). Testimony encourages participants to be central to the data collection process, giving voice in unique ways to those typically overlooked, marginalised or silenced (Wang et al., 2014). This method is useful in

permitting the verbalisation of different values and personal experiences, and facilitating the exploration and development of life or aspects of life (Sommer & Quinlan, 2009; Wang et al., 2014).

Sommer and Quinlan (2009) described testimony as the act of documenting a consenting person's compilation of first-hand accounts from living individuals, drawing on their personal experiences (Janesick, 2010). Over the past few years, this method has contributed successfully to the recording and reporting of nursing experiences (Miller-Rosser et al., 2009). Testimony, coupled with qualitative empirical approaches, tends to enhance the available sources with respect to the full spectrum of nursing practices (Janesick, 2010). Interviews, direct observation and review of documents are the basic tools that can be used as an adjunct to this approach (Wang et al., 2014). Testimony is considered important in historical research because it allows participants the opportunity to express their feelings, thoughts and memories for study purposes (Biedermann, 2001) and create a coherent story.

4.3.4 Gathering testimonies. Participants in this study were invited to present their testimony during an interview or via online submission. Giving participants options regarding how to share their story ensured that they were able to do so in the least threatening setting, which subsequently encouraged participants to have an unhindered link to their past (Miller-Rosser et al., 2009). Questions were used to provide structure for the testimony—a strategy suggested by Morgan and Guevara (2008). Questions sought to encapsulate the experience of bullying faced by nurses and to describe the wider context. Questions were drawn from the themes identified from the earlier integrative review presented in Chapter 2. Demographic information was also collected (gender, age, location) with the testimony to inform the process of analysis.

The online data collection survey is presented in Appendix A. Testing of the online survey was conducted to ensure accuracy and functionality. An information sheet formed the first page of the online data collection survey (Appendix A). Participants indicated through this online tool whether they wished to contribute their testimony online or via an interview. Interviews were conducted at a time and place suitable to participants. Participants were given the option of face-to-face, telephone or videoconference for this purpose. Interviews took approximately one hour each to complete, were audio-recorded and were transcribed verbatim. The purpose of the study was explained and participants confirmed consent verbally at the beginning of the recording. Reconfirmation of consent worked to create trust, comfort and transparency (Lewis & Ritchie, 2003). The recording also captured the researcher's language exchange and interaction with the participant. Thus, it was helpful in examining where speech, tones and emotional variations of volume, such as whispered responses, were informative in interpreting the results (Borbasi & Jackson, 2012). Interviews were transcribed by a professional transcription service. Transcripts were de-identified and assigned a specific code. This single identification helped link data sources and identify fragments of data used as evidence in reporting the results.

4.4 Data Analysis

As with every research study, the aim of this research was key to deciding the appropriate analytical approach. This is particularly the case when analytic products have multiple dimensions (such as time, process or change). Researchers who examine data over these multiple dimensions to advance the conceptual depth needed in a qualitative analysis must do so without losing relation to the meaning of the entire dataset. Often, analysis of data with a chronological pattern mostly relies on cross-sectional comparative analysis, with little consideration for the longitudinal aspect

(Grossoehme & Lipstein, 2016). In contrast, historical approaches are primarily concerned with empirical growth and require the reconstruction of individual and collective patterns of behaviour leading to fairly specific events, which limits cross-sectional analysis (Firouzkouhi & Zargham-Boroujeni, 2015).

4.4.1 Connecting critical theory and data analysis. In the spirit of critical inquiry, this section discusses how the researcher's philosophical perspective was embodied during data collection and analysis. Holestien and Gubrium (2008) argued that, by linking a philosophical perspective to study design before undertaking the research, both the research experience and the data collected may be enriched. In this research, the connection between philosophy and research design was adapted from the work by Miller and Glassner (2011). The importance of each testimony's contextual, situational nature was key to understanding bullying experiences among the participants. Therefore, what was learnt about the participants during the testimony presents what Miller and Glassner (2011) described as the 'frame', extending the setting of the testimony to a reality beyond the context. In other words, this study not only focused on what was said during the testimony, but also on the nature of the interaction, as the combination of what participants say and how they say it provides the framework through which people make sense of their experience.

To improve both the breadth and depth of the data analysis process, a three-dimensional analysis technique was developed to achieve the thick description necessary to fully capture the complex phenomenon derived from participants' experiences. A thick description of human behaviour, according to Geertz (1973), is that which describes not only the behaviour itself, but also its context in such a way as to make the behaviour relevant to the study viewpoint. This analysis revealed the phenomenon of bullying within the structures and dynamics as reported by the

participants. It exposed the power relations evident in the testimonies of the participants and evidence of the hegemonic processes and structures (and associated social and professional norms) within these testimonies.

4.4.2 Three-dimensional data analysis. According to Saldaña (2013), the task of qualitative researchers is to rigorously examine and interpret data to credibly, vividly and persuasively describe the processes of change over time via narrative. This requires the dynamic transformation and incorporation of observable human experiences into patterns in their multiple social contexts. In this study, the challenge was to bridge the gap between analysed patterns of bullying and changes over time. It was of fundamental importance to this study to choose a method that would enhance the potential for change and encourage reform. A three-dimensional approach to analysis was conceived by the researcher as a means of achieving the thick description needed to fully capture the complex phenomenon of bullying as reported by participants. This innovative approach offers a step-by-step process that generates highly organised results from summarised data. The three-dimensional analysis was helpful to manage the large amount of data and achieve a detailed, concise description of the entire dataset, without losing connection to the broader context. The three-dimensional analysis enabled a higher level of theoretical and analytical rigour, while also ensuring a degree of consistency.

The three-dimensional analysis was congruent with the epistemological, philosophical and theoretical approach of this research by bringing to the forefront a critical interpretive lens. Each dimension was particularly concerned with the reproductive influence of power and how organisations contribute to social structures (Bourdieu, 2003). This was important to generate empirical conceptualisations of bullying to enhance understanding of why it has persisted over time. In this approach, data analysis ultimately organises manifestations of social reality, which are then

reinterpreted and transformed into something new by the researcher, bringing to light that which would otherwise remain hidden. Theoretical constructs were used to map each participant's experience of bullying, revealing the various types of power and privilege. Three-dimensional analysis, as developed for use in this study, is presented in Figure 4.1 and described below.

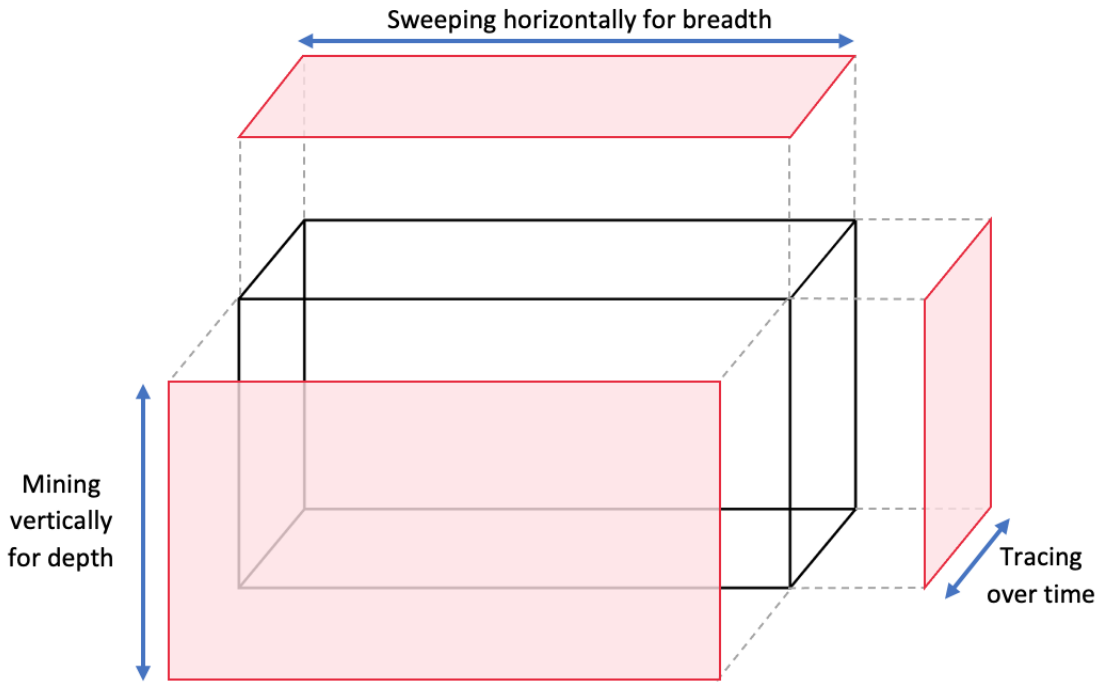

Figure 4.1. Three-dimensional analysis.

Step 1: Sweeping horizontally for breadth

Sweeping horizontally for breadth transforms the dataset by analysing the data to establish a broad qualitative understanding. It provides the structure for a more in-depth analysis of the selected phenomena.

Sweeping horizontally for breadth is synonymous with thematic analysis, as the goal is to define discourses that create identities. Each transcript was carefully read and, after familiarisation, open coding occurred. Strauss and Corbin (2008) described open

coding as the first stage of comparative analysis by coding the data in every possible way. Coding aimed to classify all data by systematically comparing them with the complete dataset to identify units of meaning (Birks & Mills, 2015). In Step 1, data were coded to facilitate a particular qualitative understanding that rendered the first dimension. Multiple iterations of analysis at the breadth dimension level were needed until no new codes emerged. This provided a basis for Step 2—mining vertically for depth.

Step 2: Mining vertically for depth

Mining vertically for depth establishes linkages and connections to further understand the phenomenon. The purpose of mining vertically for depth is to elicit rich descriptions of the experiences that build upon the broad qualitative understanding generated during Step 1.

Mining vertically for depth was systematically used to determine variations among the concepts that emerged from the breadth (first) dimension. This dimension highlighted how the reality of the study phenomenon manifested for each participant. Mining vertically for depth included evaluating and abstracting each of the codes to generate categories. The value of mining vertically for depth was that it allowed comparison across the dataset (based on a variety of factors identified in the breadth dimension), and uncovered how codes integrated with each other within the broader analysis. In Step 2, detailed, rich explanations of the experiences rendered the second dimension.

Step 3: Tracing over time

In this step, the dataset is organised and analysed chronologically to expand and enhance understanding of the breadth and depth of the studied experience over time.

The third dimension, tracing over time, focuses on changes that are evidenced as patterns that can be mapped chronologically. In this study, tracing occurred through examination of each decade-long period to identify how the phenomenon of bullying evolved over time (third dimension), providing the basis for the historiography. Tracing over time is synonymous with the storyline technique described by Birks et al. (2009), who drew on the work of Strauss and Corbin (1990). In Step 3, the production of a storyline rendered the third dimension. This dimension formed the final level of analysis and resulted in a narrative of the research that described how the major categories evolved with context across the decades. The outcomes of the three-dimensional analysis in this study (Figure 4.2) will be explored in the following chapters.

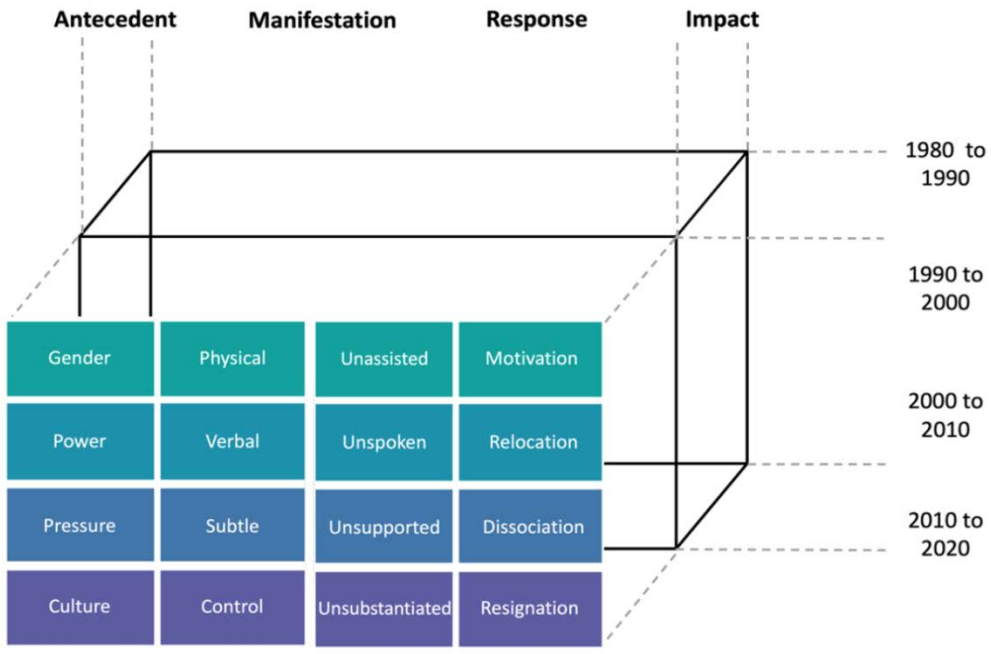

Figure 4.2. Outcome of the three-dimensional analysis in this study.

The key benefits of the three-dimensional analysis were that it allowed for convergence and versatility, retaining the key characteristics of a qualitative study. The three-dimensional analysis was therefore a method of categorising and organising qualitative data in a way that ensured contextual relevance was preserved. The three-dimensional analysis enabled each participant's unhindered views to remain associated with every dimension of their narrative, so that the context that framed their meaning was not lost. Although the three-dimensional analysis was a highly structured method of categorising and arranging large quantities of qualitative data, it was not a panacea for the problematic issues commonly experienced with qualitative data analysis, such as reducing the ambiguity of the analytical processes (Miles et al., 2014; Saldaña, 2013). Skills in qualitative research analysis were needed to properly interpret the dimensions and promote the generation of concepts, categories, explications, relationships and typologies. In addition, reflexivity and rigour remain as important in the three-dimensional analysis as they are in other qualitative analysis methods.

4.4.3 Data management. The qualitative data analysis platform, NVivo for Mac (Version 12), was used to enable effective and efficient data collection, management and interpretation (Bazeley & Jackson, 2013). The transcripts of interviews were imported into NVivo for analysis. NVivo was of particular use in the interpretative analysis of the testimonials. The ability to implement the three-dimensional analysis was simplified by having the data in one place and attaching codes to segments of text. NVivo also enhanced data analysis by enabling the sorting of testimonials chronologically.

In accordance with the National Health and Medical Research Council (NHMRC) (2018) guidelines relating to qualitative research and databases, all data were at all times systematically registered and safely stored. Electronic data were stored on

the password-protected computer of the principal investigator. According to the JCU (2012) *Best Practice Guidelines for Research Data Management*, data will be retained by the university for a period of at least five years from the end of the year of the most recent referred publication.

4.5 Ethical Issues

Any research involving people must consider ethical principles. According to Stewart (2014), adherence to ethical principles helps ensure that research findings are legally and methodologically defensible. Key principles of an ethical research approach include respect for persons, equity, non-discrimination and beneficence (NHMRC, 2018). In the conduct of this research, compliance with these ethical principles ensured the integrity of the study.

Ethical decision-making characterised this study, from the beginning of the conceptualisation and study design process, through data collection and analysis, to the end of the reporting process (Stewart, 2014). The researcher was mindful of the potential for distress during data collection. In both data collection methods, participants were reminded that they would not be identified in any published material. Participants were offered counselling services, such as Lifeline, given the distressing nature of this study. While it is not possible to determine whether participants accessed those services, no participants indicated distress during the process of data collection.

4.5.1 Ethical approval. Permission to conduct this study was obtained from the JCU HREC (HREC reference number: H7608) (Appendix B). A requirement of this approval was written support from the Australian College of Nursing to disseminate the invitation to participate, which was provided to the HREC prior to the study commencing.

4.5.2 Consent. The NHMRC (2018) *National Statement on Ethical Conduct in Human Research* (updated 2018) guided the consent process to ensure that information was adequately understood and that a voluntary, informed decision was made to participate in the study. Submission of testimony via the online site implied consent to participate. The participant had to click the 'submit' button for the survey to be included (data from surveys that were abandoned were not included). Consent to participate in an interview was obtained in advance and confirmed with a consent form (Appendix C). Such initiatives ensured continued respect for persons and provided participants with an informed choice to take part or the ability to opt-out if necessary.

4.5.3 Confidentiality, privacy and anonymity. Confidentiality of participants was preserved throughout this study. No identifying information relating to individual participants was revealed when the findings of this study were disseminated in journals, conference meetings, media interviews, workshops or seminars. A pseudonym was allocated to transcripts or in-vivo quotations from the testimonies used in this thesis, articles or seminar presentations.

4.5.4 Risk management. A risk management strategy (see Table 4.1) with contingency plans was established at the outset of the research to ensure the identification and minimisation of risks. The strategy discussed possible participant-related risks (specifically related to ensuring the enforcement of ethical standards and values, including beneficence and non-maleficence), risks to the researcher (specifically the emotional effects) and risks to the study (specifically recruitment and bias).

Table 4.1

Risk Management Strategy

Potential Risk	Strategy
	Risk to Participants: Ethical Considerations
Experiencing discomfort or inconvenience	• Consent form states and reassures participants that: ➢ Participation is voluntary and they can withdraw or discontinue ➢ Study will have no effect on current or future employment ➢ Participant privacy will be maintained ➢ Confidentially—data will be de-identified • Counselling services are available—facility based, JCU or an external provider; referrals will be made as required
Disclosing (or not) 'socially acceptable' information	• Provide participants with the option of anonymous online submission • Build trusting relationships and monitor dynamics and interactions during interviews
Coerced or pressured to participate	• Informed consent obtained at the beginning of interviews • Invitation circulated electronically via Australian College of Nurses
	Risk to Study
Achieving objectives related to recruitment and access	• Snowball sampling; data collection outside work hours; use of technology • The Australian Nursing and Midwifery Federation (ANMF) could be contacted for recruitment as a contingency
Testimonials—access and organisation	• Scheduling additional interviews to ensure adequate data collection to inform the research questions
Evolving nature	• Timeframes allocated for data collection and analysis—applied with flexibility ➢ Use of systematic documentation, storage and research processes to manage data collection and analysis
	Risk to Researcher
Emotional effects	• Mindful of surroundings; manage self professionally; maintain communication and measures to ensure safety

4.6 Outcome (Historiography)

The outcomes of qualitative data can be displayed in many forms. Once data analysis is complete, Miles et al. (2014) recommended the reduction of qualitative data into matrices for analysis at a glance. Strauss and Corbin (2008) similarly suggested mini-frameworks or conceptual diagrams that represent the study's multiple codes and categories into a manageable matrix to determine possible relationships.

In this study, findings are discussed as a historiography. Historiography provides a unique opportunity to capture the collective meaning of all participants across the dimensions of breadth, depth and time. The historiography developed from the analysis of findings and identified factors that have contributed to bullying in the nursing profession over time and allowed it to flourish. This broader framework for understanding uncovered power relations within political, historical and ideological contexts that gave rise to the nursing environment in which these bullying experiences occur. This analytical historiography is summarised in Chapter 5 and further elucidated in the findings chapters that follow.

4.7 Dissemination

Dissemination refers to a designated process that includes understanding target audiences and the environments in which research results are to be showcased in ways that promote the uptake of research in decision-making and practice (Wilson et al., 2010). Throughout the conduct of this research, there were a number of opportunities to disseminate the processes and products of the study through publications, conference presentations and workshops, at times resulting in awards and honours.

4.7.1 Publications. The following publications arose from the conduct of this research:

Hartin, P., Birks, M., & Lindsay, D. (2018). Bullying and the nursing profession in Australia: An integrative review of the literature. *Collegian*, *25*(6), 613–619.

Hartin, P., Birks, M., & Lindsay, D. (2019). Bullying in nursing: Is it in the eye of the beholder? *Policy, Politics, & Nursing Practice*, *20*(2), 82–91.

Hartin, P., Birks, M., & Lindsay, D. (2020). Bullying in nursing: How has it changed over 4 decades? *Journal of Nursing Management*, 28(7) 1619-1626.

4.7.2 Conference presentations. The following conference presentations arose from this research:

Bullying in nursing: How has it changed over 4 decades? [Paper presentation]. Cairns and Hinterland Hospital and Health Service (CHHHS) Research and Innovation Symposium, 13 November 2020, Cairns, Queensland, Australia.

Bullying in nursing: The need to make change happen [Paper presentation]. National Nursing Forum, 21–23 August 2017, Sydney, New South Wales, Australia.

Bullying in nursing: Is it in the eye of the beholder? [Paper presentation]. National Nursing Forum, 28–30 August 2018, Gold Coast, Queensland, Australia.

4.7.3 Workshops. The following workshops were conducted as a result of this research:

Bulling in nursing [Workshop presentation]. Australian Defence Force Healthcare Webinar Series, 24 April 2020.

4.7.4 Honours. The following honours were awarded as a result of this research:

Nurse, I'm being pecked on! James Cook University College of Healthcare Science 2020 Three Minute Thesis (3MT) winner.

Division of Tropical Health and Medical 'My Research Rules' Competition, October 2020—finalist.

4.8 Conclusion

This chapter has provided a description of the research design and methods of this study. It outlined critical research elements and described the participants, data collection and data analysis methods. Multidimensional data and analysis make qualitative research complex and challenging. However, embracing the challenge and finding methods to handle complexity results in a deeper analysis of change as it unfolds. Through using approaches such as three-dimensional data analysis, a qualitative researcher is strongly placed to obtain integrity-based, trustworthy and rich results. The following chapter will present an overview of the findings in this study and a precursor to the elaboration of these findings in subsequent chapters.

Chapter 5: Findings

5.1 Introduction

This chapter explores the findings emerging from this historical research study, which will be described across the next four chapters. Miller-Rosser et al. (2009) explained that, in historical research such as this, the pieces of the puzzle are arranged in such a way that the whole picture is revealed. In this chapter, an overview of the findings is reported as an advanced organiser for the chapters that follow. The chapter commences with a description of participant demographics. The findings are presented as a historiography that is then described further in subsequent chapters, which report the four major categories of findings. Reporting findings in this manner provides for an in-depth, comprehensive understanding of the factors that have allowed bullying to persist in the nursing profession and makes for a more holistic description.

5.2 Data Sources

The use of testimony methods to provide diverse perspectives was a significant feature of this research, given the gathering of information from both surveys and interviews. There were a total of 70 responses received. Of the 70 respondents, 53 (76%) completed testimonies online and 17 (24%) completed interviews by telephone. As discussed in the previous chapter, by being offered different data collection methods, participants were able to select the least confrontational approach for them, which is congruent with the role of bricolage in critical historical research described in Chapter 3. The vast majority of participants preferred the online option, likely reflecting the emotional nature of the subject matter being explored. It was interesting to note that the content of testimonies submitted on line was found to be as rich as those obtained through interview.

5.3 Demographic Characteristics

Demographic data were collected, including gender, decade of bullying experience, work location and work setting.

5.3.1 Gender. The majority of participants were female (94%, *n* = 66), as can be seen in Figure 5.1. The Nursing and Midwifery Board of Australia (NMBA) registrant data for 2019 indicated that 88.7% of registered nurses in Australia are female. Thus, this study has gender representation broadly similar to that of the nursing profession in Australia.

Figure 5.1. Gender of participants.

5.3.2 Decade the bullying experience occurred. Participants reported bullying incidents that occurred between 1981 and 2019, restricting the dataset to four decades. As can be seen from Figure 5.2, 6% (*n* = 4) participants referred to incidents between 1980 and 1989, 13% (*n* = 9) between 1990 and 1999, 23% (*n* = 16) between 2000 and 2009, and 58% (*n* = 41) between 2010 and 2020. In this study, most participants described bullying from recent decades, potentially reflecting the recency of memory and the possible retirement of nurses from the profession in earlier decades.

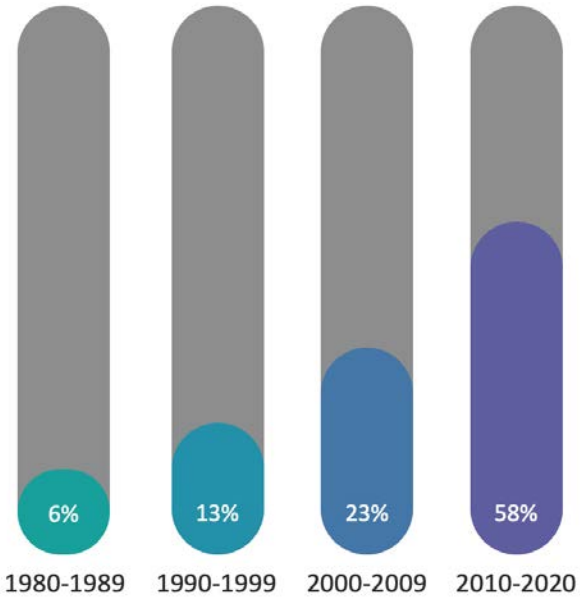

Figure 5.2. Decade the bullying experience occurred.

5.3.3 Geographical location. Participants were asked to provide information on the general geographical location in which the bullying experience occurred. Figure 5.3 shows that most participants worked in metropolitan areas when they experienced the incident of bullying reported in this study. The spread of location of the current registered nursing workforce indicates that 73% of registered nurses work in metropolitan locations, 17.7% in regional locations, 7.3% in rural locations and 2.0% in remote or very remote locations (Australian Bureau of Statistics, 2019). Given that this was not a quantitative study, caution should be used in making assumptions about the relevance of this data in explaining the location of participants' experiences relative to the broader distribution of nurses in Australia.

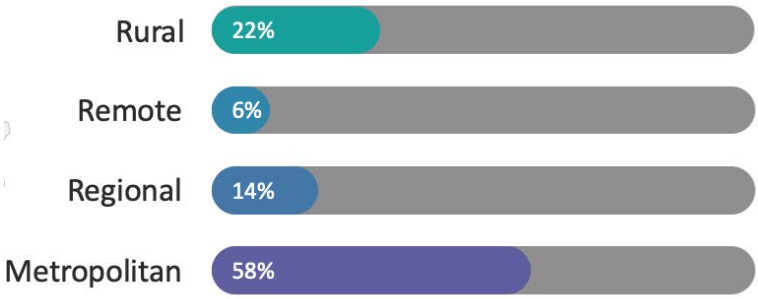

Figure 5.3. Geographical location of the bullying experience.

5.3.4 Clinical setting. The setting of the work area reported by participants as their place of employment when the bullying occurred indicates that these experiences were spread across a range of clinical contexts of the participants (Figure 5.4).

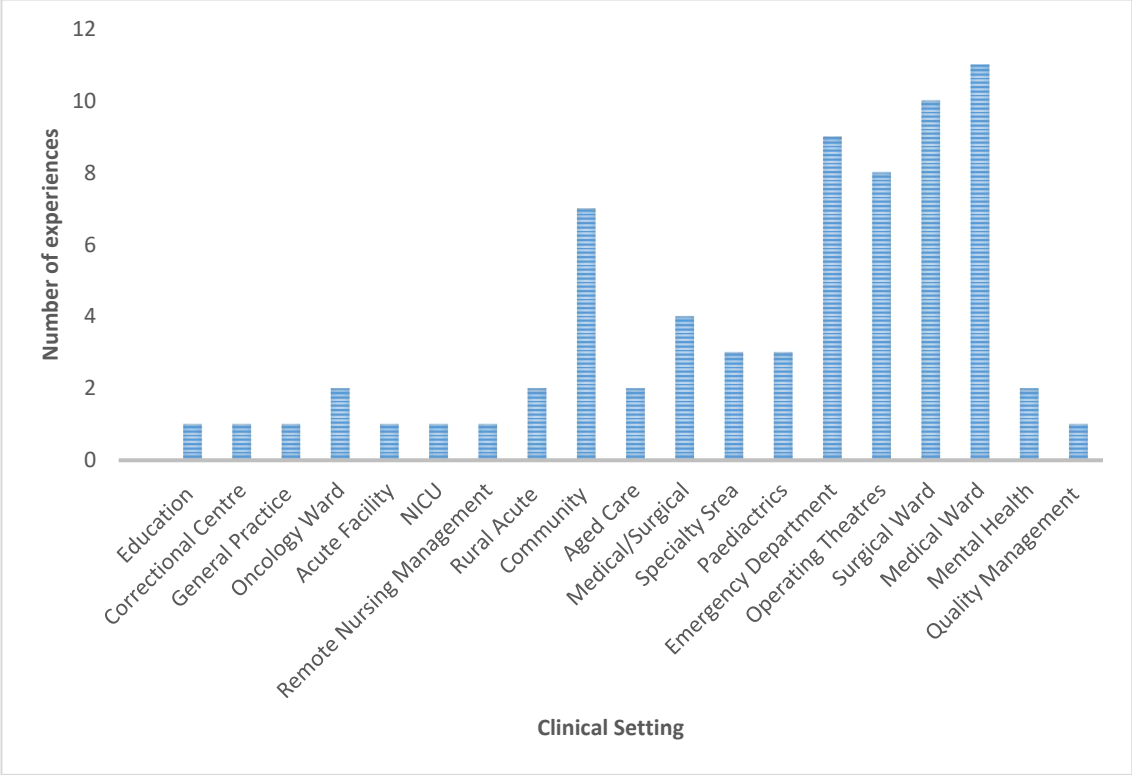

Figure 5.4. Clinical setting of the bullying experience.

5.4 Bullying in Nursing: Changes Over Four Decades

The major research findings from this study are contained in the following published manuscript:

Hartin, P., Birks, M., & Lindsay, D. (2020). Bullying in nursing: How has it changed over 4 decades? *Journal of Nursing Management, 28*(7), 1619-1626. https://doi.org/10.1111/jonm.13117

The three-dimensional analysis described in the previous chapter facilitated an understanding of the breadth and depth of the bullying experiences and how they evolved over time. The broad qualitative understanding (first dimension) developed through the first stage of this process made it possible to extract rich explanations of experiences described in the data and identify patterns within these (second dimension). The final analysis was juxtaposed over a timeline of decades to allow exploration (third dimension) of experiences over these timeframes.

The following article serves as a chronological overview of the findings of this study in the form of a historiography. While the complex categories derived from the analysis of data are explored in the chapters that follow, this article provides a snapshot of the findings and reveals that the antecedents to, manifestations of, responses to and impacts of bullying varied according to context and over time. Further, it established an organising framework for the descriptions of categories in the following chapters.

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ORIGINAL ARTICLE

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Bullying in nursing: How has it changed over 4 decades?

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Abstract

Aim: This study sought to explore how bullying in the nursing profession in Australia has changed over four decades, and why it continues to persist.

Background: Bullying in nursing is recognized as a pervasive problem. While much attention has been given to demonstrating the existence and impact of bullying in the nursing profession, little is understood about the evolution of this phenomenon and factors that contribute to its persistence.

Methods: This study employed an historical methodology using the testimony method of data collection. Testimonies were collected online and via interview from seventy registered nurses across Australia. Data were analysed using a three-dimensional analysis to produce a chronological historiography.

Results: This study found that the antecedents, manifestations, responses to and impacts of bullying in the nursing profession changed according to context and over time. The findings shed light on the role of nurse managers in the prevention and appropriate management of bullying in the workplace.

Conclusion: Prevention and intervention approaches must be developed to combat the complex and changing factors that allow bullying to persist.

Implications for Nursing Management: This study shows the role that management plays in tackling the problem of bullying in nursing. It can no longer be acceptable for culture to be used as an excuse for unacceptable behaviour, nor for power to be abused to protect perpetrators of workplace bullying. The findings discussed in this paper reveal that inexperienced nurse managers are often ill-equipped to identify and manage bullying. Nurses in management positions must recognize and acknowledge this deficit if the problem of bullying is to be effectively tackled.

KEYWORDS
Australia, bullying, historical method, nursing, testimonies


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5.5 Key Findings Across Four Decades

The three-dimensional analysis mentioned in the preceding article and described in the previous chapter generated four major categories, as listed in Table 5.1.

Table 5.1

Major Categories with Corresponding Thesis Chapters

Corresponding Chapter	Major Category
6	Antecedents to bullying
7	Manifestations of bullying
8	Responses to bullying
9	Impacts of bullying

In the next four chapters, the key findings of the study are presented. Each chapter explores one category in detail. Chapter 6 presents *Category 1: antecedents to bullying*, and identifies the issues that have allowed bullying in nursing to persist over four decades. Chapter 7 reports on *Category 2: manifestations of bullying*, which describes how the nature of bullying has changed over time. Chapter 8 reports on *Category 3: responses to bullying*, where the actions taken in response to the bullying experience are examined. Finally, Chapter 9 examines *Category 4: impacts of bullying*, and is dedicated to discussing the extensive and enduring effects of bullying on the nursing profession.

5.6 Conclusion

This chapter has summarised the critical historical research that examined four decades of bullying in the nursing profession in Australia, as described by the participants in this study. The findings highlight the pernicious nature of bullying in nursing and elucidate its ever-changing presence. The published article contained in this chapter described the key features of bullying through each decade, with a focus on the

antecedents to, manifestations of, responses to and impacts of bullying. The following chapter describes the first major category from this study, providing an in-depth discussion of the antecedents to bullying in the nursing profession.

Chapter 6: Antecedents to Bullying

6.1 Introduction

Chapter 5 introduced the descriptive findings relating to participant demographics. Chapters 6, 7, 8 and 9 are dedicated to discussing the key findings of the study, as outlined in Table 6.1: Major Categories. This chapter presents the *antecedents to bullying*, which describes the contributing factors that have allowed bullying in nursing to persist over four decades. Throughout the chapter, participant quotations are used to illustrate and reinforce the analysis presented in the narrative.

Table 6.1

Major Categories: Antecedents to Bullying

Corresponding Chapter	Major Category
6	Antecedents to bullying
7	Manifestations of bullying
8	Responses to bullying
9	Impact of bullying

It is vital to understand the dynamics that trigger bullying in the nursing profession to understand why bullying persists. *Antecedents to bullying* refers to pre-existing factors that enable bullying to occur. The findings presented in this chapter demonstrate the importance of using a critical historical perspective when seeking to understanding bullying in the nursing profession. The four main antecedents of gender, power, pressure and culture are discussed across four decades: 1980 to 1990, 1990 to 2000, 2000 to 2010 and 2010 to 2020 (Figure 6.1).

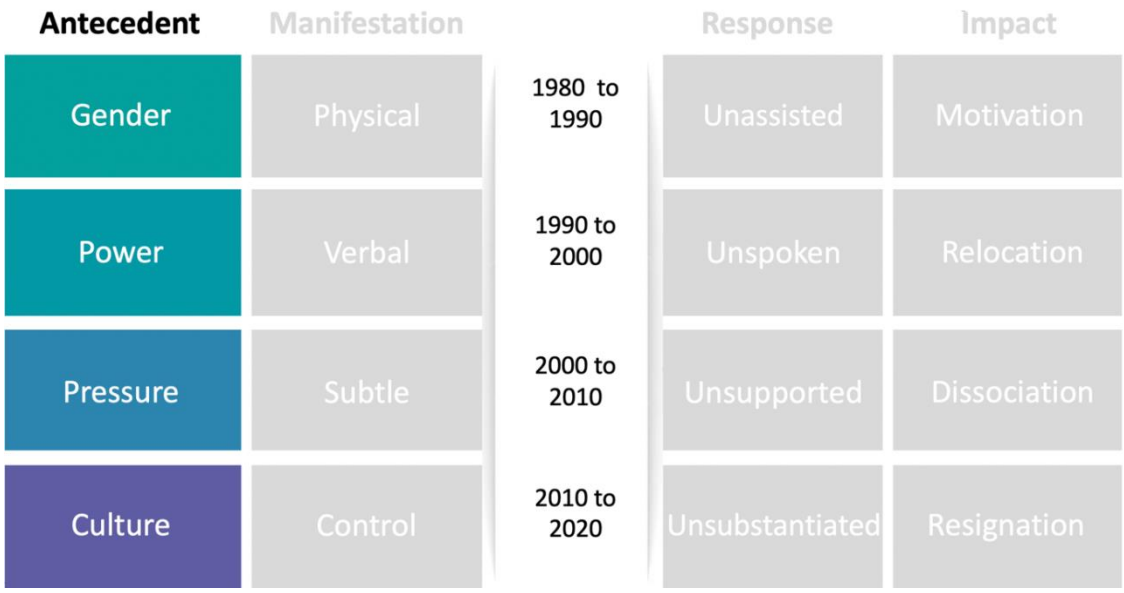

Figure 6.1. Antecedents to bullying across four decades.

6.2 Gender: 1980 to 1990

Gender was identified by participants as a significant antecedent contributing to bullying experiences during the period 1980 to 1990. During this time, a female-dominated workforce and men entering the nursing profession were considered by participants to be antecedents to bullying. Many nurses reported that the high percentage of females in the profession was a major antecedent contributing to their bullying experience. There were notable differences in how men and women handled stress in the workplace. This distinction was particularly true when dealing with change, as a number of participants reported that females displayed aggression towards each other when confronted with change.

Although participants indicated that bullying in the nursing profession was a systemic problem, inclusive of organisational culture and systems, a female-dominated presence was still the leading cause of ‘bitchy’ [T2M] bullying as part of the nursing culture:

> I think that, as a dominant female profession, I find that women tend to gossip and backstab. [T4F]
>
> I have to say most of the bullies are women—really, really sad, but true. [T3F]

These beliefs led to many participants saying that they would 'rather work in a ward of men than women any day' [T4F].

The concept of gender as an antecedent also included discussions around men entering the nursing workforce during this decade. Male nurses starting a new job on a ward comprised primarily of women rapidly found themselves the targets of bullying. The growing number of men in the nursing profession was not seen as a positive move towards gender diversity; instead, as one participant stated, 'as a male nurse I did not feel welcome' [T2M]. Participants believed that some nurses did not think men belonged in the profession, with a sense that the caring profession was only for women. Male nurses had to fight to fit in, as one male participant stated:

> As a new nurse to oncology, I was unfamiliar with the terminology and specific processes on the ward. I was given very limited orientation and was continually put down in front of staff and patients for a perceived lack of knowledge and ability. I was given the impression by the NUM [nurse unit manager] she did not like men in nursing, and there were no other males on the ward. [T1M]

6.3 Power: 1990 to 2000

During this decade (1990 to 2000), power imbalances in the workplace were described by participants as being an antecedent to nurse-to-nurse bullying. Nurses being socialised into structures with unequal power, along with diverse values and educational imbalances, provided the context for these experiences.

A perceived power imbalance, or an effort to exert power, was central to the bullying described in many of the participants' accounts. Participants identified the

status differential between new nurses and senior nurses as contributing to, and in some cases exacerbating, bullying in nursing. This power differential was not always emanating from another nurse in a senior position. Some participants expressed that an attitude of power existed when other nurses performing the same skill believed they had greater knowledge or expertise:

> When there is a perceived power [imbalance], some become abusive to those needing help, they can then influence the behaviour of those around them—'muscle flexing'—on the ward between equals. [T10F]

Participants felt that a key antecedent to bullying was the traditional hierarchical power structures, resulting in 'nurses eating their young' [I1F] and bullying being 'a rite of passage' [T8F]. The very use of such language reflects an unfortunate historical way of describing relationships and processes in the nursing profession. A number of participants spoke of experienced senior 'old school' [T5F] nurses—who were 'old dragons that started bullying [and] are still working and won't retire' [T11F]—ultimately treating others the way they have been treated: 'There are many old school nurses who don't realise they are behaving this way. This is how they were treated so the behaviour pattern continues' [T5F].

'Us versus them' [I1F] was the term used to describe power dynamics that arose out of questioning and advocacy following concerns that care was being compromised. Participants described experiences of bullying stemming from them speaking up to ensure quality patient care. The lack of collegiality and mutual respect ultimately hindered opportunities to learn from each other:

> I had been an EN [enrolled nurse] for 16 years before I graduated as an RN [registered nurse]. I continued to work in the same hospital and senior RNs expected me to go to another hospital. There were some practices that I

> questioned and proved the practices were not right with local policies and procedures. I asked why they did what they did. Instead of an explanation, I was subjected to bullying. [T12F]

A number of participants spoke about traditional values as antecedents that contributed to their experiences of bullying, stating that once-valued characteristics of nurses, such as compassion, care and sensitivity, were viewed as less important or even weak, further contributing to the 'us versus them' response:

> There is not much gratification for nursing well anymore. Now it is too technical or based on saving money; gratification is sought elsewhere, like bullying. [I1F]
>
> The value of nursing has been lost, making it easy to turn on each other, like when is a manager not a nurse? Instead of recognising each other's strengths and being united, we eat each other. [T9F]

Another challenge arising was the power clash between old and new modes of education. The divide between baccalaureate-qualified university nurses and hospital-trained nurses was another source of contention for old versus new. Although many described the move as an opportunity for senior nurses to provide wisdom and experience and new nurses to provide enthusiasm and recent education, it was labelled by one participant as the 'great divide in nursing qualification' [T6F]. Some 'thought the move to university education would reduce bullying, but it has continued' [T8F]. Instead of celebrating educational advancement, the notion of old versus new education was used as a way of excusing bullying:

> There were a lot of nurses who felt threatened. They felt threatened by university grads coming out and 'knowing everything', but not being able to do anything because there's that contrast between the lack of clinical hours that you get—and I must admit that was the case. We went from hospital training, where

> you were in the hospital all the time, into a university environment that ended up being minimal clinical hours of clinical placement, so [during] the grad year, you were supposed to get all of that under your belt. But there was hostility and they just didn't want to know about it. [T7F]

In some instances, participants felt that the desire to undertake further study was the precipitating factor for bullying: 'As I was enthusiastic about further study, I think she felt threatened by my eagerness and took pleasure in reprimanding me at every opportunity' [T8F].

6.4 Pressure: 2000 to 2010

During 2000 to 2010, pressure in the workplace was portrayed as a prime antecedent to bullying. For participants, pressure was the result of inadequate resourcing extending to insufficient staffing and further compounded by a growing number of higher acuity patients. Participants in this study discussed workload pressure as a significant antecedent. Increased workload responsibility, compounded by a 'complex healthcare' [T19F] environment that is subjected to 'constant change' [T13F], built over time to provide the backdrop for poor relationships among nurses.

Some participants felt that the increased workload pressure was 'led by the high level of patient acuity in nursing' [T17F]. Others felt that the reasons were more complex and extended beyond patient acuity. Comments were made about time pressure, budget pressure, 'leaders not being aware of what work the minions need to be doing' [T22F] and inadequate preparation to cope in this environment. Nonetheless, increasing patient complexity and a higher acuity of patients, combined with a general 'lack of time' [T19F] and significant budgetary pressure, were perceived to lead to increased bullying:

> The biggest problem is that time is money, which there is not enough of both [sic], so everyone is under the pump to get things done. It's harrowing to watch staff struggle, being criticised and told to hurry up—this is when mistakes happen. I feel sorry for the next generation; this is only going to get worse. [I4F]
>
> But we also understood that you can't just spend money for the sake of spending money, but we were getting a lot of flak. [T14F]

In some cases, participants experienced being permanently 'overburdened with workload' [T25F] and eventually not coping, leading to adverse events. The amount of work required to be completed within a particular timeframe greatly contributed to mistakes and blame:

> Many nurses come from school into nursing and have no real-life experience, so many have the schoolyard attitude. Due to the lack of nursing staff and increased workload, errors occur and it is much easier to blame others to cover yourself. [I2F]
>
> The team leader handed over a transfer from OT [operating theatre] to the ward. The receiving RN then left the ward in tears. The team leader asked me to document in the notes that a medication had been missed for the same patient. I refused, stating it was her and the RN who left in tears responsibility. I continued to receive subtle bullying and ended up in front of the ADON [Assistant Director of Nursing] for missed medication. [T24F]

While technology has enhanced healthcare, it was also identified as affecting workload pressure and contributing to the problem of bullying in nursing. Participants spoke about interactions with machines, rather than people, and feeling pressured by technology. In one instance, technology was being used to isolate a participant who was denied adequate training.

Higher patient acuity combined with inadequate resourcing was a significant antecedent:

> I performed post-mortem care of a patient in a storeroom. We had a patient who almost died in a four-bedded room; we moved him probably within 15 minutes of his death, but, to do that, we had to move another man, who was actively dying, into a four-bedded room. So, we were doing our best to compensate for our lack of environmental needs that weren't serving the patients. We had to withhold end-of-life care from another patient because he was in a four-bedded room. We were log-jammed with infection cases, dying people and radiation cases that had to be isolated. And the icing on the cake was when management decided that they were going to renovate our storeroom. [I3F]

Inadequate resourcing extended to insufficient staffing, with participants identifying this as a reason for their bullying experience. Inadequate levels of staff produced feelings of 'irritation' [T13F] and 'being unappreciated' [T21F]. One participant said 'nurses are pushed to their limit to get everything done, with the few staff available' [T15F], as a way to explain why bullying persisted at that time. In one instance, a participant revealed how pressure resulted in them becoming the bully:

> I left one workplace because I felt like I was becoming a bully. That may sound weird, but it was normal. I really care about the people I work with and would never want to make someone regret coming to work. But I regularly found myself losing it and yelling. I got in this situation where my patient just didn't get the help they needed (this is ICU [intensive care unit], where you only have one patient) and they were lying in their own poo for six hours. We had single rooms and no one would come to help assist in rolling an unconscious, six-foot, intubated man who had been a difficult intubation (so you are supposed to have

> a tube hold, as well as a person to roll them, so you can clean them up). And then the afternoon access person came on and told me I had to go to CT, so I asked if they would assist me and they refused, and I lost it. There was no way I was pushing a patient covered in their own poo all the way through the hospital—it was disgusting that no one had helped me already. I threatened to hit the nurse. I would never do it, but it just came out of my mouth. I wonder how much bad behaviour would go away if there were enough nursing staff on the floor. [T21F]

Notably, multiple participants mentioned displaced pressure from senior executive staff to nurse unit managers around resourcing restrictions. These senior nurses then displayed displaced aggression towards nurses:

> The nurse manager was working under the direction of head office. I worked there for about three years before she [sic] and had worked in [a] GP [general practitioner clinic] for 17 years. She was probably under pressure, but consistently nit-picked everything I did. [T23F]
>
> Nursing managers are pressured to place unmanageable workloads on staff. [I3F]

When participants confronted managers expressing concerns with workload or staffing issues, they described feeling ‘powerless’ [T25F] and ‘hopeless’ [T19F]. Moreover, when they voiced concerns about the amount of workload, there was little sympathy from management, who would provide excuses with an expectation that participants should do what was required because ‘other nurses can get the job done’ [T16F].

6.5 Culture: 2010 to 2020

The perpetuating cycle of bullying in the nursing profession was now labelled a ‘culture’ [T29F] that emerged, where bullying was accepted and ‘will never be fixed’

[T37F] because it did not result from any single factor. This decade saw the rise of managers inadequately prepared to deal with the bullying epidemic, which contributed to a culture of acceptance, cover-ups, lip-service and corruption. Socialisation, competition, organisational change and team dynamics all contributed to the establishment and persistence of this culture. Many participants felt that bullying was solely due to incompetent managers. There was an overwhelming sense of lack of support from managers who would 'condone bullying behaviour' [T26F]:

> The person who initiated the bullying against me has a long history of bullying behaviour that they have never been held to account for. [T53F]
>
> This person deliberately targeted individuals. She was like a schoolyard brat because the manager overlooked her multiple transgressions. [I7F]
>
> … they'd just sort of shrug and say, 'Oh, yes. She's that kind of person'. It was like, 'Okay. You're not doing anything about this'. [T28F]

A relationship can be identified between the lack of capability of managers and the flourishing of a bullying culture. Nurse unit managers were held responsible by participants for not responding appropriately and addressing bullying on the frontline. Many nurses who complained to managers were disappointed with the outcome:

> I did report it. There was a lovely document written by the nursing director saying that we were going to work in a safe environment, that we were going to communicate and there was going to be minutes, and if there were any problems that she would attend at least monthly to talk to us and be available. I thought 'oh, this is pretty good', and yet nothing happened. [T28F]
>
> Something I call 'patchwork management'. If there had been stable leadership and that leader knew me for the good nurse that I was, perhaps they would have

> been more empathetic and compassionate about what I'd been through, and more understanding about trying to get me back to work. [I5F]

Incompetence was seen to result from managers lacking the 'know-how' [T36F]. This lack of ability included poor conflict resolution skills and other manifestations of inadequate preparation to handle bullying in the workplace:

> The reality is they don't have the knowledge, skills of exposure in the area, yet are being promoted into these positions. [I11F]
>
> What made me really angry was the people who hired me already knew this was going on previously. [T45F]

In addition to poor conflict resolution skills, participants spoke about lack of consistency and transparency from nurse managers as another antecedent, particularly around promotions, which was seen as 'friend based instead of merit based' [T31F] and 'managers who let things slide for some while others have to abide by the rules' [T41M]:

> The power of people over employment means that they tend to employ like-minded. So, if you've got people with certain characteristics, they will employ people of a similar bent. So, if they see their role in management around command and control, rather than some sort of distributive power, they will employ people who fit in with that worldview more closely and I think the 'command and control' thing lines up with bullying. [I12M]

Participants in this study did acknowledge that, for nurse managers, dealing with bullying can be problematic in the fast-paced and complex healthcare environment, particularly given the increasing pressure on that environment. Some participants acknowledged that nurse unit managers tried their best, but were not supported to deal with bullying behaviour:

> Her personality is very extroverted, militant, sort of very out-there personality. She seems to be very well respected by the consultants and particularly for her clinical knowledge, so it's a difficult place to be in when one of your best clinicians is viewed by her peers as a bully. [T49F]

The lack of leadership led to bullying in the nursing profession being described by many as 'the new normal' [T30F], resulting from the behaviour 'being accepted' [T41M] by management. Worse still, the problem was actually being filtered from the top down in a process by which 'the fish rots from the head' [T45F]: 'Bullying is accepted from the top and works down' [T34F]. This acceptance of bullying fed a culture where 'shifts are seen as surviving not thriving' [T29F], which, again, helped ensure bullying continued to flourish in the profession.

> It has been tolerated and allowed; therefore, a culture has developed. It is especially bad if the management bullies. I've seen that the environment takes on the culture of their managers. A bitchy manager managers a bitchy and petty environment. [T32F]

> I've worked in many different clinical areas and academic areas and the consistency is with strong and supportive leadership, whether it be academic or clinical. If you've got a manager there who doesn't tolerate it, then the whole unit is just a brilliant place to work and it gets sorted out beautifully. But where you've got someone who is just weak and doesn't act on anything, it just spreads like wildfire, it's terrible. [T43F]

In this culture, cover-ups were seen in a context that worked to downplay the extent of bullying that existed: 'The fact that the manager knew what had happened to me and other senior nurses, but they strove to protect their friend' [T51F]. Participants commonly shared experiences about managers who voiced that bullying would not be

tolerated, then repeatedly did nothing to address it. These managers were seen to only give lip-service to addressing bullying:

> Managers need to be willing to address bullying as a real issue and actually take a zero-tolerance stance. [I5F]
>
> I thought they would appreciate—they're even an organisation that says zero tolerance to bullying, and it's all bullshit because they're honestly not doing anything about it and they hire them again and again. [T32F]

In one instance, a participant described how a manager spread lies about mediation that never occurred. Ultimately, the behaviour from management reflected an institutional culture in which social processes were more powerful than the adoption of managerial techniques founded on evidence. Socialisation to the role of nurse unit manager was noted as a significant antecedent. Participants described it as a consequence of a previous learnt behaviour and managing the way that they have been managed: 'People in high positions say the right things, then exhibit the very behaviour themselves, which then reinforces that it is actually okay to behave this way' [T50F]. Socialisation not only influenced the behaviour of the nurse unit manager, but also other registered nurses in the team who exhibited bullying behaviour. Ultimately, nurses ceased to view their behaviour as bullying, and subsequently did not regard it as a problem.

Some participants raised the notion of intent—that is, did the registered nurse feel the bullying behaviour was deliberate, or was it unintentional and part of a learnt behaviour? The intent to bully was not considered to be measurable without an admission by the bully. The majority of participants suggested that they felt specifically and deliberately targeted; however, some participants suggested the registered nurse was unaware of their bullying behaviour and its effect: 'The bullying is so entrenched in the organisation, I doubt most are even aware of their behaviours' [I6F].

Participants described the nursing profession as a culture that promotes ‘troubled’ [T31F] nurses to simply move them along. Described as ‘promotion sabotage’, this corruption created a sense of competition in the profession, which added another layer of bullying. Participants spoke about the increasing presence of ‘competition’ [T47F] in the workplace as an antecedent contributing to bullying:

> Instead of building each other up, we tear down through comparison and competition. [T39F]

> There’s a lot of competition. I’ve had younger nurses ask me why am I still working and applying for positions, so a lot of assumptions that people are doing things for other alternative reasons. [I9F]

Several participants stated they saw more evidence of bullying during this decade; however, it was suggested that exposure to bullying increased as organisational change emerged. Organisational changes played a significant role in contributing to a culture of bullying. For many participants during this time span, change within the organisation and, more specifically, the manager responsible for the change, was referred to as preceding the occurrence of bullying. While some participants in this study believed that organisational change directly encouraged bullying, others suggested that organisational change indirectly fuelled their bullying experience through the autocratic leadership style implemented from management at the time.

Ultimately, participants in this decade described the culture in which they worked as ‘hostile’ [T52F], ‘belligerent’ [T27F], ‘nasty’ [T36F] and ‘combative’ [T42F]. Without appropriate intervention from management, such an environment created distrust, disunity and ‘no sense of teamwork’ [T33F]. The dynamics of the nursing team—particularly team unity—had an effect on bullying. While a number of participants in this study believed that team collegiality was an effective means to

reduce bullying in nursing, the development of an effective team culture was hampered by constant changes in team composition. Therefore, lack of cohesion between the nursing team was identified as both an antecedent that contributed to bullying and an essential factor in moderating bullying.

6.6 Conclusion

The major findings explored in this chapter, *antecedents to bullying*, revealed some of the key issues that have allowed bullying to continue and flourish in the nursing profession over time. The findings discussed in this chapter suggest that power imbalance, workload pressure and a culture of acceptance have been antecedents for bullying in the nursing profession in Australia. To better understand how bullying has had a sustained presence in the nursing profession, it is necessary to understand the nature of the bullying behaviour to which participants in this study were exposed. These behaviours will be discussed in the following chapter as the *manifestations of bullying*.

Chapter 7: Manifestations of Bullying

7.1 Introduction

The aim of this study was to explore the phenomenon of bullying and focus in particular on why bullying persists in the nursing profession in Australia. In Chapter 5, descriptive findings were introduced in relation to the demographics of the participants. Chapter 6 examined the antecedents that contributed to the occurrence of bullying. This chapter presents the findings related to the *manifestations of bullying* (Table 7.1) and maps how the face of bullying has changed over time. Negative behaviours perceived as bullying are described and insights are provided into bullying as experienced by registered nurses in Australia. Once again, participant quotations are used to illustrate and reinforce the analysis presented in the narrative.

Table 7.1

Major Categories: Manifestations of Bullying

Corresponding Chapter	Major Category
6	Antecedents to bullying
7	Manifestations of bullying
8	Responses to bullying
9	Impact of bullying

Following discussion of the antecedents (Chapter 6) to bullying, it is important to identify how bullying is manifested. The findings presented in this chapter describe the behaviours recounted by participants that they believed constituted bullying. In analysing the experiences, no single type of bullying was evident. The behaviours identified by the participants indicated that bullying was perceived to occur across a very wide range of experiences, some of which extend beyond the common, simple image of bullying. For participants, bullying was a dynamic, multifaceted issue. The

following discussion will focus on the four main types of bullying described by participants as occurring in the nursing profession, as it has changed across four decades: 1980 to 1990, 1990 to 2000, 2000 to 2010 and 2010 to 2020 (Figure 7.1). These behaviours manifested as physical, verbal, subtle and control.

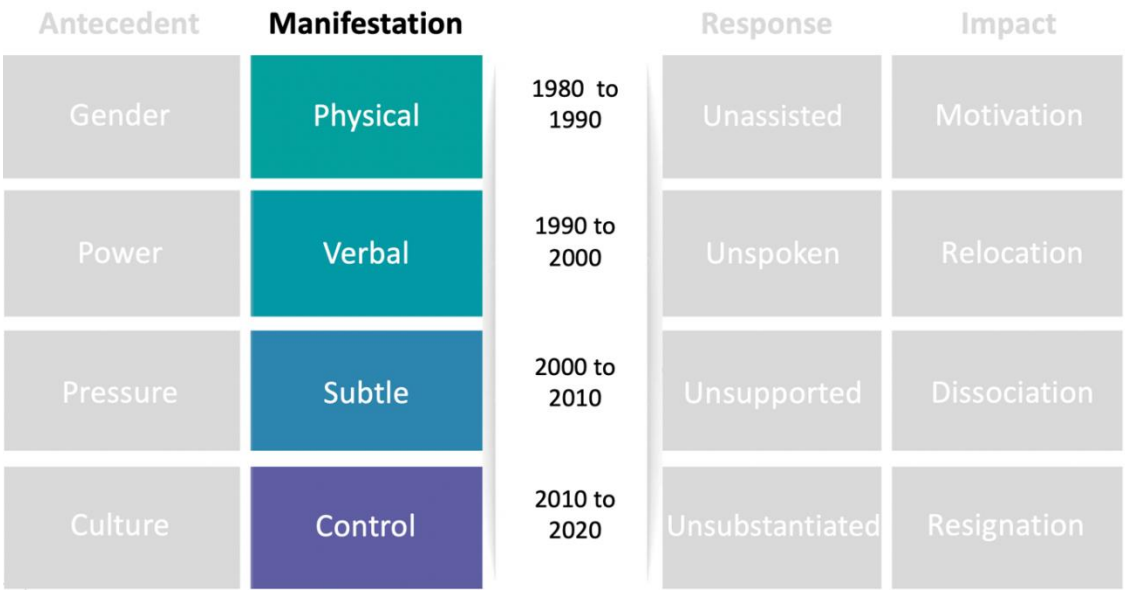

Figure 7.1. Manifestations of bullying across four decades.

7.2 Physical: 1980 to 1990

During 1980 to 1990, the manifestation of bullying behaviour experienced by participants was more likely to be physical than it was across the other decades. In describing their bullying experiences, participants highlighted that the behaviour was overt and explicit. All participants described bullying during this decade as obvious and public in nature. Bullying behaviour occurred openly in front of others, thereby attracting attention, with one participant saying the explicit 'actions were intended to be seen by others' [T3F].

Participants described frightful situations; for example, in one case, a registered nurse 'would physically hit me, while telling me what I was doing wrong' [T2M]. This

type of bullying was also described as a phenomenon that was sustained over time. The behaviour was not experienced as an occasional incident—in some cases, it spanned several years:

> Maybe my honesty and my direct approach may have been confronting, and maybe saw me as a threat, but the nurse manager physically assaulted me during the two years on the ward. [T2M]
>
> One of the colleagues always slapped my hips. It doesn't matter if it's for fun or not. It's all up to her. This happened over and over. [T4F]

Participants also described experiences that stopped short of physical bullying, but always implied it was a risk, such as being 'threatened with physical violence' [T4F] that was purposeful in nature.

7.3 Verbal: 1990 to 2000

Verbal bullying was the main manifestation of bullying described by participants during 1990 to 2000. Verbal bulling was conceptualised by participants as language that attacks an individual. In many of the experiences, verbal bullying occurred during meetings on the ward and generally in front of witnesses. Verbal bullying is generally perceived to occur when one person yells at another; however, experiences in this study revealed that nurses who employed verbal bullying were skilful and subtle, as well as obvious and observable. This type bullying was both direct and indirect, and included demeaning comments, insults, threats and abuse. There was, however, great variation in the experiences of verbal bullying by participants in this study.

A number of participants reported that the verbal bullying was indirect in nature. Participants spoke about comments made behind their back and whispers in corridors that ceased when they walked by. Conversely, the use of direct bullying was also

evident. Direct bullying occurred in front of colleagues and patients. In particular, handover and medical emergencies were a common time when bullying would occur. One participant described the behaviour as ‘hell on earth because they all carried on like it was a freak show, yelling at each other in front of the patient’ [T10F]. It was also mentioned that verbal bullying included regular interruptions and deliberately trivial questions. One participant described it as being ‘setting up to fail’ [I1F], which left nurses struggling to even understand or make sense of what had happened: ‘It was unnecessary setting up of questions that were never going to come out in a positive way’ [T8F].

Participants reported verbal bullying issues in the nursing profession that left them feeling deliberately targeted. Verbal bullying was described by participants as a method used by the bully to advance themselves in the workplace. One participant summarised verbal bullying with the following statement:

> I provided maternity cover leave for 10 months for a NUM. Six weeks after having her baby, I heard comments about my ability to do my job. This intensified in the weeks before her return and, once she returned to work, I returned to my CN [clinical nurse] position and verbal bullying occurred. The bullying was subtle and prolonged and I had actually witnessed the same behaviour towards a number of staff prior to her attention being turned to me. [T5F]

The fundamental criteria for determining participants’ perceptions of verbal bullying was whether the behaviour was interpreted to be fun or not. In some cases, this behaviour was perceived by participants as workplace banter, not meant to harm. When colleagues communicated while smiling or laughing, the verbal bullying was interpreted as playful. However, at times, the content of the interaction was crucial. This was

especially the case when the verbally bullying targeted personal characteristics. In one instance, a participant described how ‘one of my peers had carried on a distasteful joke over a period of four months toward me’ [T11F].

Participants also described regularly experiencing ‘snarky comments’ [T11F]. These comments were demeaning in nature and reported as insidious daily experiences. Participants described being subjected to persistent criticism, receiving ‘crude comments’ [T12F] and being ‘shouted at for not knowing stuff’ [T7F]. In one instance, a participant was told repeatedly that they were ‘useless due to lack of experience’ [T5F]. Verbal bullying, as experienced by participants, was generally in the form of insults or ridicule, such as humiliating a nurse in a setting where there were witnesses. Complaining about the behaviour in front of others or while others were laughing often worsened the situation. Participants initially perceived verbal bullying incidents as trivial and ignored them, but repeated behaviour saw these incidents take on new meaning for them.

Verbal bullying also included threats to professional status, as well as personal threats. These were experienced by participants as an ongoing series of verbal assaults for the purpose of pushing the staff member out of the team:

> When I spoke up and refused to receive a paediatric patient for cardiac monitoring on an acute adult ward, I was told my registration was on the line and [was] belittled and spoken to like I was uneducated. [T9F]

Often, the verbal bullying was accompanied by a dominating physical presence:

> I get called into the NUM’s office with no pre-emptive idea about what it was about. The office was very small. I first went into the office with the original nursing unit manager who was returning from leave. I was seated and then the current NUM covering walks in. She closes the door and stands, blocks my exit.

> And she proceeds to fire accusations at me. I'm cowering in the corner. But really, she was destroying me. Virtually, she was telling me I was a bad nurse. [T6F]

Unfortunately, participants in the study described experiences demonstrating an escalation in verbal bullying that was hostile and expletive-laden in nature: 'he started telling us that he was just f*cking sick and tired of all the f*cking sh*t that you f*cking nurses bring to this place' [T12F]. Personal and situational variables were recognised by participants as triggers to the verbal abuse:

> He came holding the book, the DDA [Drugs of Dependence] book, and just slammed it on the table really hard and says, 'How do you explain that? You haven't even f*cking signed the DDA book. I'm sick of your lazy f*cking arse'. [I1F]

7.4 Subtle: 2000 to 2010

During 2000 to 2010, the manner in which bullying expressed itself in nursing changed considerably to manifesting in more subtle ways. Bullying was fundamentally hidden and sly. Experiences were so subtle that they may not have been apparent to others who were present when bullying was occurring. Subtle experiences included intimidation, exclusion, gossip and exploitation.

Subtle bullying exchanges embedded into normal work activities during this decade were found to be more common than overt forms of bullying. The use of subtle 'intimidation of colleagues' [T22F] was perceived by participants as a way that the bully was able to torment from a distance. Such behaviour was viewed by participants as the mechanism by which the bully tried to demonstrate their superiority, power and ability to exert control over others, with one participant stating 'her manner was one of intimidation' [T18F]. While not an obvious behaviour, participants described tyrannical

conduct—for example, it was expected that the bully would talk and everyone else would simply ‘sit and listen’ [T22F].

Participants described experiences that were similarly subtle in nature, yet also used as a way to exert power and authority. Participants suggested that the bully used this behaviour intentionally and strategically in an attempt to intimidate by undermining them:

> When trying to advocate for nursing staff at a meeting, my line manager sneered at me and repeatedly asserted that nobody knows what I’m talking about and I’m not making any sense. [T15F]

Similarly, there was suggestion that the bully was able to determine a colleague’s most vulnerable trait and use that weakness as leverage:

> The NUM will repeatedly call me into her office to berate me over the smallest of things and has a knack of finding your weaknesses and exploiting them, knowing full well she has made me cry, she will keep going and going and going. [T22F]
>
> The professional bully is smart—they are subtle in their behaviour and who they prey [upon]. [I2F]

Exclusion in nursing was commonly reported. Exclusion took on many forms, including withholding essential information and exclusion from professional development opportunities. Participants described exclusion tactics as ‘not acknowledging me’ [T14F], ‘ignoring me when I entered the room’ [T25F] and ‘deliberate isolation’ [T21F]. Several participants shared examples of deliberate withholding of information from colleagues—for example, ‘I … was not told about meetings I needed to be at or changes that were taking place’ [T18F]. Although this type of bullying was not overt or observable, this act of omission was detrimental to the

victim's job performance. This experience was labelled as 'categorical sabotage' [T14F] that was designed to humiliate and undermine performance:

> Information was withheld. I was put in a number of excruciatingly embarrassing situations because I wasn't privy to the information. [I4F]
>
> Another nurse not speaking to me, talking to all other nurses except me—this was during handover and I needed to know what had happened to continue the care. [T16F]

Participants described exclusion as having a ripple effect, which, in some cases, created opportunities for further isolation:

> I had been an EN for 16 years before I graduated as an RN. I continued to work in the same hospital, but senior RNs expected me to go to another hospital. There were some practices that I questioned and proved the practices were not right with local policies and procedures. I asked why they did what they did. Instead of an explanation, I was subjected to isolation. [T13F]

In some instances, registered nurses felt it would have been easier to deal with 'someone yelling at me all the time' [T20F] than with workplace exclusion.

Participants also shared examples of exclusion that were social in nature. Many reported that feelings of isolation served to remove them from the group or team, making them feel different and that they did not fit in. As the decade progressed, this social isolation was experienced through 'eye rolling' [T13F]. One participant expressed that this type of bullying did not involve confrontation, but rather passive intimidation: 'they started picking on me, little things at a time, like just hostility and unfriendliness and eyes rolling and stuff like that' [T13F].

Described as the 'sick and twisted sister' [I4F] of bullying, these more subtle forms of bullying also included acts of 'gossip' [T17F]. Participants noted that the use

of gossip and spreading rumours about colleagues was a malicious activity that was seen to be enjoyed by some. In such cases, the bully used rumours and gossip as 'tools in their back pocket' [I3F] to damage the reputation of others. Backstabbing in the nursing profession was also a growing issue of concern during this period. Given that nurses need to work as part of a team all day and all night, colleagues should be their most valuable resource. However, the participants suggested that backstabbing colleagues created a team of fear—fear that colleagues would take whatever was said or done and turn it against another to that person's detriment.

Exploitation was also described as a form of subtle bullying during this time. Registered nurse bullies were unconcerned about their colleagues' welfare and would take whatever action was necessary to achieve career goals, irrespective of whether colleagues were harmed in the process: 'It culminated in a staff member deliberately damaging equipment to try and show that I was incompetent, as I could not fix it' [T24F]. The subtle manifestation of bullying was also opportunistic, in that the bully would encourage others in the workplace to take part in these negative behaviours when the opportunity arose:

> I've just felt isolated, excluded. With the new team that's now there, they are now doing it to me (and my colleagues) and I said to the nurse manager—I had a breakdown at work, I just couldn't stop crying. And I said 'the CNC [clinical nurse consultant] doesn't have to do anything anymore, the others do it for her'. So they're not telling me things, and these are clinical things, they're not handing over things. And then I come to work and I'm expected to go on an outreach that could be planned. I think if you're going to be doing the nursing process, and there's time for planning—like there was four days that they didn't tell me, and I could have planned and researched that patient, rung the facility,

> found out what they had tried, what exactly were the behaviours, what are the families saying, what are the staff saying, what does the GP [general practitioner] say, what medication—there's a whole usual process. But I get to work and 'oh, you're going on an outreach today to assess this person'. And I thought 'okay, that's alright, don't mind, but it would have been nice if you'd told me'—I could have planned for that. [T21F]

Participants described the manifestation of bullying in this decade as 'cliques of nurses huddled together' [T17F]. This was labelled by one participant as 'mean girls' [T13F] to express the experience of negative connections in the workplace. One participant described how the bully was able to 'hide behind the group' [T19F], so the bullying behaviour was not traceable back to one particular person. The experiences reflected a nursing team that lacked true cohesiveness through a process of social normative influence—that is, behaving the way everyone else behaves. In other words, it was a case of either bully other people or be bullied yourself.

7.5 Control: 2010 to 2020

Participants' experiences during 2010 to 2020 evolved from the previous subtle tactics and manifested as inexperienced managers seeking to establish authority in the workplace. Experiences can be categorised under the theme of *control* to better understand the varied experiences that registered nurses endured in relation to workplace bullying. This control was in respect of the working environment, and centred around micromanagement, unrealistic expectations, workload allocation, roster preferences, career obstruction, impeding collaboration and blame-shifting. The diverse range of tactics used in this category further demonstrate how bullying behaviour can be covert, rather than openly aggressive.

Participants identified bullying as being ‘watched’ [T34F] or ‘followed’ [T45F] unnecessarily in the workplace. This led to a perception of being micromanaged through ‘excess scrutiny’ [I11F]. Many participants described managers who would find problems with everything that was done. Participants also shared that they ‘weren’t allowed’ [T42F] to perform particular tasks or even schedule necessary meetings. In some instances, participants had to ‘ask for permission’ [I6F] to complete tasks that were required of them, with one participant asking ‘when did it become a problem for someone to cover you to go the bathroom?’ [T51F]. Participants in the study also described unrealistic expectations to complete tasks without receiving clear goals from management. One participant described feeling like a ‘robot’ [T17F] at work, having to complete every task to exact specifications, which were unknown. Ultimately, this led to participants being sabotaged for not living up to expectations.

Further, unfair workload allocation was identified by participants as a mechanism for bullying. In some cases, these nurses were assigned tasks that the bully did not wish to undertake themselves. Workload allocation also involved receiving an ‘unsafe patient allocation’ [T30F] and ‘excess work … be[ing] dumped’ [T28F] on participants. This dumping was reported to be accompanied by threats, both direct and indirect, regarding job security:

> Her method of operation was she would target people, make personal comments, and punish them with allocations of where they worked in the department and threaten getting fired. [I9F]
>
> The NUM allocated patient loads. He thought it was funny to team me up with another nurse related to size. I’m 184 cm tall and was repeatedly allocated with five-feet nurses purely for his entertainment. When I said something, he would

> tell me to find another job. Clearly, health and safety of patients was not his concern. [T53F]

Conversely, participants also spoke about the rising incidence of the removal of workload responsibility:

> I was targeted because of my experience in operating suite of some 30+ years. They had an agenda of wanting young and malleable staff so they could mould the staff to what they wanted. The problem was that I had worked for the private healthcare facility for nine years at a different campus and the work ethics didn't transfer to new campus. Subsequently, I was micromanaged, had portfolios removed and even had my situation referred to as 'the battered wife syndrome', meaning I could choose to stay, but be prepared for continued abuse. [T41F]

Concerns were raised about unfair rostering and managers ignoring the fact that staff have personal lives outside the workplace. In some cases, requested days off or annual leave were denied, which was labelled as bullying by participants:

> At the time in my personal life, I had issues and requested time off [and] I was denied and told to make sure my personal life didn't interfere with work. [T36F]
>
> There was the death of a colleague and I applied to go to his funeral and I was told that the family didn't want work colleagues there, so I didn't attend—and that was not the case and I had a lot of people approach me, 'Why wasn't I there?'. [I12F]

Participants believed that bullies held, or had access to, 'considerable organisational resources' [I6F] and legitimate authority to dismiss them or otherwise obstruct their career progression. Bullying was seen to be more prevalent around promotion by sabotaging a nurse's position. Participants gave examples of bullying as management playing favourites and therefore restricting career advancement; however,

many participants voiced that this type of bullying could not be substantiated in the form of a report. An example was a selection committee chaired by a nurse manager that followed correct process, yet covertly ensured that a particular nurse was not selected for promotion.

Controlling the work environment in this way was a mechanism by which the bully could force colleagues to understand that they were in charge and had the ability to adversely affect their position as a registered nurse. Participants suggested that threats to their employment were used to force them to recognise the bully's control and follow their instructions, or simply give in and remain fearful:

> Our NUM will knowingly exclude me from training that everyone else in my ward gets the opportunity to do, then when application time comes for CN promotions, will hold it against me that I haven't had said training. [T26F]
>
> My role was a secondment role which I had been doing for six years successfully. There were two of us doing these roles in the district; it is a state-wide funded role. Change in the district Director of Nursing (my line manager). She had previously been the local DON [Director of Nursing]. She tells both of us that she wants us gone, as it's time for someone else to 'have a go'. She appoints her crony as the local DON to replace her and a known bully to oversee us. She proceeds to micromanage us, tell us we are useless pieces of sh*t, spread lies about us, undermine our self-confidence. [T37F]

Often, these controlling managers ignored or dismissed opinions of staff, demonstrating their failure to recognise the importance of collaboration. One participant expressed concern that the control from management felt 'like a wedge driven between colleagues' [T29F]. Participants described how this controlling behaviour had implications for the way the team interacted with each other, with one participant

stating ‘the NUM would never call me by name’ [T31F]. By itself, this experience may not appear to be significant; however, there were multiple experiences from participants in this study with a belief that using a nurse’s name is a form of recognition for their contribution and value in the workplace. Conversely, these bullies were known to try to use their job title as a way of demanding respect from colleagues. However, participants noted that, while typically respecting the position, they often failed to respect the person.

Participants also spoke about management assigning blame to others for their own mistakes. A number of participants described finger-pointing as the type of bullying to which they were subjected. Usually, this type of bullying included evidence of a pattern, where the behaviour was directed at one colleague at a time. This suggested that, when participants viewed the situation with objectivity, they could see that the bullying behaviours covered a longer time span than just the experience they shared: ‘The NUM targeted him first, then, after he resigned, she and the acting manager went full-frontal assault on me’ [T41F].

Nearly all the experiences during this decade showed that bullying—in the form of control—systematically undermined an individual, while being justified in the eyes of the bullying manager. Notably, during this time, participants also shared a variety of examples to illustrate their experiences of witnessing colleagues being targeted by management. Further, participants discussed how this behaviour set the scene for a hostile workplace culture because rarely was the controlling behaviour challenged. One participant described witnessing a colleague be punished and ridiculed, suggesting the nature of behaviour from management as ‘simply one of being unkind’ [T32F].

7.6 Conclusion

The findings discussed in this chapter have considered the manifestations of bullying and highlighted an array of experiences by registered nurses across four decades. The changes over time have important implications for interventions and emphasise the need to avoid simplistic definitions of bullying in the nursing profession. Subtle forms of bullying became even more prevalent as they came to replace more explicit acts. Regardless of the manifestation of bullying behaviour, the negative effect on the registered nurse is profound. These consequences of bullying will be discussed in the next chapter as the *responses to bullying*.

Chapter 8: Responses to Bullying

8.1 Introduction

Chapter 5 presented the participants and the context in which the testimonials gathered in this research were explored and interpreted. Chapter 6 described the antecedents that contribute to bullying and have allowed it to persist, while Chapter 7 explained how the manifestations of bullying have changed over the decades. This chapter presents the *responses to bullying* (Table 8.1). This category describes the action taken in response to the bullying experience from the participant and organisational perspective. As in the previous findings chapters, quotations that provide the most illustrative examples of participants' experiences are used to support the discussion.

Table 8.1

Major Categories: Response to Bullying

Corresponding Chapter	Major Category
6	Antecedents to bullying
7	Manifestations of bullying
8	Responses to bullying
9	Impact of bullying

In attempting to cope with their experiences, participants employed a variety of strategies. *Responses to bullying* provides an in-depth discussion of these strategies, including consideration of how bullying was handled by the organisation itself. The following discussion will outline the responses to bullying under the following themes—unassisted, unspoken, unsupported and unsubstantiated—as bullying has changed across the decades from 1980 to 1990, 1990 to 2000, 2000 to 2010 and 2010 to 2020 (Figure 8.1).

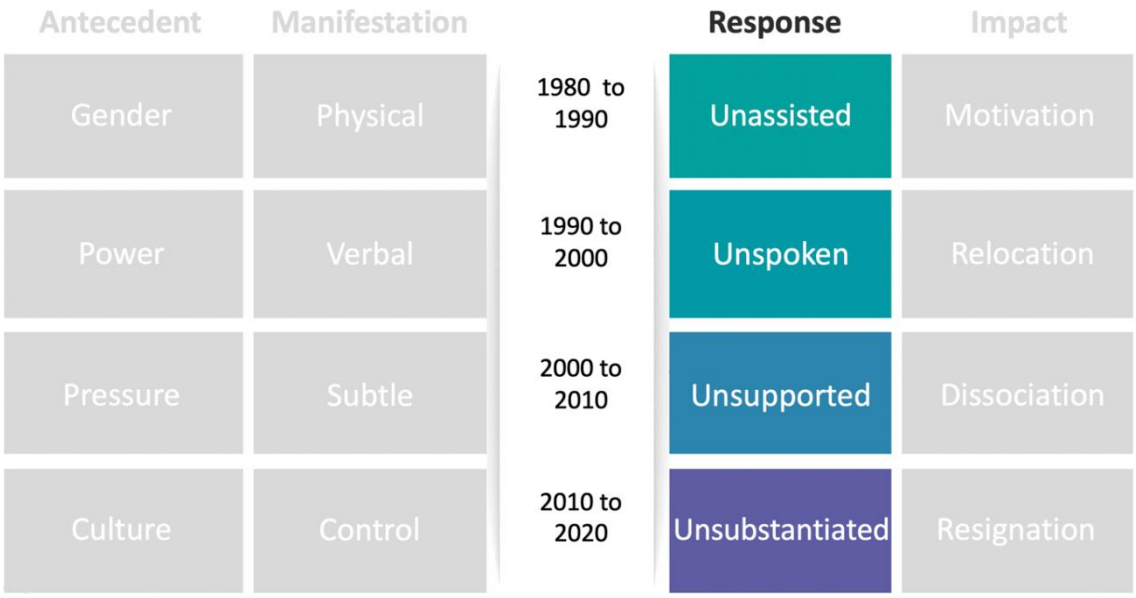

Figure 8.1. Responses to bullying across four decades.

8.2 Unassisted: 1980 to 1990

Over the course of this decade, participants typically dealt with the bullying themselves, unassisted by organisations. For participants, there was no need or desire to further escalate to obtain assistance for their bullying experience. Participants believed they were not going to change the behaviour of the bully, so they could only change their response to the situation. The main strategy used was confronting the bully. Confrontation included face-to-face conversations with the bully or countering the actions of the bully:

> The first indication of problems came on when I was in the process of discussing patient priorities with another nurse. The charge nurse interrupted and dismissed me like I was a child. I later informed her that this attitude was unacceptable. My concerns were disregarded of course. [I2M]

Confrontation alone was ineffective in stopping bullying in the workplace, but it did empower the participants, which is further explored in Chapter 9, in respect of the impact of bullying.

None of the participants during this time reported the bullying experience. The main reason for not reporting was the potential effect on social relationships. Participants spoke about not wanting to cause issues in the ward or disrupt the function of the nursing team. There was an element of respect for senior roles and also 'knowing the bully' [T1M] personally, affecting the decision to not formally report. Conversely, one participant downplayed their experience and said 'it really would have to escalate to a dangerous level before reporting' [T3F], demonstrating there was a greater tolerance of bullying behaviour during this period.

8.3 Unspoken: 1990 to 2000

Participants during 1990 to 2000 often sought to forget, ignore or deny the bullying they experienced from colleagues; thus, the experiences were left unspoken. A number of participants believed that to 'remain silent' [T5F] in these circumstances was the ultimate act of survival of bullying. It was a common misconception that if they could 'turn the other cheek … they will leave you alone' [T7F]. One participant recalled 'from when I was a child, I was taught to just ignore bad behaviour, to just let it happen, don't react and it will stop' [T12F]. The intent was to not give the bully any reaction in the hope it would deter the behaviour from occurring; however, this was not the case. This lesson from childhood needed to be unlearnt decades later, as participants recalled many experiences of bullying continuing. Ignoring the problem did not make it go away:

> Sticks and stones may break my bones, but words will never hurt me. Or so I thought. Sticks and stones may break my bones, but words will haunt me forever. [T11F]

Participants during this period thought they were the only ones being targeted. This was a consequence of bullying being left unspoken, with participants left 'suffering in silence' [T6F]: 'One of the problems is it feels like you are on your own and it can be difficult' [I1F].

Not only was the bullying left unspoken, but participants also discussed how colleagues rarely, if ever, came to their defence when bullying was occurring. The main response from colleagues was silence. One participant described how she was being forced into 'playing a game' [T10F] in which she did not want to participate, creating obvious animosity between the participant and the senior nurse bully. The participant further recalled that, over the next two to three months, not a single colleague spoke to her about it. Ultimately, for participants, the unspoken nature of the problem during this decade accommodated and thus failed to provide relief to their relentless exposure to bullying.

Sadly, at times, when the bullying remained unspoken, participants came to believe that 'if you can't beat them, join them' [T7F]. Many participants confessed to joining in as a way to cope, hoping they would no longer be a target. Admitting that it was easier to display the very same behaviour modelled before her, one participant commented 'I gave up, just to fit in' [T8F].

It is unsurprising that the unspoken incidents of bullying during this time also went unreported. Only 33% of participants during this time reported their experience. The main reason for not reporting was a perceived lack of faith in the support systems

in their organisation. Participants who did report stated that ‘unfortunately nothing’ [T5F] happened after reporting anyway:

> I did report it, but it’s so exhausting to continue the fight. [T9F]
>
> There was no one in a position that was high enough I could go to and I didn’t have any confidence that I would be backed up. [I1F]

Believing that ‘nothing can be done about it anyway’ [T8F] contributed to participants feeling powerless. The less control they thought they had, the more likely they were to downplay the bullying or ignore it entirely. This dangerous dynamic simply masked the problem and did not address the behaviour. Some of the participants described their coping strategy as ‘just avoiding situations’ [T11F] where they could be subjected to bullying. In one such example, a participant recalled eating their lunch while sitting on the toilet to avoid unfavourable interactions during shifts.

8.4 Unsupported: 2000 to 2010

Participants generally underwent a variety of stages, drawing support from within themselves and seeking support from outside to survive their experience of bullying. While there was less acceptance of bullying during 2000 to 2010, as evidenced by a significant increase in reporting of bullying experiences, these claims were largely unsupported by the organisation. Sixty-nine per cent of participants who experienced bullying during this decade reported the experience. Most of the participants who reported bullying behaviour stated that their report did not progress and there was no outcome: ‘They make a lot of noise, but absolutely nothing happens’ [I3F].

Consistent with the suggestion that the acceptance of bullying in the nursing profession is a significant contributing factor to its persistence, participants were told to ‘suck it up, because that is how nursing is’ [T18F]:

> I was told to tolerate it by accepting that these people have always been this way. [T24F]
>
> I mentioned that I felt excluded and they simply laughed. I mentioned that I felt bullied to the supervisor and she replied ‘they do it all the time’. [I2F]
>
> I was just told to grit my teeth and bear it. [T13F]

The lack of response from human resources when reporting bullying in the workplace was a repetitive issue raised by participants during this decade. Based on these participant experiences of reporting bullying, the response to their reports was not always positive. In fact, the response shared by participants who decided to report the bullying they had experienced or witnessed was overwhelmingly disheartening:

> The realisation that this level of bullying was even possible, let alone happening to me, was overwhelming. Then to have it thrown back in my face and made to feel like I was making it up was shattering. [T16F]

The lack of any possibility for negotiation and having the allegation dismissed immediately without investigation were also identified as concerns. It was common for participants to be told they were ‘overreacting’ [T24F], ‘overdramatising’ [T21F] or ‘inflating the story’ [T15F]: ‘When I went to HR [human resources], I was told to be more resilient. Two years of being bullied and abused uses that up!’ [I4F].

For participants, the lack of support planted seeds of self-doubt. Many participants believed they were now somehow to blame: ‘It’s a difficult thing to prove and takes a huge amount of courage to report. I was made to feel like I was partly to blame’ [T17F]. Moreover, there was a belief among participants that not action was taken to address bullying ‘so the group was not disrupted’ [T19F]. Participants often spoke about nursing as a collective profession and the importance of valuing each

individual member, but stressed that this should not be at the expense of group conformity.

Participants spoke about the effect of being told how they should feel, which worsened the experience of bullying. The process of undergoing negotiations or not having the opportunity to do so, and human resources not listening to concerns, was regarded by participants as ‘organisational bullying’ [T23F]. This same experience was labelled by another participant as ‘bullying by proxy’ [T13F] to describe how this participant was subjected to further bullying by those to whom the problem was reported. Participant testimonies suggested that some organisations supported or condoned bullying to the extent that nurses were placed at a higher risk of being victims of this behaviour. There was also a general perception by nurses in this study that organisational policies were not protecting those they were designed to protect. This failing was reinforced as perpetrators of bullying were often those who were protected and even promoted. This situation further contributed to participants not reporting subsequent acts of bullying.

Of greater concern for most participants was that ‘reporting only exacerbated the problem’ [T17F]. Negative responses from reporting included a breach of confidentiality, a lack of negotiation and worsening of the bullying. The study participants reported specific examples of human resources personnel sharing the reported information or the bully receiving preferential treatment. Such integrity breaches undermined the reporting process and created distrust. Nurses in this study described how comments were made to other staff about their performance, which both violated privacy and disrespected them: ‘I went to HR and was told to prove my claim and they tell me despite promising confidentiality it gets worse’ [T15F].

One of the participants in the study had effectively become a whistle-blower, yet was unaware of this. This participant described that she took ‘pictures of the chaos that we were working in, including the blocked fire escape’ [TI3F] and submitted an incident report. Unfortunately, this report was unsupported, as the participant then experienced both unofficial and official reprisal. This nurse was subjected to very subtle, often ambiguous, pernicious and hard-to-document behaviour from the nurse unit manager. She then received an official notice from human resources to step down while an investigation was conducted into her disruptive behaviour in the team.

Very few of the participants discussed using the counselling service that was provided by the organisation. Some participants stated that one of the disadvantages of this strategy was that it would create a ‘permanent record of their experience and demonstrate an inability to function as part of a team’ [T22F], which could be used against them later in promotional or disciplinary situations. ‘There was a perception that reporting would hinder possible promotions’ [T20F] and a fear of retaliation from management. It is highly problematic that a staff member demonstrating non-tolerance for bullying and reporting this behaviour would be perceived as a problem, rather than being perceived as someone actively seeking ways to combat bullying in the workplace.

Contrary to the previous decade, participants often described experiences of soliciting support from other nurses as a way of surviving. Generally, participants relied on other nurses to provide a sense of security and self-worth. Based on the participants’ testimonies, socialising with other nurses reinforced their sense of belonging—a message that appeared to be lacking from management. Thus, socialising with other nurses was more than just entertainment. Although participants did not explicitly state that this was a strategy for survival, the experiences implied that socialising was a major element in their response. The participants mainly socialised with those who shared a

common understanding and tacitly understood how the other was feeling and what they had experienced. However, despite participants insisting that there was value in peer support, there were some significant reservations. In these cases, this support was seen to 'contribute to the underlying unhealthy culture' [T14F] within the nursing profession: 'Speaking to a colleague on the same ward just perpetuated the negative and pessimistic culture that already existed' [T25F].

8.5 Unsubstantiated: 2010 to 2020

Many study participants attempted to report bullying incidents in the workplace during 2010 to 2020. Eighty-three per cent (83%) of participants reported the experience of bullying to the organisation during this time. Participants in the study felt they provided what they considered clear evidence. At first, participants felt encouraged by the responses from management. However, after lengthy meetings and, in most cases, a significant period of time, the report was dropped and labelled an 'unsubstantiated claim' [T37F] because of insufficient evidence. Many of the reported situations were perceived to remain unresolved.

When bullying was reported, the initial response from management was a suggestion for participants to raise the issue with the person who was alleged to be a bully. This resulted in an overwhelming negative psychological response from the participants. Most refused to do so, stating that 'it is management's responsibility to bring inappropriate behaviour to an employee's attention' [T36F]:

> I reported it to the manager and got advice to go straight to the person, which put me in a vulnerable position. [T28F]
>
> The evidence I needed to supply was overwhelming and the first thing I had to do was speak to the person who was intimidating me! I couldn't go through with it. [I6F]

The participants suggested it was important at the outset of an investigation that all parties be made clear about the process and its purpose. Many experiences included ‘blurring lines between fact-finding’ [T28F] and action following the investigation. This led to significant issues in the response to bullying for the participants. Concerns were raised with investigations being very susceptible to issues of bias, as there was significant emphasis placed on the reporting nurse’s performance and reputation. Such factors, according to participants, bore ‘little relevance to whether or not bullying had occurred’ [T39F]. Participants suggested a lack of policy guidance, as this type of ‘background checking’ [T33F] was not demonstrating reasonable management action. The process was permeated with biased information, as only a select few were asked to provide background information or performance reports, and these were usually individuals in management positions: ‘It was difficult because we were an extension of the executive unit so there were no other witnesses to confirm. I felt extremely isolated’ [T51F].

The participants felt it was imperative that investigations be conducted in confidence. The need for confidentiality was primarily related to preventing an unnecessary chain of negative reaction within the workplace, as well as a way of preventing prejudice during the investigation: ‘Everyone knows everyone in nursing. I just wanted a fair assessment of my situation from someone who didn’t know the bully and therefore have any motives at play’ [T26F].

The speed with which the investigation was undertaken was also a very important factor for participants. Investigations that took unnecessarily long caused further problems in the workplace and were attributed to an increase in psychological damage:

> The duration of time that I was made to wait before HR did anything was completely unacceptable. I lodged my initial complaint in April 2017, it was ignored until February 2018. This was significantly damaging to me psychologically, as it made me doubt myself and I was constantly concerned for my safety at work. [I11F]

Concerns were also raised about receiving timely feedback throughout the investigation. The majority of participants were not informed regularly about progress and some were 'never given any feedback' [T29F] at all. Participants emphasised a lack of transparency from the organisation in regard to the investigation.

A significant problem that often arose was that those conducting the investigation moved away from what was actually reported to what they assumed happened. Participants felt that the best evidence would come from the source; however, some participants were not asked to provide written accounts of their experience. Conversely, after submitting an account of events, multiple participants were advised to make significant amendments. This had serious implications, as many participants indicated that the requested changes were focused on the language used—particularly the word 'bullying'. The poor use of language was further explained by one participant claiming 'no one actually named it [as bullying]' [T41M] throughout the investigation.

Some participants were asked to provide a medical certificate or other evidence of damage to establish bullying allegations. However, proving the physical and emotional toll of bullying was a huge challenge. Some participants felt that this was an unreasonable request and subsequently chose to drop the allegation. Other participants began blaming themselves for their experiences and only sought medical assistance

once they reached the ‘tipping point’ of physiological impact, which is explored in greater detail in Chapter 9.

Participants described how labelling a bullying claim as unsubstantiated meant there was never an acknowledgement of the bullying from the organisation, and subsequently no action to deal with it:

> Reporting felt like going up against the gang and, unless you’ve got game, you’ll lose. [T50F]
>
> The nurse was never spoken to about the incident I reported. [T31F]

Thus, bullying was permitted to progress in the workplace, with participants ultimately manoeuvred into a position in which they were unable to defend themselves. Participants were left with ‘nowhere else to turn’ [T40F] and having ‘no one outside of the organisation to help’ [T34]. Further, determining that a claim was ‘unsubstantiated’ vindicated this lack of support from the organisation:

> I reported the incivility. No support was provided other than being told I needed to learn to get along with the RNs. [T48F]
>
> I also reported it to the organisation, and got essentially no support. [T53F]

In one instance, after being told that their evidence for a claim of bullying could not be substantiated, a participant shared the same evidence with an external law firm, which comprehensively found that the bullying allegations could indeed be substantiated. This situation further emphasises that there was no reason that the employer of the participant could not prove the conduct of bullying in this case.

A common reason given for an allegation to be labelled as unsubstantiated was that the bully or bullies denied the claims—it was ‘their word against mine’ [T43F]. Given that the outcome of any investigation was determined on the balance of probability, it was dependent on consideration of which scenario was more likely. This

situation created an adversarial position and led to finding ‘someone who was right and someone who was wrong’ [I7F]. This situation also generated a victim/villain narrative, which created blame and was ultimately divisive. The investigation process reproduced the very behaviour it was seeking to address. This process not only replicated the behaviour, but also reinforced it, giving rise to a passive acceptance of bullying. Many participants felt that more damage was caused by the reporting process than by the actual bullying experience.

Labelling bullying as a personality conflict also contributed to the narrative of one person as a victim and the other as a villain. Participants felt that ‘the investigation never got to the heart of why bullying occurred’ [I12M] initially and never considered the interconnections between people and the culture in which they work. Shockingly, for two participants, after being told their claim was unsubstantiated, the focus was placed on them for making false allegations:

> It was the last straw. They got the better of me. I couldn’t be there anymore. [I5F]
>
> Management handled it very inappropriately. They escalated it up. The nursing unit manager, who was a new manager and had never met me or worked with me as a nurse, escalated it up through two levels of nursing management to the point that I got a phone call to step down from the Director of Nursing, ‘You can’t come to work. We’ve got no suitable duties for you. You’re distressing your colleagues too much’. [T32F]

This quotation illustrates what one participant referred to as ‘patchwork management’ [T47F], resulting from high management turnover and managers not getting to know staff. There was a sense from participants that, had management known them better, they would have realised the severity of the problem and their ‘cry for help’ [T45F].

One participant asked ‘why should it have to end with someone killing themselves in order to get an outcome?’ [T38F].

The reasons for not reporting were similar to those from the preceding decades, yet centred around being unable to prove the claim and being ‘afraid to speak up, as the bullying can get worse, nothing changes and you risk being labelled a trouble-maker if you speak up’ [T30F]. Participants also believed that their resistance to the bullying behaviour triggered an escalation of the bullying and a sense that, the more they talked about the behaviour, the more ‘stigmatising communication’ [T44F] was used by the bullies to discredit them. This again deterred others from trying to intercede because of the fear that they would fall victim to the same bullying behaviour:

> I think nurses are scared to speak up in case it makes the situation worse and the bullies have the power, and can’t admit they are doing anything wrong. It always gets turned around to the victims. [T35F]

8.6 Conclusion

This chapter has provided detailed insight into the *responses to bullying*. These findings demonstrate that the reporting of bullying increased as the decades unfolded, but this increase was not matched by action. Claims relating to bullying are difficult to prove and the findings suggest that organisational action or inaction further exacerbates bullying. The organisational response raises an important, and possibly rhetorical question: was the system failing those it was supposed to protect? The next and final findings chapter presents a discussion of the *impacts of bullying*.

Chapter 9: Impacts of Bullying

9.1 Introduction

The aim of this study was to identify factors that contributed to bullying over a four-decade period, and allowed it to continue in the various settings in which nurses were employed. In Chapter 6, the antecedents that contributed to bullying were discussed. Chapter 7 described the manifestations of bullying, while Chapter 8 discussed the responses to bullying. This chapter presents findings relating to the *impacts of bullying* (Table 9.1). As in the preceding chapter, the most illustrative participant quotations are used to reinforce the points being made.

Table 9.1

Major Categories: Impacts of Bullying

Corresponding Chapter	Major Category
6	Antecedents to bullying
7	Manifestations of bullying
8	Responses to bullying
9	Impacts of bullying

The findings discussed in this chapter expose the extensive and enduring impact of bullying in the nursing profession, which varied across the decades from 1980 to 1990, 1990 to 2000, 2000 to 2010 and 2010 to 2020 (Figure 9.2). Consistent with other categories, the impacts of bullying had characteristics specific to each decade. In contrast to other categories, however, there were a wide range of short- and long-term effects that were common to participants' experiences, regardless of the decade. These effects functioned as precursors to the ultimate impact of bullying on participants (Figure 9.1). This chapter will commence with an overview of these precursors, prior to a discussion of the impacts that were evident across each decade.

9.2 Precursors Common to All Periods

While the experiences described by the participants revealed short-term and long-term effects, most revealing was a pattern of precursors, common to all periods, that contributed to the effects on participants. The continuum started with anxiety, which led to participants becoming 'shells of themselves', experiencing hypersensitivity and ultimately reaching a 'tipping point'. This process is unlikely to be a linear, cause-and-effect situation, but a complex interplay of factors.

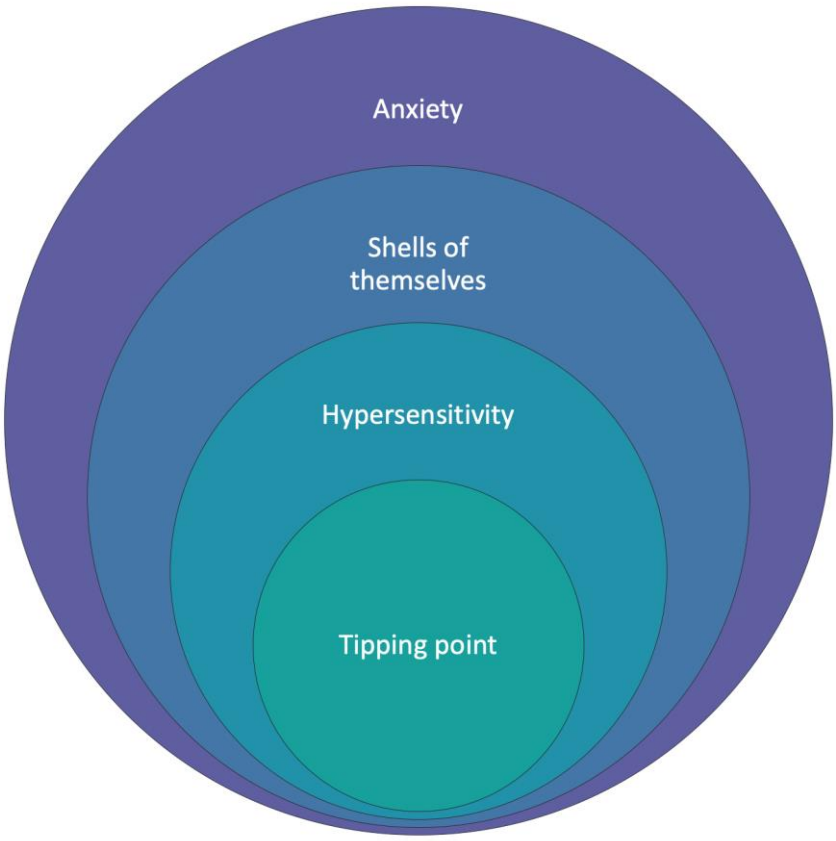

Figure 9.1. Impact precursors.

9.2.1 Anxiety. The most frequently expressed impact, at least initially, was anxiety. Participants described the anxiety from bullying as escalating and progressively worsening the longer the experience was endured. In the early stage of bullying, the participants sought to comprehend what was happening and why. Many participants

recalled questioning what was wrong with them to somehow explain the bullying behaviour: ‘I still have episodes of anxiety, sadness and anger as I drive past the hospital’ [T48F].

The physical manifestations of anxiety in the form of sleep problems, hypertension and headaches also began to appear. Many participants reported that, shortly after ‘feeling anxious all the time’ [T4F], they were experiencing difficulty sleeping. Lack of sleep combined with frustration and resentment created further physiological effects. Participants attributed hypertension to the anxiety associated with their bullying experience:

> my blood pressure went up and I had to go on tablets. [T39F]
>
> I am still on anti-anxiety meds and anti-hypertension meds. [I9F]

Many participants sought assistance from a general practitioner because of the physical manifestations of bullying they were experiencing:

> [I] saw my GP, who diagnosed me with anxiety and depression and had to see a clinical psychologist for counselling, which I am still continuing. [T45F]
>
> Increased anxiety and diagnosed with PTSD [post-traumatic stress disorder]. [T30F]

9.2.2 Shells of themselves. The impact of anxiety would eventually begin to show, slowly at first, but with increasing intensity. Anxiety eroded the registered nurse’s self-worth, self-image, self-esteem and self-confidence, resulting in a significant reduction of their sense of self: ‘my anxiety levels rose considerably, I did not recognise myself’ [T34F]. Participants spoke about constantly doubting their ability, feeling insufficient and lacking confidence. One participant expressed that, even ‘after 16 years of nursing, I now have zero confidence to show for it’ [T52F]. A number of participants

in the study reported bullying to have a demoralising effect on them, consequently creating a sense of personal loss and feelings of inferiority:

> I went through a period where I really didn't have any confidence at all. I was considering giving up nursing. I thought 'how can I nurse when I haven't got any confidence?' And these are problem-solving, decision-making activities that I'm involved in. [T14F]
>
> My confidence plummeted and I was in tears a lot. I felt like my work wasn't good enough, which in turn started to translate that I wasn't good enough. People commented from a previous workplace that the life was being sucked out of me. I have also seen other colleagues become shells of themselves upon entering the profession. [T26F]

It was also noted that, for participants, once confidence was lost, it was difficult to regain:

> The loss of confidence in my ability to nurse has stayed with me. [T23F]
>
> I still suffer panic attacks when I think about what happened. [T6F]

Participants reported that, before long, assumptions were made about their work capability, which seriously damaged or erased future employment and career prospects:

> So when somebody tells you you're not very good, giving you the feeling that you're incompetent or that you're no good in any way, yeah, you make more mistakes, your thought process is gone, your confidence. [T25F]

By the time participants realised the severity of their condition, the psychological injury became apparent and the impact continued to increase exponentially. One participant described the damage as 'beyond repair' [T28F], with it creating 'a state of being psychologically senseless' [T11F].

9.2.3 State of hypersensitivity. The increasing level of anxiety sustained over a period also created a state of hypersensitivity. Participants discussed how bullies would continuously question their actions and decisions to the point that some participants 'had feelings of helplessness and paranoia' [T29F]. Concerns were also raised about being suspicious of colleagues' intentions, especially management, and about difficulty determining what was reality and what was imagination:

> I am now paranoid and expect nothing from anyone. I am friendly at work, but have no friends. [T51F]
>
> I would hyperventilate and became paranoid about the motives behind any decisions made and conveyed to me. [T38F]

This state of hypersensitivity resulted in participants not only questioning colleagues, but also questioning themselves:

> You're constantly asking yourself why—why am I an easy target? Because, like I say, it's not the only time—there were other incidents and it was more subtle, in a different way, that you kind of wonder, 'Whoa, did I do anything wrong? Why are you treating me so hostile?', and, yeah, it's not the first time that it happened. [I7F]

Participants in this study reported increased dependence on alcohol in response to the bullying experience to numb their sensitivity: 'I turned to alcohol, which is still an issue' [T22F]. Participants described how the outcome of alcohol use had a devastating effect on their professional careers. Their sick days increased, leading to further exacerbation of the bullying. The majority of participants who took sick leave usually did so only for short periods; however, some participants reported taking months off. Conversely, two participants reported not taking any sick leave, as this would give the bully 'more ammunition' [T43F], bringing awareness to an element of

'presenteeism', where participants were psychologically or emotionally unwell, yet felt pressure to attend work and perform their jobs.

A number of participants also reported the experience of having the effects of bullying spill over into their personal life, causing strain on relationships outside of work. Being hypersensitive in this context saw them permanently tense and defensive, which placed an intolerable burden on marriages and personal relationships:

> shall we add impacts on marriages and children? My youngest son was doing his HSC [Higher School Certificate], witnessing his mother as a bit of a wreck and dealing with family breakdown. [T50F]

9.2.4 The tipping point. Trapped by a job they love, yet a workplace they hate, constantly worried by the threat of job loss and financially dependent on their income, some participants reported that the anxiety continued to increase exponentially. Finally, it reached a tipping point:

> The straw that breaks the camel's back. [T42F]
>
> I reached a point and realised things had to change. [T7F]
>
> I just had enough. [T18F]
>
> It was just the worst experience I've ever been through and I just couldn't cope with it any longer. [I5F]

For some, the tipping point was reached after the appearance of counter-bullying behaviour—when the bullied became the bully: 'I left one workplace because I felt like I was becoming a bully' [T21F]. Built-up anxiety resulted in the participants displaying the same behaviour to others that was causing anxiety in them. Participants identified turning their frustration onto other staff who were more vulnerable: 'I nit-picked a graduate nurse because I could' [T37F].

Others reached tipping point after an actual or potential risk of harm to patients occurred or clinical care was compromised. An increasing sense of exclusion, withdrawal and self-doubt were indicative of a working environment beyond safe operating limits. Constantly moving goalposts, unsafe rosters and withholding of information caused participants to become disoriented at work, leading to mistakes:

> They didn't pass information on to me, didn't consult with me, just issued conflicting sort of directives and the like. And patients were stuck in the middle. [T52F]

> I made two medication errors because my roster was all over the place. [T47F]

There were concerns that the impact of bullying would lead to an abrupt and sometimes catastrophic end. Participants believed that bullying contributed to self-harm and suicide, and comments were made about a medical diagnosis being a triggering point:

> You know, I think I'm doing amazingly well to not have killed myself. [T27F]

> Management made comments about her suicide attempt, saying, 'if you're going to do it, do it properly'. I just know that the people who contributed to a suicide attempt have to go to work and deal with that. [T16F]

9.3 Impacts Through the Decades

Alongside the common effects of bullying described above, bullying impacted participants in ways that were unique to each decade. Regardless of how or when the tipping point was reached by the participants, what followed were experiences characteristic of the timeframe. The following section discusses impact variations through the decades of 1980 to 1990, 1990 to 2000, 2000 to 2010 and 2010 to 2020 (Figure 9.2).

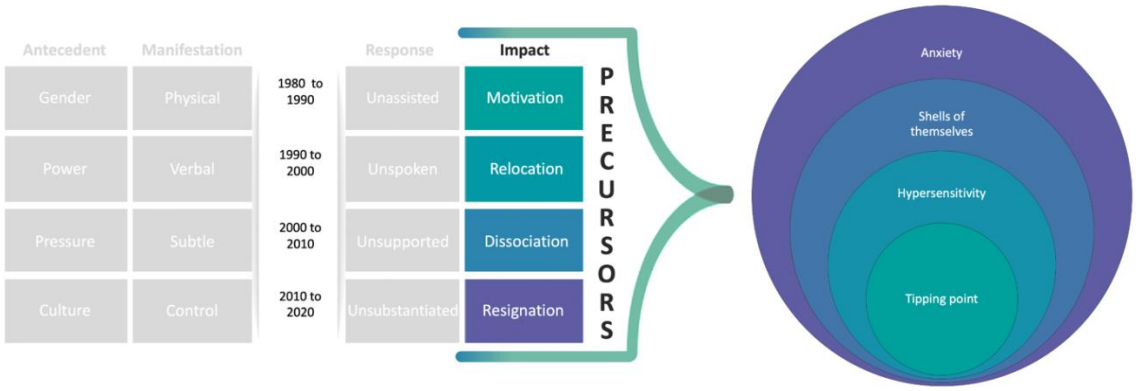

Figure 9.2. Impacts of bullying across four decades.

9.3.1 Motivation: 1980 to 1990. In this decade, unlike any other, the bullying experience created motivation in participants. During this decade, participants felt they emerged as survivors and long-term winners, with positive developmental outcomes from their experiences. Participants were determined to overcome the incivility and bullying behaviour, and to not back down or leave. Participants described the experience as making them 'strong' [T3F] and tough enough to support themselves, so 'it was not necessary to seek or accept support from others' [T1M]. Motivation testified to the establishment of a new equilibrium and new purpose for the participants. In one instance, 'positive stress [was] harnessed to boost performance and motivation' [T2M]. Although participants were still able to make sense of the behaviour as being unacceptable, it did not dismantle them entirely: 'I worked harder to prove that I had a place in the profession' [T2M].

The love of nursing and their work and remembering why they decided to become a nurse and how hard they had to work were all mentioned as factors that stopped participants from giving up and leaving the profession. Participants spoke about wanting to break the chain of bullying and ensure this did not happen to others: 'Through this experience, I became a very strong advocate for our profession' [T3F].

However, making these lasting changes was not easy. The process was described by participants as an ‘uphill battle’ [T4F], but possible with ‘small consistent steps taken every day’ [T2M].

9.3.2 Relocation: 1990 to 2000. Victims of bullying during this decade reported lingering effects on their ability to function well in their current role, resulting in a final impact of relocation. During 1990 to 2000, the majority of participants spoke about leaving the work environment where they were experiencing bullying and relocating to find a new position:

> I moved to another area of nursing. [T8F]
>
> I moved job and will never work for that organisation again. [T12F]

Relocating had a greater impact on some participants than others—particularly those who moved a considerable distance to find another nursing position. In one instance, a participant found another job in a different city, and had to move away from her family:

> I had to take a position in [another town]—I’m Sydney based—and leave my family in order to earn a living and to commute out there weekly and pay for additional accommodation. And I was out there for four and a half years before I was able to secure a position back in Sydney. [T7F]

Often, when participants relocated to another workplace, the bullying stopped. In such cases, the participants saw the bullying as an isolated or exceptional event. However, when reflecting on their experience, they realised that these assumptions could be unfounded: ‘I had to get away from it and thought surely it can’t be all like this, and it did work for me. But obviously [bullying] is still a problem’ [I1F].

The dominant drive behind relocating discussed by participants was the need to take care of themselves. Participants took the action of relocating so they would not be harmed. As one participant stated, ‘I just had to get in first’ [T9F], as though leaving

was a pre-emptive strike. These participants demonstrated that control over their working life was important to them.

9.3.3 Dissociation: 2000 to 2010. The term ‘dissociation’ is used to describe participants becoming complacent and having a surrender mindset towards their bullying experience. Participants in this study from 2000 to 2010 described feeling overwhelmed and hopeless by their perceived powerlessness. The constant drive to achieve unrealistic work demands and expectations resulted in being physically and thus emotionally weak. Participants developed an unresisting attitude to their bullying experience and demonstrated compliance and submission to the bullying:

> It’s just the way it is. [T18F]
>
> Nothing is going to change. [I4F]
>
> It will never be fixed. [T13F]

Participants knew the behaviour was unfair and unjust, yet felt powerless to do anything about it. They believed that submission to the bully would negate the bullying behaviour. These registered nurses saw no way out of the situation, so concluded there was no point challenging the bullying behaviour. Compliance seemed the most expedient reaction for survival; however, once this attitude was established, it was difficult to break:

> I’m still working in the area, but my soul is broken. The [bullying] behaviour continues and I don’t know that anything can be done about it. [T23F]
>
> I waited too long and had a complete breakdown. [T25F]

Participants during this time spoke about not being about to ‘recall a time’ [T33F] when they did not feel negative about the nursing environment. Participants were psychologically stuck, describing the pain being as raw today as when the experience occurred during 2000 to 2010.

Generally, participants preferred that those ‘who are responsible’ [T24F] did not know how they felt about the bullying experience at the time. There was a general consensus among participants that avoiding displaying emotions or reacting was a result of nurses being taught not to display emotions at work. Consequently, they expressed feelings of being ‘misunderstood’ [T17F], even among colleagues. Participants during this time recognised that they were experiencing bullying, yet assumed that this was ‘part of the job’ [T20F] and should be taken for granted.

Ultimately, these participants accommodated bullying without leaving nursing. Rather, they distanced themselves from involvement at work, thus leaving in a figurative sense. Not only did these nurses distance themselves in the workplace, but some also expressed becoming distanced in other ways. Participants would ‘miss meetings or not become involved in discussions at work’ [T19F], other than what was required of them. Dissociating in this way ultimately affected workplace satisfaction, which was deflated through a lack of interaction between colleagues and isolation from the organisation.

The level of dissociation was so great that it also persisted well beyond the experience. Some participants were even reluctant to name the act of bullying. Many participants expressed that they were not encouraged to talk about bullying prior to having the option to participate in this study. As one participant said, ‘I have not discussed this with anyone’ [T15F].

9.3.4 Resignation: 2010 to 2020. Destruction of teamwork and a negative organisational culture ultimately led to an increase in resignation from employment. Many participants reported that, when performance is continually criticised in a variety of ways, and every attempt to do better is met with further criticism, a point comes

when one must leave. During 2010 to 2020, after reaching the tipping point, participants were too stressed to perform to their full capacity and ultimately left the profession:

> I resigned one month short of 11 years. [T26F]
>
> I am glad I had family and friends to back me up. It made me reflect and think I don't want my future to look like this and ended up looking elsewhere for a career. [T42F]

Participants who reported resignation referred to it as an 'escape' [T34F]. Such experiences meant that decisions to leave were made as acts of avoidance. Participants reported they were 'extremely angry' [T47F] and 'hurt' [T53F]. Others reported leaving out of fear—fear that they were not good at their job; that the pressure would continue; and that this experience would have broad, shattering, life-long effects: 'These people were not only intent on ruining my professional career, but they were intent on damaging my community reputation as well' [I8F].

A number of participants spoke about not wanting to leave, yet eventually coming to believe that it was the only remaining option:

> I left the community, which was a shame, because it's left a stale taste in my mouth, having worked in that community a long time, and got on well with people, and liked them. [I11F]

Another participant labelled their experience of being forced out of their role. This participant described a working environment that did not support nurses, while demanding that they perform in a professional caring role:

> I reported the incident and, as I relayed the story, was in tears. Her solution was to find another ward for me to work in. Sounds good, but not at that time—I was effectively paraded around multiple wards in a very distressed state. No one ended up needing such a nurse. I was forced to resign. I liken it to being in high

> school again. If you are not in the popular group, look out. I wish I had chosen a different career. [T32F]

Participants showed a strong sense of grief over the loss of their professional life, especially those who left after a considerable time in nursing. One participant shared that they had been unable to mourn the loss. The impact of this loss was different for different participants—some participants expressed exonerated freedom, while others expressed hurt and pain.

The participants during this timeframe also alluded to a sense of fatigue from fighting against the bullying for an extended period, and then eventually leaving. As one nurse said, 'I'm just so tired from fighting it' [I6F]. Some participants left one workplace only to find that they were again working in a similar bullying environment, and eventually removing themselves from the profession altogether: 'I left one workplace only to find that [bullying] is everywhere' [T49F].

Often, participants would conclude their testimony with an experience that happened to another colleague. Participants shared their experience of being a witness to bullying occurring in the workplace. In all cases, the other colleagues also left the organisation and this was presented as 'proof' [T29F] of the participants' claim—that all nurses who are targets of bullying will eventually leave their role or the profession: 'Those [bullying] people seem to remain in positions, sometimes in power, while the people they bully end up leaving' [T40F].

For participants in this study, the decision to leave related to organisational factors, rather than individual ones. The reasons for leaving were significantly influenced either directly or indirectly as a result of the management of the bullying experience. Participants pointed to the limitations of management in respect of the systems and processes in place to deal with bullying. Participants often felt management

‘downplayed what had happened’ [T41M] or was ‘not hearing what being said’ [T35F], which was followed by a lack of action. As a result, participants felt ‘trapped and left with only one option—out’ [T46F]. Thus, management appeared to be complicit in the bullying process, and an important question is: where was the accountability and expression of their duty of care?

The participants also spoke about the lack of follow-up after they had resigned: ‘no one asked me why I resigned, which is quite disgusting’ [I7F]. For participants, this further exacerbated management’s failure to address bullying in nursing, showing scant respect for nurses and a lack of valuing of staff. For many participants, this failure reinforced the decision to leave as the only possible escape from bullying.

9.4 Conclusion

This chapter has provided the fourth and final major category of the findings—the *impacts of bullying* in the nursing profession as felt by the participants. These findings demonstrate that bullying in the nursing profession had significant and variable impacts upon the study participants. This included intensifying negative effects upon their psychological and physical wellbeing, decisions about the sustainability of employment and their nursing career, and even a need to leave nursing entirely. While it is possible for physical injuries to heal, the emotional and psychological consequences of bullying may remain with a registered nurse for a lifetime. In Chapter 10, the findings presented in Chapters 6 to 9 are discussed in the context of the existing literature.

Chapter 10: Discussion

10.1 Introduction

The aim of this study was to identify factors that contribute to bullying and gain new insights into why it has persisted in the nursing profession in Australia. Experiences of registered nurses across four decades were obtained and analysed, and described in Chapters 6 to 9. As presented in the preceding chapters, analysis of the experiences of participants informed the development of four major categories that helped explain the phenomenon of bullying in the nursing profession. This chapter considers the findings in light of existing literature to situate them within the broader field of knowledge. A chronological approach is used to consider the historical context in which bullying occurs. Oppression theory is then explored and applied to the complex problem of bullying in the nursing profession. Use of this framework aids in understanding the evolving and sustained nature of the problem in Australia.

10.2 A Persistent Problem

The first section of this chapter presents an overview of the findings in the context of the extant literature about bullying. Although there is much discussion in the literature about the dimensions, causes and effects of bullying in nursing, a consistent motif is that it remains a persistent and pernicious problem (see Chapter 2). In this section, the literature is discussed chronologically to facilitate alignment of existing knowledge about bullying in the nursing profession with the findings of this study. This discussion highlights the relevance of this research and enhances understanding of the complex and evolving dynamics of bullying over time.

The testimonials in this study go back as far as 1981, and this corresponds with the emergence of the first published research on the topic of bullying in the nursing profession. Kohnke (1981) described nurses as being a vulnerable group and spoke

about the incidence of nurses being physically assaulted while at work. Duldt (1981) identified horizontal violence between nurses as a potential explanation for low job retention rates. Roberts (1983) proposed that a key explanation for bullying behaviour among nurses could be found in the theory of oppressed group behaviour. Historically, absolute obedience to physicians was imperative, which created a nursing profession that felt oppressed and powerless, and whose members turned their frustrations inward, particularly towards those perceived as less powerful (Kohnke, 1981; Treacy, 1987).

Participants' experiences in this study were similar to those described by Meissner (1986), who asked 'do nurses eat their young?'. Meissner (1986) reported that experienced nurses were finding ways to mock newly qualified nurses or students for their questioning and lack of experience, instead of being compassionate and caring towards them. Contrary to the findings of this current study, Cox (1987) reported that bullying was primarily verbal in nature; however, Cox similarly found that the most common strategy for dealing with bullying was speaking to the perpetrator.

From 1990 to 2000, there was a steady increase in reporting of the various forms of bullying that intruded into nursing's organisational culture globally (Farrell, 1999; Kaye, 1996). Hoff (1990) and Field (1996) both proposed that bullying in nursing was inescapable and likened the experience to domestic violence situations, where victims endured bullying over a long period. Similar to the findings of the current study, bullying was described as a violence cycle that included silent observers and lengthy endurance of the behaviour until the victim realised what was occurring.

McMillan (1995) first provided evidence that nurses were powerless at all levels of the organisational structure and in all nursing areas. He reported, alarmingly, that almost one in three nurses recounted having experienced bullying for more than two years. Similar to participants in the current study, the majority of these nurses preferred

speaking to a colleague about their bullying experience, but generally did not find it helpful. Very few sought counselling from the organisation because of a lack of trust. McMillan (1995) highlighted that there were similarities between bullying in nursing and domestic violence in society, with victims of bullying being made to believe it was their fault and responding by seeking to please the bully or, worse still, joining them.

The influence of the environment on bullying gained greater prominence in the literature from 2000 to 2010. Lewis et al. (2008) supported a finding from the current study that staff shortages due to working conditions were linked to creating an environment conducive to bullying. However, the literature during this time suggested that the majority of contributing factors for bullying related to role modelling for students. Randle (2003) produced evidence that bullying was a learnt behaviour, suggesting that nurses were taught to intimidate each other. In Great Britain, nursing students identified several instances of preceptors intimidating them, citing several examples of the expectation that they would act in a similar way as part of their rite of passage into the profession (Curtis et al., 2007; Randle, 2003). Szutenbach (2008) and Deltsidou (2009) described how students were subjected to bullying while on clinical placement, and reported that these nurses were then socialised to behave the same way. A study by Deltsidou (2009) indicated that nurses regarded this negative behaviour as natural, resulting in those behaviours being allowed to continue.

The 2002 to 2005 Queensland Health Minister, Gordon Nuttal, revealed to the Morris Royal Commission that a culture of bullying had destroyed Queensland's healthcare system (Davies, 2005). This revelation highlights the damaging effects of bullying in nursing and the profound consequences for the profession and the organisations in which nurses work. Burnes and Pope (2007) found that nurses who were bullied or subjected to negative behaviours in the National Health Service in

England felt alone, vulnerable, afraid and not respected in the workplace. Other impacts of bullying identified by Murray (2009) and Deltsidou (2009) included psychosomatic conditions, such as fatigue, poor eating habits, sleep disturbances and the onset of physical illnesses. Yildirim (2009) stated that some nurses showed signs of post-traumatic stress disorder, with reports that bullying had been linked to suicide.

Murray (2009) described what he called a 'wall of silence' used by organisations to help silence the bullying epidemic. Silence involves managers actively favouring people who behave in this manner by defending them and helping them succeed. Consistent with the findings reported in the current study, participants who experienced bullying during this period were left with an overwhelming feeling that management considered bullying an appropriate and acceptable behaviour in the workplace.

Considerably more literature on bullying in nursing is evident from 2010 to 2020. Many of the issues from the previous decade continued to be apparent in this literature. Dong and Temple (2011) raised the issue of silencing in the nursing profession, in which nurses did not question the status quo and remained silent to prevent conflict. However, Donegan (2012) found that, when bullies do not see a response from the victim, this gives the bully confidence to escalate to even harsher tactics. Consistent with the findings reported in the current study, DeMarco et al. (2012) noted that inadequate nursing support in the workplace, together with a culture of silence, served to protect perpetrators.

One of the key effects of operating in a culture that encourages or condones bullying is that bullies become adept at using different tactics to target individuals. Hutchinson, Vickers et al. (2010) found that bullying in the nursing profession took the form of personal attacks, erosion of professional competence and unreasonable work allocation. In a study from the United Kingdom, Carter et al. (2013) described the most

common types of bullying as ignoring the individual and allocating unpleasant or unsafe tasks. The various bullying tactics leave nurses with little alternative for a resolution. Sauer (2012) indicated that bullying resulted in nurses not only quitting their employment, but also leaving the nursing profession. Indeed, evidence shows that newly registered nurses frequently leave the profession within the first two years of their employment as a result of bullying (Parker et al., 2014).

Rodwell and Demir (2012b) described the main impact of bullying as being psychological distress and depression. Carter et al. (2013) found that some participants indicated that their performance was affected because they were unable to focus on the procedures and activities required for their patients. Carter et al. also found that, because they were unable to focus on the procedures and activities necessary for their patients, some participants suggested that their performance was impaired. Similar issues were identified by Laschinger (2014), with bullied nurses more often involved in medication administration errors and fall-related patient injuries. Participants in Rodwell et al.'s (2014) study had lower levels of enthusiasm and dedication to their jobs as a result of bullying, resulting in higher absences in the workplaces.

It is commonly believed that bullying in nursing is a hidden epidemic, with most incidents not reported (Becher & Visovsky, 2012; Moore et al., 2013). Becher and Visovsky (2012) and Moore et al. (2013) both stated that, as a consequence of the rise of covert tactics, bullying is likely to be unreported. These researchers originally discovered that bullying could be interpreted and ignored as rude conduct and branded as a clash between personalities, and it was not until behaviour progressed into more visible behaviours that it was reported as bullying. Conversely, data from the current study show that the problem is likely to be readily identified and reported by nurses

who encounter bullying. While this finding indicates less tolerance for bullying in the workplace, it begs the question as to why this behaviour persists.

10.3 An Oppressed Profession

A trend emerging in the literature above is the concept of nurses being an oppressed group (Dinmohammadi et al., 2013; Duchscher & Myrick, 2008; Rooddehghan et al., 2015). In most research examining bullying in the nursing profession, the focus was on the effects of bullying as a result of oppression (Hutchinson et al., 2006; Rahm et al., 2019; Roberts et al., 2009; Rodwell & Demir, 2012a). Four decades ago, Roberts (1983) discussed oppression theory in relation to nursing and provided a compelling case for why bullying existed in the profession. According to Freire's (1972, as cited in Au, 2007) oppression theory, oppression exists when one group exploits and controls a less dominant group with status, prestige and power (De Lissovoy, 2008), resulting in the creation of a dominant and subordinate group (Medina, 2013). Roberts (2000) found that many of the attributes of an oppressed community, such as low self-esteem and feelings of powerlessness, were present in the nursing profession. The nursing profession, founded on hierarchical structures and consisting primarily of women, was established as a subordinate role to the medical profession (Dong & Temple, 2011). Resistance to this oppressive regime within nursing can result in hostility as an expression of suppressed anger within the subordinator group. One of the defining features of hegemonic oppression is that both dominant and subordinate groups internalise and accept the division as normal (Dong & Temple, 2011; Medina, 2013). The outcome is that no one questions or even notices the oppression over time (De Lissovoy, 2008). This pattern was evident in the behaviour of other nurses to which participants in this study were subjected. In this study, for example, nurse managers were perceived as no longer being a member of the nursing

group and referred to as a powerful dominant group of middle managers who reinforced (unknowingly or otherwise) oppressive relationships.

The findings of this study support the epistemological premise that, when subordinates identify behaviours or conditions as natural, necessary or inevitable, it is most aggressively repeated (Kincheloe & Maclaren, 2000). Oppression was revealed in this study by both nurse managers' acceptance of bullying in the profession and unwillingness to address the bullying behaviour. When new managers are inducted into an existing negative culture, bullying thrives because it is viewed as an acceptable way of getting things done (Salin, 2003). In this study, participants felt that nursing management further exacerbated oppression, instead of seeking to transcend or address this issue.

The dominant health and patriarchal medical model has historically marginalised nurses (Powell, 2016; Speedy, 1986) and, as a result, nurses are submissive in a battle to transcend oppression (Dong & Temple, 2011; Dover, 2016). Roberts (2000) suggested that low self- and group-esteem and poor identity in nursing are key factors preventing the nursing profession from being motivated to address their oppressed state. Further, Dover (2016) reported that oppression in a group contributes to reactive and irrational behaviours, leading to continued oppression that inhibits the functional capability of the group within a profession.

According to Roberts et al. (2009), oppressed behaviours in nursing are perpetuated by the hierarchy within the profession. The social nature of the nursing profession means that nurses are not a homogeneous group, as the group comprises several divisions and subgroups (Paterson et al., 2003). These include nurse administrators, nurse educators, nurse practitioners, clinical nurses, registered nurses, enrolled nurses and assistants in nursing (Lowe et al., 2012). Each of these has its own

responsibilities, beliefs, viewpoints and behaviours that may well contradict or cut across those of the other groups and subgroups that collectively make up the profession. Unfortunately, within nursing, the professional differences that are visible have been reported as divisive, rather than differential (Speedy, 1986). Nevertheless, Chaboyer et al. (2001) suggested that, although the nursing profession lacked some cohesion, this was an issue prevalent in other healthcare professions and some negative views could therefore be anticipated. As shown by the findings described in the previous chapters, participants in this study clearly perceived a culture of 'us and them'. The discord present within the clinical contexts of participants in this study had a direct effect on the degree of distress felt by the participants and is likely connected to the conventional positions that perpetuate the traditional structure of the profession within organisations (Koch et al., 1999).

During the 1800s, Florence Nightingale contributed to the establishment of two groups of nurses (infirmary-trained nurses and general hospital-trained nurses) and it is possible that the paradigm that continues to exist in the nursing profession today originated from this segregation (McCrae & Kuzminska, 2017). Goodrick and Reay (2010) claimed that the two-tier nursing structure introduced by Nightingale has evolved into the division of registered nurses and enrolled nurses. In contemporary nursing, this distinction is still experienced in terms of education, skills, scope of practice and position designation (Jacob et al., 2013). Registered nurses are endowed with higher responsibility than their enrolled nurse peers in a manner similar to that of 1800s England middle-class nurses, who were assigned to the more prestigious ward sister role following general hospital training (McCrae & Kuzminska, 2017). Role segregation in the hierarchical model of registered nurses and enrolled nurses is just one layer of the structure that has come to characterise the profession.

Abel-Smith (1960) and, over four decades later, Jervis (2002) suggested that, from the 1800s to the present, the ‘chain of command’ has been an important part of nursing. The nursing profession has its roots in both the church and the military, and each of these institutions employed strict discipline through their preserved traditions or bureaucracy (Hadikin & O’Driscoll, 2000). Promotion through the hierarchy was possible for those who displayed dedication and obedience, while nurses who broke with traditions and laws were disciplined by being publicly humiliated or terminated from their job (Dingwall et al., 2002). Other nursing staff would ostracise and ridicule nurses who questioned supervisors (Duffy, 1995; Jervis, 2002). Nurses soon discovered that it was important to adapt, as is the case in many other careers, if they were to advance. Participants in this study were mindful of the need to adapt to the environment to be considered for promotion, as well as the consequences of ‘ruffling feathers’. Similar to Matthiesen and Einarsen’s (2007) argument relating to the treatment of those who are viewed as different, in this study, reporting bullying was seen as defiance of the accepted behaviour and was therefore met with disciplinary action for some participants. Disciplinary action culminated in the participants becoming nervous, resulting in them questioning their ability to work as a nurse. Conversely, those demonstrating obedience and unquestioning behaviours were granted promotion.

When an organisation promotes an employee who has bullied a co-worker or subordinate, it provides an incentive for others to do the same. By sabotaging the work performance of another colleague, the bully may improve their own status within the organisation (Hutchinson et al., 2009). The findings of this study verified bullying as a way of gaining enhanced status, thereby legitimising, sanitising and reframing bullying behaviour as part of a management style.

Nursing continues to function as a hierarchical structure across a chain of command (Ewens, 2003; Wellman et al., 2020). Individual nurses within the nursing profession, depending on the rank the nurse holds, have a certain position on the linear chain that is either equal or inferior to those further along (Ewens, 2003; Jervis, 2002). Duffy (1995) suggested that the use of oppressive and inflexible performance measures helps hierarchical structures thrive. In the current study, the culture of the workplace affected how participants viewed the significance of their experiences with regard to bullying behaviours. Subsequent reactions of participants to their workplace colleagues were largely constructed in response to the elevated levels of internal stress and anxiety felt at the time.

Historical nursing literature indicates that nursing has been subjected to patriarchal and hierarchical oppression (Dinmohammadi et al., 2013; Duchscher & Myrick, 2008; Rooddehghan et al., 2015). As Hutchinson et al. (2006) previously highlighted, the factors contributing to bullying in nursing have received little attention. It has been 40 years since Roberts (1983) described nursing as an oppressed group, yet bullying has remained a persistent problem that sees the profession trapped in history.

10.4 Trapped in History

Interpretation and understanding of a social reality that incorporates human interactions and relationships is promoted by a shared language, historical past and social background (Lewis et al., 2008; Yildirim, 2020). Such understanding and meaningfulness derive from the sharing of socially situated personal experiences, locally and historically embedded knowledge, and other worldviews that help people construct and contextualise themselves as part of a community or society. Ultimately, understanding the social and cultural context in which human interaction occurs is vital to interpreting research findings (Bourdieu, 2003) and perhaps no more so than in

research into the phenomenon of bullying. Although the social world and individual actions within it are socially constructed, there are permanent mechanisms that form and affect these actions within a field (Bourdieu, 1998, 2003). Bourdieu (as cited in Bourdieu & Wacquant, 1992) clarified this concept using a game metaphor:

> We can indeed, with caution, compare a field to a game … although, unlike the latter, a field is not the product of a deliberate act of creation, and it follows rules or, better, regularities, that are not explicit and codified. Thus, we have stakes … which are for the most part the product of the competition between players. We have an investment in the game … players are taken in by the game, they oppose one another, sometimes with ferocity … We also have trump cards, that is, master cards whose force varies depending on the game: just as the relative value of cards changes with each game, the hierarchy of the different species of capital (economic, social, cultural, symbolic) varies across the various fields. (p. 98)

Such mechanisms are embedded in professional contexts such as nursing. Mechanisms are the associated language and behaviour, known as an implicit way of doing things (Bourdieu, 2017; King, 2000). This is the mechanism that has allowed bullying in nursing to become entrenched and flourish for at least the past 40 years.

The findings of this study provide further evidence of power-related oppression within the hierarchical structures of the nursing profession. They also reveal how this context continues to fuel ever-changing antecedents and further discourages dissent that may challenge the prevailing conditions that allow bullying to persist. Organisational initiatives and zero-tolerance campaigns are welcome and vitally necessary initiatives to help ensure that the nursing profession begins to fully address the impact and damage caused by bullying. As was established in Chapter 5, these steps alone are insufficient to

solve this mutating, malignant problem. All too often, new initiatives amount to little more than window dressing that fails to address the broader, more systemic root causes (Butler et al., 2018; Westbrook et al., 2018). The findings of this research challenge the belief that it is possible to ensure safer, more supportive nursing workplaces by either initiatives or policies. A quotation often attributed to Albert Einstein defines insanity as doing the same thing over and over again and expecting different results (Nissen, 2020). The nursing profession continues to perpetuate this behaviour, decade after decade, as the antecedents, manifestations, responses and impacts continue to change. It is clear from the findings of this study that the only hope for creating safer nursing working environments for the future is to recognise bullying as a major problem and address the current contributing factors.

One major finding from this study is that, when those who hold a position of power fail to fix the problem, they become part of the problem. Analysis of the testimonies gathered in this study clearly showed that, for the participants, responsibility for addressing the problem was held by nurse managers. However, as discussed above and in support of the findings from Harrington (2010), in an organisational structure characterised by powerful economic and performance discourses and loss of autonomy, the findings of this study suggest that actions to eradicate bullying may be almost impossible for nurse managers to execute effectively.

The findings from this study indicate that nurse managers may be under pressure from other dominant members of the organisation to act rapidly and protect senior management. The apparent defence by senior management in response to bullying allegations indicates the presence of what Hutchinson, Wilkes et al. (2010) called ‘alliance networks’. These are informal alliances between managers that help silence the issue by problematising the target and thereby shielding the individual accused of

bullying. Nurse managers themselves may be members of these alliances through their apparent collusion with those who hold the power. In their longitudinal studies on the experiences of bullying, Hutchinson, Wilkes et al. (2010) suggested that, because nurse managers are compensated by organisational processes, such as performance indicators and evaluations, informal partnerships are cultivated among those who have the ability to influence and change to ensure that their own needs are met. Therefore, by transferring responsibility back to the target or turning a blind eye, nurse managers become complicit in reducing, dismissing or denying bullying, as was described by the participants in this study.

Oppression was evident through the burden placed on nurse managers themselves, reinforcing the intractable nature of bullying in the nursing profession. Through this pressure, senior management use their status within the organisation to protect their interests by manipulating the situation by urging nurse managers to not investigate bullying allegations. This pressure seems to be framed within a risk-averse discourse that aims to safeguard the organisation from legal or reputational harm. Participants felt the organisation was more interested in protecting the company from risk than in addressing the cause of the bullying behaviour. The supremacy of senior management can be seen to restrict the way nurse managers perceive behaviour and act within the organisation. Addressing bullying would clearly be in the best interests of organisations, given the considerable impact of bullying described by participants in Chapter 9.

The greater tendency to report bullying incidences evident in the experience of participants in this study suggests that nurses are failing to develop into nurse managers who proactively intervene when bullying is reported. More significantly, the actions from the nurse manager to bullying allegations seem to generate additional conflict

between the nurse and nurse manager. The additional conflict appears to be centred around responsibility for investigating a bullying accusation and subsequently resolving the issue and communicating the final decision. Surprisingly, while the participants in this study discussed that nurse managers should resolve bullying cases, most testimonies revealed that nurse managers deferred this decision to the human resources department. Even nurse managers who made a decision regarding a bullying investigation often sought human resources' approval for their decision. Applying a critical lens reveals that this deferment may be a result of the perceived lack of autonomy, power or capability of nurse managers to respond appropriately to an allegation of bullying. For those who are targets of bullying, this scenario creates tension. If the position of nurse managers is restricted in this manner and the decision-making associated with managing complaints of bullying rests with human resources, this outcome can conceivably be interpreted as inaction.

10.5 A Roadmap for Reform and Emancipation

Hoffman and Chunta (2015) emphasised the role of nurse managers in raising awareness and the value of combating bullying rapidly when it is recognised. Gilbert et al. (2016) found that witnessing bullying substantially added to the willingness of the nurse manager to take action to tackle the matter. Insufficient leadership, as described by participants in the current study, is clearly a facilitating factor in bullying that continues to drive nurses to leave organisations. Thus, nurse managers are in a position to take positive action that will reduce or eliminate bullying in the profession (Castronovo et al., 2016; Lindy & Schaefer, 2010; Parchment & Andrews, 2019). Nurse managers must first acknowledge that the bullying of nurses does occur and that it is their responsibility to address this problem (Arnetz et al., 2019; Parchment & Andrews, 2019). This study demonstrates that it is essential for nurse managers to recognise that,

if a nurse perceives they are being bullied, then that is the reality for them. In fact, the phenomenon of bullying rests to some degree on the perception of the individual who is the target (Matthiesen & Einarsen, 2007). The belief that nurse managers do not respond appropriately to bullying allegations was viewed by participants as compounding the initial bullying. In these cases, the loss of the nurse's voice and lack of affirmation of their experience was seen as further unfairness, inequality and disempowerment, which characterise an oppressed group, as described earlier. The findings of this study demonstrate that the very organisational mechanism that should provide an avenue for nurses to be heard instead functions to mute the account of the nurse by inaction, denial and management complicity. A critical factor in relation to the management of bullying is the need for nurse managers to listen to every nurse who reports or raises the possibility of bullying occurring in the workplace and respond accordingly.

The manifestation of bullying identified in this study during 2010 to 2020—that of control—should be of special concern to those in management. The findings from this study showed that those who demonstrated control were often the same person to whom the bullying claim was reported. A frequent experience for participants in this study was that their formal or informal complaints were dismissed and labelled unsubstantiated. Clearly, the nurse manager, who had the power to act, was often failing to do so.

During this most recent decade, culture was identified as an antecedent to bullying. Nurse managers have a major role to play in contributing to and shaping workplace culture. Kavanagh and Ashkanasy (2006) and Lee et al. (2016) viewed culture as a strong management force; thus, if there is the existence of a bullying culture, managers are in a position to change it. In any organisation, there exist discrete work units, and these units—such as a hospital ward—may harbour a culture of

bullying. Moss et al (2017) note that changing culture is the most challenging task an organisation will encounter, however, once there is awareness of the behaviours that manifest within a workplace culture, steps can be taken to diminish negative effects, such as poor performance and diminished competence, which were impacts of bullying identified in this research. A change in behaviour leads to a change in culture, which in turn diminishes an environment where bullying is accepted.

The findings from this study have important implications for the development of nurses to the manager role. Jenkins et al. (2012) and Omari and Paull (2017) found that nurse managers' inaction was due to a lack of management training, which led to a concern from nurse managers that any efforts by the manager would be perceived as bullying (Jenkins et al., 2012; Omari & Paull, 2017). This research identified that questioning decisions, being required to undertake responsibilities, being required to work below a level of expertise, having responsibility removed and being subjected to unreasonable supervision were all manifestations of bullying. As was established in Chapter 2, it is clear that bullying is in the eye of the beholder. Viewed from the perspective of the manager, such actions may not be perceived as bullying, yet, from the view of participants in this study, this behaviour constituted bullying. The main means by which this situation can be avoided is for workplaces to maintain open, two-way communication, where the expectations regarding performance of both parties can be clarified and agreed upon (Murray, 2009; Rahm et al., 2019). An open, trusting climate, where honest and transparent two-way communication between staff is the norm, can make a significant contribution to achieving a bullying-free workplace.

Nurse managers should be concerned about any bullying behaviour that occurs, whether it includes all or some of the bullying behaviours identified in Chapter 7. Bullying impacts both the individual and the profession as a whole, particularly given

that it may ultimately lead to the resignation of a nurse from the profession. Bullying is a concern for nursing students too, as found in an Australian study conducted by Curtis et al. (2007), who examined the experiences of bullying during clinical placement. This research examined the effects of witnessing bullying on nursing students' recruitment and retention rates. The authors expressed concern that bullying contributed to the rise in the number of nursing students who did not complete their pre-registration course over the preceding decade—another compelling reason for those in management positions to ensure bullying is eradicated.

For registered nurses and nursing students, exposure to negative behaviours appears to have been normalised throughout the generations. Bullying in nursing may be trapped in history; however, an understanding of the changing antecedents, manifestations, responses and impacts can provide an explicit roadmap for reform and emancipation. As suggested in the literature, bullying in nursing is entrenched in historical factors linked to oppression. This study has revealed how these factors also result in nurse managers being unable to effectively deal with the pervasive problem of bullying. Exposing and challenging the potential power differentials that exist in social reality, including in the nursing profession, can lead to the reduction of power imbalances, thus creating the conditions for change.

10.6 Conclusion

While bullying has changed over the decades, this evolution has not been in a direction that can help enforce effective solutions. Differences in power and the way it is used in the nursing profession in Australia enable bullying to flourish. The relative disparity in power relations between nurses themselves and their own feelings of disempowerment further complicate the situation. Often lacking the requisite personal and organisational resources, nurse managers have been charged with handling the

bullying epidemic, while themselves under significant pressure. While these nurses have the potential to create change, they become part of the problem when they fail to do so. It is a fundamental finding of this study that the way in which power is used by members of the nursing profession is an important consideration if we are to break down disparities and boost the status of the most disempowered nurses. The implications and recommendations for addressing this requirement will be considered in the next final chapter.

Chapter 11: Implications, Recommendations and Conclusions

11.1 Introduction

The aim of the research described in this thesis was to identify the factors that contribute to bullying in the nursing profession in Australia. The research methodology and design used to address this aim have been explained and the results described in the context of the broader literature. The thesis is concluded in this final chapter. This chapter reviews the intent of this study and the methodology employed to answer the research question. An evaluation of the study is presented to reassure the reader of the quality of the final product. The chapter will conclude with consideration of the implications and associated recommendations derived from the findings of this research.

11.2 Revisiting the Purpose of This Study

The critical historical methodological approach used in this thesis has ensured that the study has addressed a number of specific gaps within the literature in the area of bullying in the nursing profession. The analysis of first-hand data produced findings that contribute to the knowledge and understanding of bullying in a number of ways. First, these findings have enabled an examination of the context in which bullying exists, revealing the metamorphosis of bullying in the nursing profession over four decades. Second, an understanding has been established regarding how and why bullying occurs in the nursing profession. Finally, this research has uncovered what Australian nurses themselves conceptualise as bullying behaviour.

11.2.1 Research question and aim. The research question for this study was: why does bullying continue to flourish in the nursing profession in Australia? The aim was to determine the factors that contribute to bullying and allow it to persist in the various settings in which nurses are employed.

11.2.2 Research design. To address the aim of this study, a critical historical methodology was employed. Testimony method was used to gather data that described the bullying experience by participants. These data were then analysed and presented as a sequence of events in the form of a coherent narrative. A three-dimensional analysis was used to extend and develop an understanding of the experiences over time. In this process, testimonies were coded to generate a broad qualitative understanding (first dimension), which offered a basis for a more in-depth analysis that extracted rich explanations of the experiences (second dimension). The final analysis was juxtaposed over a timeline of decades to reveal a chronology of changes (third dimension).

11.2.3 Research findings. The findings are summarised in Table 11.1, with the corresponding chapters.

Table 11.1

Major Categories with Corresponding Chapter and Change Over Decade

Corresponding Chapter	Major Category	Change over decade
6	Antecedents to bullying	Gender Power Pressure Culture
7	Manifestations of bullying	Physical Verbal Subtle Control
8	Responses to bullying	Unassisted Unspoken Unsupported Unsubstantiated
9	Impacts of bullying	Motivation Relocation Dissociation Resignation

11.3 Evaluating the Quality of This Critical Historical Research

This study used historical research methods within a critical framework. The critical approach has epistemological roots that uncover distorted contextual truths from historically grounded information. This approach facilitated the achievement of the aim of the study, but also the goal of working towards improving the working conditions for nurses by exposing distorting elements of power.

The research described in this thesis is analysed in this section to verify the quality of the end product. Villaverde et al. (2006) argued that a critical historical research approach gives attention to groups of people who have been overlooked and questions some of the conventional assumptions and conclusions of historical research. However, as noted by Rendle et al. (2018), a challenge exists for assessing the quality of qualitative research. While discipline-specific standards are available for research traditions, most literature on qualitative research assessment aims to provide criteria that are commonly applied generically.

Tracy (2010) offered eight universal criteria, indicating that each quality criterion can be achieved through a variety of ways, the combination of which depends on the individual researcher and their background and philosophical lens. Her eight 'big-tent' criteria for excellent qualitative research are presented in Table 11.2.

Table 11.2

Eight 'Big-tent' Criteria for Excellent Qualitative Research (Tracy, 2010)

Criteria for Quality	Techniques in This Research	Evidence in This Research
Worthy topic	The topic of the research was: • relevant • timely • significant • interesting	Chapters 1 and 2
Rich rigour	The study used sufficient, appropriate and complex: • theoretical constructs • samples • contexts • data collection and analysis processes	Chapters 3 and 4
Sincerity	The study was characterised by: • self-reflexivity about subjective values and biases • transparency about the methods and challenges	Chapters 1, 3 and 4
Credibility	The research was marked by: • thick description, concrete detail and explication of knowledge • multivocality	Chapters 5 to 9
Resonance	The research influenced, affected and moved particular readers or a variety of audiences through: • aesthetic, evocative representation • naturalistic generalisations • transferable findings	Chapters 6 to 9
Significant contribution	The research provided a significant contribution: • conceptually/theoretically • practically • morally • methodologically • heuristically	Chapters 10 and 11
Ethical	The research considered: • procedural ethics	Chapter 4
Meaningful coherence	The study: • achieved what it purports to be about • used methods and procedures that fit its stated aim • meaningfully interconnected literature with the research question, findings and interpretations	Chapters 10 and 11

The use of the eight 'big-tent' criteria for excellent qualitative research by Tracy (2010) made it possible to assess the consistency and rigour of this study comprehensively. In addition to having greater awareness and respect to ensure the quality of research, this process of evaluation increased trust in the credibility of the

research findings as an inexperienced researcher. As indicated by Birks and Mills (2015), to evaluate the quality and rigour of the qualitative research process, enhancing the skills of qualitative researchers is necessary.

11.4 Implications and Recommendations

A concerted and multidimensional approach is needed to combat workplace bullying in nursing. The following implications of this research, and the associated recommendations, are drawn from the experiences of participants as presented in the findings of this study. The implications stemming from the study also include empowering nurses with knowledge of how oppression in a clinical setting may flag the presence of, or potential for, bullying behaviours. This study does not suggest that there is a definitive cause and effect between the presence of oppression and an increased risk of bullying behaviours; however, it is proposed that an enhanced understanding of contextual oppression may be an additional way for nurses to view the phenomenon within the profession.

Participant responses and the current literature suggest that the problem of bullying in nursing needs to be more clearly defined. For participants in this study, there appeared to be no consistent acknowledgement of what constitutes bullying behaviour in nursing. For nurse managers, it appears that bullying must comprise a particular behaviour, which, from the study participants' perspectives, was nearly impossible to prove. When bullying is defined in narrow terms, very few claims may ever be proven. As a result, the root causes of bullying (as outlined in the preceding chapters) will not be resolved. The first step towards improving this situation is for the nursing profession in Australia to clearly define the problem. Assuming ownership and accountability through such clarification will empower nurses to confront workplace bullying.

Recommendation 1	Clearly define the problem of bullying to facilitate more effective identification and management

The findings of this research suggest that a certain amount of bullying occurs in the nursing profession without anyone except the target being aware that it is occurring. Even the perpetrators may be unaware of the impact of their behaviour on others. Thus, nurses must be prepared to detect and respond to bullying. To move forward and change how nurses interact with colleagues, nurses must first recognise what is happening to them and around them. When nurses are powerless, marginalised or exploited, and there is a palpable sense that a dominant group is defining or controlling them, there is a chance that they are at risk of exposure to bullying behaviours. It is therefore imperative that nurses critically examine their individual and group behaviour. They may benefit, for example, from being alerted to the concept that power abuse may result from both organisational and individual factors. Rather than perceiving and experiencing bullying behaviours solely in the realm of individual causes, nurses could instead gain an increased depth and breadth of understanding of the broader factors, and an associated sense of empowerment in the knowledge that they are not exclusively responsible for the perpetuation of the bullying that they experience.

Freire (1970, as cited in Diemer et al., 2016) describes one approach that could be used to engage nurses to critically self-appraise interactions with colleagues, especially in the context of workplace incivility. Existing educational programs rarely include such content. While many address to a limited extent how to respond to bullying, they often fail to consider the factors that contribute to the problem in the first instance. An understanding of individual and organisational factors that contribute to the persistence of bullying can be achieved through inclusion of such concepts in formal

award programs, from undergraduate through to postgraduate level. Continuing education activities run by educational institutions and professional organisations could similarly include a focus on the antecedents of bullying, as well as its management. Armed with this knowledge, nurses will be in a position to identify and appropriately respond when exposed to this pervasive problem.

Recommendation 2	Implement educational programs that prepare nurses to detect and respond to bullying

The findings of this research indicate that novice nurse managers are often ill-equipped to recognise and handle the consequences of bullying. If the issue of bullying is to be successfully addressed, nurses in management roles must acknowledge this deficit in their repertoire of skills. Makie (2017) identified nursing managers as being crucial to addressing the bullying epidemic and highlighted the need to provide them with the necessary skills to allow them to rise to this challenge. Comprehensive educational initiatives that specifically focus on the role of nurse managers in respect of bullying need to be incorporated into formal and informal educational programs, both new and existing. Nurse managers need to be provided with the necessary information and skills to unpack the nuanced nature of bullying and address the needs of all those affected. Educational programs must include the ability to recognise the ethical implications of interpersonal dilemmas, and develop the requisite skills for challenging unethical behaviour in practice. Such initiatives will assist nurse managers to better handle bullying and become more involved in reducing the incidence of incivility in the workplace.

Recommendation 3	Include specific content on addressing bullying in educational programs that are designed to develop the nurse as nurse manager

The responsibility of organisations to build caring environments was described by Bridges et al. (2020), with methods to help workers who participate in emotionally intense work. Interventions involve collective efforts to create a supportive working culture that facilitates collaboration, wellbeing and the reduction of stress. Teamwork, as suggested by Sharma (2017), should become part of the core of nursing profession. Wards and units operate more efficiently and effectively when they work as a cohesive team (Sharma, 2017). Teamwork should characterise the entire profession and be celebrated when it is successfully demonstrated. Nursing leaders who promote teamwork in clinical practice and appreciate and respect the efforts of nurses contribute to the development of a safe work climate. Collaboration and coordination, joint decision-making, transparency and appropriate staffing levels that facilitate effective and efficient nursing practice are other primary factors contributing to a healthy work culture.

Recommendation 4	Foster environments that promote a compassionate and collaborative workplace culture

Establishing a positive workplace culture requires an investment in staff. Organisations should provide details on the availability of internal and external staff support services and actively take steps to recognise, report and minimise the risk of bullying. To further promote wellbeing, employees should be encouraged to take

advantage of paid leave, as suggested by Allen et al. (2015), and use job breaks in a safe way. It is recommended that workers leave the assigned unit whenever possible, 'switch off', and try to physically distance themselves from the job to alleviate tension and reduce the risk for burnout. Vinckx (2018) advised that, when applying for a new position, nurses complete due diligence. This will allow the nurse to gain insight into the atmosphere of the new team they will be joining or their new manager's leadership style. Vinckx (2018) also advised the need to resist the desire to take home the work environment's tension and strain, as this can have detrimental effects on personal relationships with family members and friends.

Recommendation 5	Invest in mandatory protective measures and supportive frameworks that promote the wellbeing of nursing staff

Simply having a policy on bullying or proclaiming that an organisation is a bully-free zone has proven insufficient in ensuring a bully-free workplace. Policies are an important part of every workplace, but their efficacy in handling bullying behaviour remains uncertain. The greater the incidence of bullying within an organisation, as shown by Sauer and McCoy (2018), the less likely protective measures are in place to address bullying in the workplace. Healthcare organisations with dysfunctional working environments that concentrate exclusively on financial measures create highly challenging situations for vulnerable, inexperienced nurses and their more seasoned co-workers who are involved in these behaviours (Berry et al., 2016). These organisations must therefore develop well-defined frameworks to support nurse managers to handle allegations of bullying, as the findings of this study suggest that nurse managers are often unaware of policies and procedures for managing this problem. These frameworks

are critical in addressing the lack of procedural fairness that was reported by participants as an impediment to reporting instances of bullying.

Recommendation 6	Establish a well-defined framework for handling allegations of bullying within organisations

For more than 40 years, bullying has persisted in the nursing profession. Such behaviour has a clear and significant effect on the outcomes of healthcare, patient safety and patient satisfaction (Kieft et al., 2014). It is clear from this current study and earlier work that bullying also plays a role in employee satisfaction, collaboration and teamwork between individuals and teams, and the retention of nursing practitioners in an already challenged workforce (Olsen et al., 2017; Steele et al., 2020).

Nurses are responsible for resolving professional disputes and recognising sources of stress that can elicit emotional responses when reacting to workplace bullying perpetrators. Further, when approached by or witnessing the behaviour of a nursing bully, individual nurses and healthcare organisations have a responsibility to embrace and reinforce zero-tolerance attitudes. At the macro-level, through targeted policy development, leadership education and implementation of a robust incident management framework, healthcare organisations will be better equipped to proactively resolve the otherwise divisive and destructive nature of bullying among nurses.

No nurse is resistant to the impacts associated with bullying, whether directed at themselves or their co-workers. Not only does bullying exist, but it seeks to compromise the physical and psychological protection and wellbeing of committed nurses and the patients for whom they are responsible for providing care.

11.5 Directions for Future Research

Future research must identify and evaluate best practices in eradicating bullying in nursing once and for all. Such research will provide a stronger evidence base for the development and implementation of prevention and management strategies. It should also include nurse managers' perceptions of and responses to bullying to identify strategies found to be effective. Research that identifies successful manager qualities and skills to help address bullying and other forms of incivility in nursing should also be undertaken.

Recommendation 7	Undertake research to establish the perspective of nurse managers regarding bullying

Considering the study participants' suggestion that bullying can only be addressed through a variety of strategies and interventions, there is an immediate need for well-designed, international collaborative research to examine successful strategies used to eliminate bullying. Such research will assist in the creation of local, national and international evidence-based policies and legislation intended to reduce the impact of bullying on nurses and the patients for whom they provide care.

Recommendation 8	Explore strategies that contribute to bully-free nursing environments

Given that the vast majority of current commentary and research on the issue of bullying within healthcare is from within the nursing profession itself, coupled with the sluggish speed at which meaningful positive change in bullying behaviours is occurring,

it seems prudent that research contributions from disciplines outside nursing (such as human resources or other health professions) may offer a fresh insight or perspective to the issue. More research that unpacks the full gamut of behaviours and factors contributing to bullying can produce a richer understanding of the context in which bullying persists. Further, such work will allow researchers to identify whether there are common conditions evident in those professions with a higher incidence of bullying behaviours.

Recommendation 9	Undertake a broader investigation of bullying inclusive of other professions

11.6 Limitations

The findings of this study must be considered in light of its limitations. Researcher bias is the first possible limitation considered. This was a qualitative research study intended to investigate and understand the views of others. The researcher, as in all qualitative analysis, was placed as the study instrument and a participant in the process (Birks, 2014). As such, although recognised as part of the method, the analysis and interpretation of data and findings can be affected by a degree of subjectivity. Subjectivity may derive from the researcher's philosophical perspective, personal experience or prior knowledge. To alleviate and combat this effect, reflexivity was used. Regular advisory meetings to check and test various sections of the study process were used to evaluate the online survey, interview questions and data analysis. To further support minimising the influence of the researcher, a detailed review of each process and outcome of the study was undertaken and included in this chapter.

Further, this study was based on the experiences of Australian nurses and may subsequently not be supported beyond this cohort of participants. This is not to suggest that nurses in contemporary workplaces outside Australia would not have experiences that resonate, possibly quite strongly, with the findings of this work. However, the goal was not to generalise outcomes, as this is not the intent of a qualitative study. Rather, this research sought to gain a deeper understanding of the phenomenon of bullying of nursing in Australia across a four-decade period and explore and describe the reasons that this behaviour persists.

Moreover, the greater availability of potential participants over recent years resulted in the numbers in each decade being skewed. Nevertheless, the use of the three-dimensional data analysis demonstrated data saturation over the four decades. The limitations of this research also included the reliance on self-disclosure in the form of testimonies. The potentially distressing nature of the subject matter may have dissuaded some individuals from participating who had no desire to re-examine a previous negative experience.

Finally, study participants were recruited using only one professional organisation in Australia. However, the opportunity to participate in this study was shared beyond the original organisation, which, alongside media coverage, mitigated this limitation to some extent.

11.7 Conclusion

‘You really, really, don’t want to be in my shoes’ [T4F].

This chapter completes this thesis. To describe the factors contributing to bullying in the nursing profession, this study used critical historical methodology to uncover the evolution of the problem. Collectively, the results reflect the multifaceted nature of this phenomenon and shed light on the many variables that have caused this

dilemma to persist to the present day. The impact of bullying shared by participants in this study implores the profession to find a better way forward. A future that ensures that interactions between nurses are hallmarked not by oppressive mechanisms, but by mutual compassion, empathy and consideration for others, is clearly desirable. While bullying is a complex, multidimensional problem that cannot be understood in isolation, this study serves as an important reminder of its pernicious nature and ever-changing presence in Australian nursing. It is vital that we understand the factors leading to the emergence and growth of this phenomenon, given its profound consequences and impacts upon the wellbeing of nurses, patients and the profession as a whole.

Epilogue

The aim of this study was to explore nurses' experiences of bullying from a critical perspective. Such experiences have shown that there is a discrepancy between the stereotypical image of nurses as caring and the experience of nurses in reality. The revelation of the experiences was often painful for participants. Some of the events had not been shared before, and nurses were concerned that sharing was a sign of weakness. I believe that the nurses who shared their testimony are brave. There is much that can be learnt from their suffering.

Bullying in nursing manifests in many ways as a consequence of various contextual antecedents that have evolved over time. Many of the nurses in this study had reported the incident, yet felt that no one advocated on their behalf. The lack of action highlighted that bullying in nursing was seen as part of the job, taken for granted, and accepted and condoned by individuals, as well as organisations. Bullying does not only have implications for individual nurses, but permeates the entire nursing profession.

Bullying is a real threat to the nursing profession. Understanding the factors involved and complexity of bullying is a necessary first step if we are to see change. Change simply will not happen unless and until the profession rises to the challenge it faces. In the end, the nursing revolution we so desperately need to eliminate bullying will come from the deep and profound respect, compassion and admiration we have for each other as nurses.

There is a lot at stake. We need to stop asking 'is it bullying?' and shift focus from describing the problem to addressing it. I challenge all nurses to recognise that bullying in nursing is real. I also challenge all nurses to bravely break the silence, break

the cycle and change this narrative, and be nurses who strive to make nursing the very best it can be.

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Appendices

Appendix A

Bullying in the nursing profession in Australia

INFORMATION SHEET
PROJECT TITLE: 'The caring profession: In need of a cure?'

You are invited to take part in a research project about bullying in the nursing profession in Australia. The study is being conducted by Peter Hartin, a Doctor of Philosophy candidate at James Cook University. Peter is supervised by Professor Melanie Birks and Associate Professor David Lindsay. This study aims to explore the phenomenon of bullying in the nursing profession and why it persists today.

You are being invited to participate in this project because you are currently or have previously been registered as a nurse. If you agree to be involved in the study, you will be invited to describe your experience of bullying while working as a registered nurse. Your participation will involve either being interviewed by the researcher or submitting a written account of your experience through an online submission. You will be guided during the interview or when completing the online submission through the use of questions that ask you to provide details of your experience of bullying. You are not required to answer any question if you are not comfortable doing so.

Interviews will take approximately one hour and will be conducted in a place and at a time convenient for you. These may be conducted in person or via telephone or videoconference. You will be asked to sign a consent form prior to the interview and may be contacted at a later stage and asked to provide additional information. Alternatively, you may submit your experience via an anonymous online submission. The amount of time it takes to provide your experience via an online submission will vary; however, you need not complete your submission all at once and can return to it at a later time if you prefer. Submission of your written account will imply consent for it to be included in the study.

Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice. Please note that as the online submission is anonymous, it will not be possible to withdraw your responses once you submit.

Retelling the story may have an emotional impact on you. If this happens, we encourage you to contact counselling services such as Lifeline (13 11 14).

If you know of others that might be interested in this study, please pass on this information sheet to them so they may also contact the researcher to volunteer to participate.

Your responses and contact details will be strictly confidential. The data you provide will be retained in a locked cabinet or password-protected computer and only the researcher and his supervisors will have access to it. The data from the study will be used in research publications, conference presentations and reports. You will not be identified in any way in these publications.

If you have any questions about the study, please contact—Peter Hartin.

Principal Investigator: Peter Hartin
College: Healthcare Sciences
James Cook University
Phone:
Email: peter.hartin@jcu.edu.au

If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, QLD, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

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3 Please indicate whether you are interested in participating in an interview or would prefer to provide a written account of your experience via an online submission:

- O Yes, I'm interested in providing an online submission (1)
- O Yes, I'm interested in being interviewed (2)
- O No, I'm not interested in participating (3)

Skip To: 12 If Please indicate whether you are interested in participating in an interview or would prefer to pr... = Yes I'm interested in being interviewed

Skip To: End of Survey If Please indicate whether you are interested in participating in an interview or would prefer to pr... = No I'm not interested in participating

Display This Question:

If Please indicate whether you are interested in participating in an interview or would prefer to pr... = Yes I'm interested in providing an online submission

4 Are you currently or were you previously a registered nurse?

O Yes (1)

O No (2)

Skip To: 5 If Are you currently, or were you previously a registered nurse? = Yes

Skip To: End of Block If Are you currently or were you previously a registered nurse? = No

Display This Question:

If Please indicate whether you are interested in participating in an interview or would prefer to pr... = Yes I'm interested in providing an online submission

5 **The first set of questions will capture some details to assist in understanding the context of your experience.**

What is your gender?

O Male (1)

O Female (2)

*

6 What year were you first registered?

_____

*

7 What year did this experience of bullying take place?

_____

8 What was the location? (e.g. metropolitan, rural, etc.)

_____

_____

_____

_____

_____

9 What was the setting? (e.g. medical/surgical ward, specialty area, etc.)

_____

10 What was your position in the organisation at the time of the experience?

_____

_____

_____

_____

_____

11 Who were the other people involved?

_____

_____

_____

_____

_____

Display This Question:

If Please indicate whether you are interested in participating in an interview or would prefer to pr... = Yes I'm interested in being interviewed

12 Thank you for your interest in participating in this study. Interviews will take approximately one hour and will be conducted in a place and at a time convenient for you. These may be conducted in person or via telephone or videoconference.

Please complete the form below with your preferred contact and we will be in touch.

O First name${m://FirstName}${m://FirstName} (1)
_____

O Surname${m://LastName} (2)
_____

O Email${m://Email1}${m://Email1} (3)
_____

O Phone number${m://ExternalDataReference}${m://ExternalDataReference} (4)
_____

Skip To: End of Survey If Thank you for your interest in participating in this study. Interviews will take approximately on...(First name${m://FirstName}${m://FirstName}) Is Displayed

End of Block: Block 1

Start of Block: Request for interview

Display This Question:

If Are you currently, or were you previously a registered nurse? = No

13 **Unfortunately, you do not meet the qualifications for the survey. Thank you for your time.**

Skip To: End of Survey If Unfortunately you do not meet the qualifications for the survey. Thank you for your time.() Is Displayed

End of Block: Request for interview

Start of Block: Experience

14 **The following question will give you the opportunity to tell us about your experience. You are invited to provide as much or as little detail as you would like.**

15 Please describe the experience in your own words.

_____

_____

_____

_____

_____

End of Block: Experience

Start of Block: Block 4

16 **The final set of question will help capture the impact of your experience.**

17 Did you report the incident?

O Yes (1)

O No (2)

End of Block: Block 4

Start of Block: Block 4

Display This Question:

If Did you report the incident? = Yes

18 What was the outcome of it being reported?

_____

_____

_____

_____

_____

19 How did this experience affect you in the short and long term?

_____

_____

_____

_____

_____

20 Were there any factors present at the time that contributed to the experience?

_____

_____

_____

_____

_____

21 Literature continues to report bullying as a problem in nursing. Why do you think it persists today?

_____

_____

_____

_____

_____

Q33 What strategies do you think are needed to address bullying in nursing?

_____

_____

_____

_____

_____

22 Do you have any other comments you would like to make about your experience?

_____

_____

_____

_____

_____

End of Block: Block 4

Appendix B

This administrative form has been removed

Appendix C

This administrative form has been removed