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Acceptance Culture Theory: A Constructivist Grounded Theory on Bullying of Junior Doctors in the New Zealand Healthcare System

A thesis

submitted in partial fulfilment.

of the requirements for the degree

of

Doctor of Philosophy in Human Resource Management

at

The University of Waikato

by

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THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2024

Abstract

Workplace bullying has been a serious workplace concern for centuries, with individuals confronting various forms of abuse, mistreatment and bullying at work. Historical accounts indicate that the powerful Egyptian pharaohs strategically lured tribal people to work at their construction sites, which led to submission, slavery and bullying. Regardless of the era, the enduring nature of bullying issues illustrates that individuals can misuse their power by using bullying to establish control and authority over other individuals. In contemporary environments such as New Zealand (NZ) healthcare organisations, workplace bullying remains a significant threat that exposes healthcare workers, including junior doctors, to health and safety issues.

Despite literature documenting the prevalence and harmful impacts of bullying on NZ junior doctors, there is a lack of theoretical explanations behind bullying in this context. This notable gap in understanding the explanations of bullying impedes effective prevention and management of workplace bullying among NZ junior doctors. The research aimed to explain the bullying process among NZ junior doctors with the objective of facilitating prevention and management.

Twenty doctors (n=20) from various specialities in medicine and surgery participated in in-depth interviews. Data collection and analysis were guided by the Constructivist Grounded Theory (CGT) approach. Seven core categories resulted from the data analysis. Six provided explanations of bullying, highlighting the complex interplay of many factors, including social and individual characteristics of the bullies and victims, team dynamics, hierarchy, organisational culture, systemic factors, and acceptance culture. The seventh core category described the prevention and management of bullying.

CGT analysis of the data led to the development of Acceptance Culture Theory (ACT), which is the contribution of this study. ACT outlines the social process of acceptance of bullying at multiple levels of individuals' ecological systems. An acceptance of bullying at the micro level caused individuals to endure and accept bullying, with effects seen at multiple levels (micro, meso, exo and macro) that perpetuated an acceptance culture of bullying in the individuals' work environments, keeping them trapped in a cycle of bullying.

Effective prevention and management are possible by breaking the acceptance culture using comprehensive approaches encompassing macro, meso, exo, and micro levels. Alleviating hierarchal structures, frequent changes in leadership, organisational support, changes in policies and procedures, and a robust reporting system are critical for the effective prevention and management of bullying. By addressing the root causes of workplace bullying, a safe and healthy workplace can be offered for NZ junior doctors.

Dedicated to family and friends

To my daughters, for your unconditional love, warmth, and care, which fill my life with joy.

To my mother, Zak, for your compassion and the sacrifices you have made to help our family succeed.

To my late father, Bashir M., for infusing a desire for knowledge and wisdom in me.

To my late brother Aasim Bashir, thank you for being a role model and for teaching me the virtues of resilience and tenacity. I have got your vision.

To all my siblings for offering me the gift of your presence and being my strength in challenging times.

To my friends (you know who you are) for your love, care and support. Life is wonderful when I have you around.

Acknowledgements

I would like to offer my deepest gratitude to Professor John Oetzel, whose unfaltering encouragement and support were the pillars of my doctoral journey. His support provided clarity and a sense of direction that made it possible for me to navigate challenges with grace and dignity. His expertise and discernment not only raised the quality of my research but also provided my learning with deep wisdom and academic sophistication.

I also extend my appreciation to Professor Mark Harcourt, for his invaluable guidance and mentoring, which imparted rigor to my research. His dedication to helping me improve my research skills made a huge difference in my progress. My heartfelt thanks to Associate Professor Polly Atatoa Carr, for her advice and constructive feedback. Her focus on refinement and quality significantly elevated my thesis.

My thanks also go to the Dean of Waikato Management School, Associate Professor Stuart Dillon, whose commitment to providing facilities and professional development opportunities provided a favourable environment for my research and professional growth.

Professor Kathryn Pavlovich is dedicated to facilitating doctoral candidates' success. Her kindness, positive influence and unwavering support have been a great source of strength for me.

I offer my sincere thanks to Associate Professor Peter Sun, who provided avenues for professional growth and development. His support massively improved my teaching skills.

I am very grateful to Dr Hataya Sibunruang, who has been a constant source of inspiration. Her keen insights and positive reinforcement have kept my spirits up throughout the doctoral journey. Her continuous support was instrumental in bringing me clarity when I needed it the most.

I greatly appreciate the help provided by Amanda Sircombe, Helena Wang and Lori Jervis in accessing resources for research and professional development. Their support helped me successfully navigate my academic journey.

I am deeply indebted to the faculty and staff at the Centre for Tertiary Teaching and Learning (CeTL). Their guidance and facilitation made a significant impact on my research skills, teaching practices and professional development.

My thanks go to the participants in this research, whose willingness to share experiences and perspectives provided validity. Without their support, it would have been a challenge to explore the critical issue of workplace bullying.

I am grateful to my peers and colleagues at the Waikato Management School, whose support and collaboration helped me transform intellectual challenges into growth opportunities.

Finally, I offer my most profound respect to my teachers from F. P. High School and P. U. College of Pharmacy, who believed in me. Their gentle care, guidance and inspiration left an indelible mark on my heart. I will always be grateful for their contributions in shaping my life.

Sarah Bashir

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Chapter 1: Introduction

In many professions throughout New Zealand (NZ), workplace bullying is a problem for employees and managers (Lempp et al., 2020; O'Connor, 2020). One in five workers experiences bullying each year (WorkSafe, 2014) and workplace bullying has severe impacts on employees in the healthcare sector (Ariza-Montes et al., 2013). For some healthcare workers, the experiences of workplace bullying are so significant that they alter the meaning of work (i.e., the association between individuals' internal worlds and the workplace context). A loss of sense of purpose leads to workers needing to adjust their day-to-day activities to cope with the impacts of bullying (MacIntosh et al., 2010). In addition, several studies report that bullied healthcare employees show poor resilience and suffer from insomnia, emotional trauma, and stress, which in turn impairs their performance (Ekici & Beder, 2014; Hoel et al., 2020; Mayhew et al., 2004; Namie, 2003; Zhou et al., 2022).

Scholars use different terms, such as employee abuse or mistreatment, to describe workplace bullying (Thirlwall, 2015). Regardless of the term used, most accounts describe workplace bullying as repetitive aggressive behaviour toward an employee or a group of employees over a period that may result in psychological, physical and organisational consequences for the bullied employees and the organisations (Catley et al., 2013; Einarsen et al., 2002; Thirlwall, 2015). Similarly, WorkSafe New Zealand (2014) defines workplace bullying as recurring unreasonable behaviour towards an employee or a group of employees, which eventually leads to physical and psychological issues for employees. WorkSafe New Zealand describes unreasonable behaviour as actions that may be considered unjustified by a reasonable person in a similar situation. Workplace bullying may include victimising, humiliating, intimidating or threatening a person (Employment New Zealand).

My motivation to undertake a PhD on this topic came from my experience working in the healthcare sector as a clinical pharmacist, meaning that I brought a personal understanding

and views to this study. During my university and work life in Pakistan, I dealt with reports of gender-based harassment and bullying of colleagues on many occasions. During my training and clinical placement, I experienced and witnessed gender-based bullying and cyberbullying on many occasions. After graduation, I worked as a clinical pharmacist for two large public hospitals. This revealed a broader picture of bullying and cyberbullying, and how inefficiently these problems could be managed in healthcare organisations. Despite numerous reports of bullying, most bullying issues at my workplace remained unresolved, resulting in bullied employees quitting their jobs to join other organisations in search of healthy work environments. Due to my personal experiences, I assumed that female employees are bullied more than their male colleagues, especially in cultures that are characterised by low gender egalitarianism (low equality across genders) and high-power distance (unequal power distribution in a society). Second, I believe that in the healthcare sector, managers and leaders are more concerned about chasing the organisations' strategic goals than about employee wellbeing. Lack of support from managers and leaders results in unresolved issues among colleagues leading to an escalation in bullying behaviours. While these are my personal biases and experience, I wanted to better understand bullying from a systematic research perspective; hence my desire to pursue this topic in my thesis.

This chapter introduces workplace bullying in general and in the healthcare sector in particular. Specifically, it presents an overview of workplace bullying of junior doctors and what is known already about this topic. This chapter also briefly summarises historical accounts of workplace bullying, with definitions, types, and consequences. In addition, a detailed overview of current understandings of antecedents of bullying, and the prevalence of workplace bullying with a particular focus on the NZ medical profession, is presented. The second part of this section discusses the knowledge gaps in the literature that form the basis of this study. Finally, the research aims are noted.

1.2. Historical Accounts of Workplace Bullying

Researchers have studied bullying for decades (Darby & Scott-Howman, 2016). Early accounts of workplace bullying emerged in 1976 from American psychiatrist Carroll M. Brodsky, who effectively discussed the negative impacts of systematic and continuous mistreatment and abuse of employees in organisations in his book *The Harassed Worker* (Brodsky, 1976). Brodsky focused on describing the process of employee abuse and mistreatment that leads to negative consequences on employees' well-being and productivity.

Research involving workplace bullying before the 1980s was minimal and primarily based on narratives rather than facts (Monks & Coyne, 2011). After this period, researchers' interest in workplace bullying increased rapidly (Monks & Coyne, 2011). Research involving workplace bullying and harassment began in the early 1990s, developed in the late 1990s, and particularly advanced in the early 2000s (Einarsen et al., 2010). Research on bullying expanded in Europe, North America, and Australia after the publication of the works of Einarsen and colleagues in the early 2000s (Allison & Bastiampillai, 2016; Carter et al., 2013; Einarsen et al., 2010; Lutgen-Sandvik, 2008). Later, researchers in South America and Asia also became interested in workplace bullying (Akella & Akella, 2020; Einarsen et al., 2010; Majeed & Naseer, 2019; Nielsen et al., 2011). As a result of scholars' interest in workplace bullying, several descriptions of bullying behaviours were offered (Daniel & Metcalf, 2016; Darby & Scott-Howman, 2016; Einarsen et al., 2002). These descriptions of the extent of bullying behaviours are discussed below.

1.3. Prevalence of Workplace Bullying

Researchers have identified workplace bullying as a global pandemic because of the critical prevalence rates, magnitude, and impacts of bullying (Majeed & Naseer, 2019). Descriptions of bullying prevalence rates vary from country to country (Nielsen et al., 2010). In the United States, 35% of adults have been reported to have directly experienced workplace bullying; and,

indirect effects of bullying were experienced by 21% of adult US Americans (Majeed & Naseer, 2019). One in ten workers in Britain reported experiencing workplace bullying (Nielsen et al., 2010; Nielsen et al., 2011). While bullying has been described to affect 51% of workers in Turkey, less than 3% of workers are reported to experience bullying in Denmark (Nielsen et al., 2011). Prevalence rates may also vary in the same country (Nielsen et al., 2011). For example, another study indicated a prevalence rate of 13% in Denmark (Nielsen et al., 2010)). This variation in prevalence rates within the same country or even across countries, may occur due to differences in measuring methods (i.e., based on definitions of bullying), sampling strategies, and data collection procedures used by different scholars (Nielsen et al., 2011; Saunders et al., 2007).

The magnitude and prevalence of workplace bullying also vary from occupation to occupation (Darby & Scott-Howman, 2016). For example, in New Zealand, bullying is described as a common problem in tourism, social services, health, education, and hospitality (Blackwood et al., 2017; Catley et al., 2013; D'Souza et al., 2019; Darby & Scott-Howman, 2016). Certain areas are labelled as 'hotspots' for bullying in these occupations (Darby & Scott-Howman, 2016; WorkSafe, 2014). For example, education and healthcare sector employees in New Zealand experience higher rates of bullying than employees in other professions (Darby & Scott-Howman, 2016).

1.4. Defining and Describing Bullying Behaviours

Although I offered a working definition of bullying in the opening section of this chapter, the literature provides a wide variety of definitions of bullying (Slattery et al., 2019; Younan, 2018). Further, researchers and practitioners exploring workplace bullying find it challenging to provide a specific definition of bullying, as is generally seen in emerging research areas (Saunders et al., 2007). Accordingly, scholarly literature uses different terminologies and descriptions to illustrate workplace bullying (Anusiewicz et al., 2021; Yamada et al., 2018).

Because of the difference in the terminologies used to describe workplace bullying, bullying is described broadly, with many different aspects (Hogan et al., 2020; Daniel & Metcalf, 2009). These definitions often include intimidation and harassment, bad behaviours, and even aggression or violence (Fernández del Río et al., 2021; Jenkins et al., 2012; Daniel & Metcalf, 2009). While researchers in the United Kingdom, Australia, and Northern Europe have used the term 'bullying', 'mobbing' is used mainly by German scholars to describe the

bullying process (Carter et al., 2013; Daniel & Metcalf, 2009). Similarly, North American researchers have explored the topic of bullying in the workplace under various terms, including workplace harassment, abusive behaviour, and workplace aggression (Henning et al., 2017; Omari & Paull, 2016). The terms workplace incivility, employee abuse, and victimisation have also been mentioned in the literature (Keashly & Jagatic, 2002; Daniel & Metcalf, 2009).

To help resolve the definitional and terminological diversity, this section identifies the following key facets that identify workplace bullying: (1) the nature of unreasonable behaviour; (2) the frequency of bullying; (3) the ability to cause harm (i.e., impacts or risks of harm) to individuals; and (4) power-imbalance between the bully and the bullied (Caponecchia & Wyatt, 2011; Saunders et al., 2007).

1.4.1 What is Considered Unreasonable Behaviour?

The explanation around what is considered 'unreasonable' relates to the "reasonable person test", which is legally based on whether or not a supposedly reasonable individual observing the relevant events will consider such behaviour reasonable (Caponecchia & Wyatt, 2011; Dollard et al., 2014). Reasonableness is often considered a troublesome feature of workplace bullying because it is often related to individuals’ perceptions (Dollard et al., 2014). Because of this, it might be hard to differentiate between reasonable and unreasonable behaviours (Caponecchia & Wyatt, 2011). And therefore, discussing the events with colleagues, family

members, and friends might help get another perspective to assess whether or not the situation represents unreasonable behaviour (Caponecchia & Wyatt, 2011).

Unreasonable behaviours fall into two categories: direct or personal attacks and indirect or task-related attacks (verbal or non-verbal) (Stein et al., 2020; WorkSafe New Zealand, 2014). Direct attacks may include verbal abuse, social exclusions, threats, unjust criticism and sarcastic behaviours (Stein et al., 2020; WorkSafe, 2014). Indirect or task-related attacks involve not appreciating employees' contribution, lack of managers' support, lack of understanding of roles, under-work, social exclusion, scapegoating, and work over-loading or giving impossible deadlines and/or targets to employees (Stein et al., 2020; WorkSafe, 2014).

While clear guidelines are present in the literature to identify bullying behaviours, scholars argue that in the absence of clear organisational policies and well-explained workplace rules, assessing the reasonableness or unreasonableness of behaviours presents issues around reporting of bullying incidents (i.e. under-reporting and over-reporting of specific behaviours) (Caponecchia & Wyatt, 2011; Malinauskiene & Leisyte, 2017). Thus, other elements that may help to identify bullying are the frequency and duration of bullying behaviour.

1.4.2. Frequency and Duration of the Bullying Behaviours

While some scholars identify workplace bullying based on targets' descriptions of bullying behaviours (i.e., whether or not they have been bullied), other researchers suggest that bullying primarily involves social exclusion, offending, harassing and negatively impacting someone's ability to perform tasks over a period of time, repeatedly and continuously (e.g., weekly over 6 months) (Einarsen et al., 2002; Malinauskiene & Leisyte, 2017; Vickers, 2010). This description emphasises that bullying is a continuous process, making bullied individuals victims of constant abuse involving systematic and repetitive actions and negative behaviours (Anusiewicz et al., 2019; Katrinli et al., 2010; Samnani & Singh, 2012). Given that scholars have described workplace bullying as unreasonable behaviour or actions that may be

considered unjustified by a reasonable person in a similar situation, for it to be regarded as bullying, unreasonable behaviour should be repetitive (WorkSafe, 2014). In summary, unreasonable behaviours must be frequent rather than occasional (Caponecchia & Wyatt, 2011; Einarsen et al., 2010). As a result, researchers' interpretations of workplace bullying generally focus on the type of (adverse) effects of unreasonable or negative behaviour on the target, the frequency and repetition of the negative behaviour, and the presence of the element of power imbalance between the bully and the bullied individual for a behaviour to be labelled as bullying (Saunders et al., 2007).

Bullying, behaviours are characterised by a pattern or many occurrences over a period of time (Caponecchia & Wyatt, 2011; Chan-Mok et al., 2014; Einarsen et al., 2002; Vickers, 2010). Although a single occurrence may be a part of a series of happenings or unreasonable behaviours leading up to bullying, single incidences may warn of an upcoming repeated unreasonable behaviour that indicate the frequency of the unreasonable behaviours (Caponecchia & Wyatt, 2011). For this reason, the pattern of unreasonable behaviours is an essential element that needs to be considered when considering an incident of bullying (Caponecchia & Wyatt, 2011).

Some accounts suggest that unreasonable behaviours need to happen every week over 6 months to be considered bullying (Caponecchia & Wyatt, 2011; Leymann, 1990). A more lenient guideline for determining how frequently an unreasonable behaviour occurs to be considered as bullying was introduced by Einarsen and colleagues (Einarsen et al., 2002). The literature supports the notion that unreasonable behaviour only needs to be more than occasional to be considered bullying (Caponecchia & Wyatt, 2011; Salin et al., 2019; Sansone & Sansone, 2015). This emphasises that different researchers have suggested different frequencies for negative behaviour to be named bullying, ranging from once a week to bi-weekly over 6 months, and even throughout the employment history or over the last 12 months

(Einarsen et al., 2002; Salin & Hoel, 2011; Saunders et al., 2007). Saunders et al. (2007) compared various features of bullying from different perspectives in scholarly and practitioner accounts and legal and general definitions of bullying; they noted that accounts mostly have the common feature of a frequent negative behaviour that primarily results in harmful effects' rather than a single incident or occasional occurrences of negative behaviour, unlike the case of harassment (Saunders et al., 2007). For this research, workplace bullying as a repetitive behaviour resulting in negative impacts is taken into account as a component of the definition of workplace bullying.

1.4.3. Ability to Cause Harm

Workplace bullying is also identified by the risk of harm to the individual (WorkSafe, 2014). For example, employees experiencing bullying behaviours may suffer from various psychological and physical problems such as stress, anxiety, depression, and cardiovascular disease (Bernstein & Trimm, 2016; Farooq et al., 2021; McTernan et al., 2013; Xu et al., 2019). Bullying behaviours are characterised by both physical and verbal types of abuse, which may cause severe consequences and harm to individuals in various ways (Anusiewicz et al., 2020). For example, direct verbal bullying behaviours can result in verbal abuse, overt exclusion of the worker being targeted, spreading rumours, and/or withholding resources and information that could negatively impact or harm work performance (Etienne, 2014). Workplace bullying may also harm a victim's reputation both personally and professionally (Etienne, 2014). Constant criticism of the victim's performance, continual social criticism of the target's work, and sarcasm are bullying behaviours that may affect victims' self-confidence leading to indirect personal and professional harm (Etienne, 2014).

1.4.4. Power Imbalance

A key feature of the workplace bullying is a power imbalance; a target is bullied to an extent where they feel powerless to defend themselves against the bully (Salin, 2003a, 2003b). This

power imbalance may prevail among colleagues; senior managers and supervisors may bully their subordinates, or various individuals may team up to bully a supervisor who has authority over them (Salin, 2003b). Such imbalances of power in groups and teams can cause disputes and conflicts which escalate over time and the bullying increases the power imbalance due to its repetitive nature (Salin, 2003b).

In summary, bullying can be described by considering four aspects: (1) it involves unreasonable behaviours; (2) it is repetitive and frequent; (3) it can cause harm; and (4) it entails an element of power imbalance between victims and perpetrators. While the above definition of bullying is consistent with the description of bullying indicated in literature (Einarsen et al. 2020), it is to be noted that power imbalance may initially be seen as unreasonable behaviour, escalating, rather than being a pre-condition. In disputes-based bullying (i.e., among groups and teams), interpersonal conflicts can drive the bullying behaviour, but power dynamics may still develop as the situation proceeds. For this study, therefore, workplace bullying is defined as repetitive unreasonable behaviour/s driven by a power imbalance, which has the ability to cause harm. The impacts of workplace bullying are discussed in the next section.

1.5. Impacts of Workplace Bullying

The consequences of workplace bullying have been well-researched and are well-known. Workplace bullying has well-described severe consequences at individual, organisational, and social levels (Boudrias et al., 2021; Darby & Scott-Howman, 2016; Høgh et al., 2021). At individual levels, bullying causes various psychological and physical effects (Djurkovic et al., 2003). Psychological effects may include stress, inability to judge, anxiety, anger, impaired concentration, memory loss, and post-traumatic stress disorders (Appelbaum et al., 2012; Lever et al., 2019). Physical impacts of bullying on individuals may range from headaches, sleep disturbances, cardiovascular disorders, and gastrointestinal issues (Lever et al., 2019; Xu et al., 2019).

In addition to the individual impacts of bullying, scholars have also noted organisational effects of bullying. These include decreased organisational productivity, which may be damaging and costly for employees and organisations (Appelbaum et al., 2012). Studies also indicate that bullying in organisations may lead to decreased job satisfaction, increased employee turnover, low levels of organisational commitment, and increased absenteeism (Appelbaum et al., 2012).

Workplace bullying can have severe social impacts. These include poor interpersonal relationships, impaired interactions, and reduced worker communication (Einarsen et al., 2002). For example, Anusiewicz et al. (2019) suggest that these social factors increase turnover rates among healthcare employees. In addition, there are adverse effects on the relationships of employees outside of the workplace (Lewis & Orford, 2005). Social impacts of workplace bullying significantly lead to the development of bullying behaviours in the workplace because of the potential severity of their negative consequences on many workers (Han & Ha, 2016; Hauge et al., 2010).

1.6. Antecedents of Bullying

Avoiding negative consequences at these three levels has led to significant research on identifying the predictors or antecedents of bullying. Antecedents may be individual (e.g., the personalities of perpetrators and victims), organisational (such as management and leadership styles, workplace culture, organisational policies and procedures, work organisation, workplace relationships and characteristics of the workforce) and social (e.g., violations of social values and unjustified behaviours) (Einarsen et al., 2002; Nielsen & Einarsen, 2018)

Individual factors resulting in workplace bullying indicate can happen due to perpetrators bullying the victim to feel confident, hide their social incompetence and attain workplace benefits such as promotions and career advancements (Einarsen et al., 2002). In addition, decreased social competence in bullied individuals, and highly self-conscious

behaviours, can lead to workplace bullying (Einarsen et al., 2002). Although some researchers have explored individual antecedents of bullying, many scholars argue that individual factors such as personal attributes do not significantly explain other bullying behaviours in workplaces, because there are organisational aspects that must also be present to foster bullying and therefore, these factors must be identified to improve prevention and management of workplace bullying (Einarsen et al., 2002).

These organisational antecedents of bullying include management and leadership styles, workplace culture, and organisational policies and procedures (Einarsen et al., 2002). Similarly, work organisation, workplace relationships, and workforce characteristics may also lead to bullying (Einarsen et al., 2002). Bullying may also occur due to a lack of trust and aggression in an environment where bullying problems are neither identified nor addressed (Einarsen et al., 2002; Lipinski & Crothers, 2014).

Social factors such as violation of specific social values and individuals' perceptions of interpersonal, distributive, and procedural injustice (i.e., injustice due to institutional incapacities, policies, and laws) may cause feelings of frustration, a sense of attack on personal identity, and anxiety, which may eventually result in workplace aggression (Einarsen et al., 2002). Such social antecedents may lead to incidents of aggression-related bullying in the workplace (Einarsen et al., 2002).

Research on workplace bullying is conventionally based on traditional approaches involving the antecedents, processes, and impacts of workplace bullying, which are generalisable across various occupations and contexts (Glasø et al., 2011). While this traditional approach may contribute to scholarly literature, some researchers argue that studies on workplace bullying must include context-specific approaches, including factors and problems, because such approaches will identify important factors that play a role in the management of bullying and will ensure the health and safety of employees (Glasø et al., 2011).

For this reason, some studies have explored various contextual factors in specific professions. The remainder of this chapter focuses specifically on the healthcare context, which is the focus of this thesis. It also discusses the critical research gap, purpose and research question guiding this study.

1.7. Bullying in the Healthcare Context

Workplace bullying in healthcare is found to be more common than in other professions such as social services, the public sector and hospitality (Chambers et al., 2018; Darby & Scott-Howman, 2016). Some scholars argue that this is because of the nature of the healthcare sector's work, which is primarily based on emotional and interpersonal interactions (Chambers et al., 2018; Montgomery et al., 2020). Researchers paid significant attention to the topic of workplace bullying in their studies in the 1980s and 1990s (Cox, 1987; Einarsen, 1999; Sheehan et al., 1999). Helen Cox (1987) discussed the prevalence of bullying among nurses, focusing on the influence of verbal abuse on nurses' turnover rates and identification of the sources of verbal abuse. In the 1990s, a survey of medical students explored the bullying occurrence, severity, and abuse, pointing out that 46.4 per cent of medical students experienced abuse at some point during their training in junior years.

In contrast, 80.6 per cent of medical students were abused in their senior year (Silver & Glicken, 1990). Several other studies also offer insights into the prevalence of workplace bullying in healthcare settings. Lever et al. (2019) pointed out bullying as a frequent phenomenon among healthcare employees, with a prevalence rate of 26 per cent. Similarly, bullying has been found to be a significant challenge in the Australian healthcare sector (Chadwick & Travaglia, 2017). In a survey of 174 doctors in Australia, 75 per cent of the participants reported being bullied (Askew et al., 2012). A study of nurses presented similar results, indicating an alarming percentage of 64.85 Polish nurses regularly encountered bullying (Serafin & Czarkowska-Pączek, 2019).

Although bullying is widespread across all healthcare professions, certain healthcare occupations have reported higher bullying rates than others (Darby & Scott-Howman, 2016). This reason for that has been proposed that some occupational environments (e.g., hospitals) have more high-pressure and high-stress work environments than other healthcare settings (Kelly, 2015). In New Zealand, there is evidence of significant workplace bullying among healthcare workers (Blackwood et al., 2017; Blackwood, 2015; Catley et al., 2013). Blackwood et al.'s (2017) study of nurses in a New Zealand hospital found that work environment factors such as organisational support can influence bullying behaviours as well as interventions for bullying management. Another study conducted by WorkSafe NZ suggested that 90% of nursing students in NZ hospitals were victims of workplace bullying during clinical training (WorkSafe, 2014). Similarly, a study by Clendon & Walker (2012) reported that NZ nurses' workplace experiences included bullying on a frequent basis.

Nevertheless, Blackwood et al.'s (2017) study found that the NZ nursing profession is at high risk for bullying. The study indicated certain work environment factors in the NZ healthcare organisations at the individual, societal and organisational levels (e.g., societal pressure, lifestyles of healthcare employees, government pressure to meet healthcare goals using limited resources, training levels of employees, and diverse workforce etc.) can not only initiate or escalate bullying. Still, they may also impact how healthcare employees respond to bullying interventions. Thus, the work environments of healthcare organisations can be studied to explain how bullying proceeds or escalates and what effective prevention and management mean for healthcare employees (Blackwood et al., 2017).

Workplace bullying of junior doctors in NZ organisations is a particular concern because of its deleterious effects on the well-being of healthcare employees, healthcare services and patients (Hart, 2018; Kelly, 2004; Quine, 2003; Scott et al., 2008a). Importantly, doctors' exposure to workplace bullying has adverse healthcare outcomes (Samsudin et al., 2018).

Junior doctors' exposure to workplace bullying has adverse consequences for the healthcare sector (Samsudin et al., 2018). In turn, workplace bullying also hinders doctors' learning, harming their ability to provide quality patient care (Samsudin et al., 2018). Because doctors are at a greater risk of bullying, this may also have detrimental effects on the patient's safety outcomes; thus, bullying management in this occupational group demands greater attention from researchers (Chatziioannidis et al., 2018; Samsudin et al., 2018; Wolf et al., 2018).

Chambers et al. (2018) found that the prevalence of bullying in the NZ medical profession is 38 per cent, with one negative incidence related to bullying or abuse happening on a daily or weekly basis. The study also indicated that 37.2 per cent of medical practitioners self-reported bullying incidents, while 67.5 per cent witnessed bullying. Emergency medicine was found to have increased rates of bullying (i.e.47 per cent) with consequences ranging from impacts on the personal well-being of medical practitioners to compromised patient outcomes (Chambers et al., 2018).

The NZ Resident Doctors' Association (NZRDA) reported in 2015 that junior doctors in NZ experienced bullying regularly (Darby & Scott-Howman, 2016). This report also highlighted junior doctors' concerns regarding the management of workplace bullying (Darby & Scott-Howman, 2016). The study suggested that most junior doctors believed managers would not consider taking any actions following formal complaints of bullying (Darby & Scott-Howman, 2016; Scott et al., 2008a). Reports of abusive behaviours in intensive care units prompted the College of Intensive Care and Medicine of Australia and New Zealand to investigate the issue of bullying. A formal survey of the trainees and fellows of the college identified a moderate to high prevalence rate of bullying, that is, about 32 per cent (Venkatesh et al., 2016). Despite research indicating the moderate to high prevalence rates of bullying in the NZ healthcare sector and acknowledgement of the consequences of bullying, there is an absence of significant scholarship that could help to identify and explain this bullying in the

NZ context. Therefore, evidence to facilitate the prevention and management of bullying is absent. This highlights the need for further research in this area because workplace bullying in the medical profession is becoming a serious problem (Chambers et al., 2018; Gardner et al., 2020).

Further, despite the prevalence, bullying issues are often not resolved. For example, it is reported that only 1 out of 34 nurses in NZ who experienced bullying had their concerns resolved (Blackwood et al., 2018). The prevalence and lack of resolution of bullying have broader impacts at various levels; therefore, identifying and explaining bullying is critical to effective prevention and management.

Lack of interest from managers and supervisors in preventing and managing bullying can increase workplace bullying levels (Hauge et al., 2007). A survey of NZ's junior doctors suggested that most doctors believed managers would take no significant action if a formal complaint reporting workplace bullying was made (Darby & Scott-Howman, 2016; Scott et al., 2008b). Lack of support from managers might lead to bullying of junior doctors in NZ hospitals (Hart, 2018; Kelly, 2004; Quine, 2003). A medical council report of interns' training at Waikato District Health Board (DHB) highlighted concerns regarding bullying of junior staff (Scott et al., 2008b). In summary, despite the high prevalence rates of bullying in the New Zealand healthcare sector and medical workforce and the recognition of the adverse impacts of bullying on patient outcomes, it remains unaddressed--emphasising a need for further research.

1.8. NZ Healthcare System and Bullying Regulators and Legislation

NZ's healthcare system was previously a publicly funded, structured network of 20 District Health Boards (DHBs) managed by the NZ's Ministry of Health (Tenbensel et al., 2023). Initially, each DHB provided services and funding to a specific geographical region in NZ. However, after the NZ healthcare sector Pae Ora (or healthy features) reforms in 2022, the DHBs dissolved, and Te Whatu Ora and Māori Health Authority (Te Aka Whai Ora NZ) were

created as two essential government bodies responsible for planning, funding, and providing public health services across NZ (Akmal et al., 2023; Tenbensel et al., 2023). Te Aka Whai Ora was disestablished and folded into Te Whatu Ora on 1 July 2024 as part of the initial of the new government led by the National Party to create an integrated system; this was met with criticism by health professional and Māori activists (Came et al., 2022). Te Whatu Ora works in association with the Public Health Agency and the Ministry of Health, which offers strategic direction and policy oversight in the NZ health sector (Tenbensel et al., 2023). This overall system aspires to bring equitable access to healthcare services for all New Zealanders (Akmal et al., 2023; Tenbensel et al., 2023).

Within the NZ healthcare system, skilled workforce shortages and increased demand for resources have been found to pose profound health and safety challenges, including bullying that can significantly impact the wellbeing of workers and compromise patient outcomes (Bentley et al., 2014; Blackwood et al., 2017). Thus, the role of regulations and legislation in NZ becomes imperative in the prevention and management of bullying.

Workplace bullying in NZ is regulated by a combination of legal frameworks, governmental oversight, and institutional policies (Cobb, 2017). The primary legislation governing bullying and harassment in New Zealand workplaces is the Health and Safety at Work Act (HSWA) 2015, which holds employers responsible for providing a safe working environment for all employees (Cobb, 2017). Under this law, employers are required to manage risks to the health and safety of their workers, including risks related to bullying (Gardner et al., 2013). In addition to the HSWA 2015, NZ has other related laws which may correspond to health and safety in organisations (Gardner et al., 2013). These are the Human Rights Act 1993 and the Employment Relations Act 2000 (Beck, 2018; Cobb, 2017). These laws can provide a legal framework for dealing with the challenges of bullying, harassment, and discrimination in the NZ healthcare sector (French et al., 2014).

According to the Health and Safety at Work Act, it is the responsibility of employers to make sure that the workplace is safe for workers and remains bullying-free (WorkSafe, 2015). Employers are required to create a psychologically safe, bullying and harassment-free work environment (Catley et al., 2013; Palshikar, 2018). They need to prevent bullying from happening and address it promptly if it occurs (WorkSafe, 2014). Workplace policies need to clearly define bullying and mention the reporting processes and actions to take so bullying can be addressed (Crimp, 2017). Employers must also investigate bullying complaints in a timely manner to make sure that both the victim and the alleged perpetrator are treated with respect (Gardner et al., 2020). If required, workplace support, including counselling services, must be provided to both the victim and perpetrator to facilitate mental and emotional wellbeing (Gardner et al., 2020). Training and awareness of health and safety issues and educating employees about the adverse impacts of workplace bullying are also some other responsibilities of employers (O'Driscoll et al., 2011).

Employees also have rights and responsibilities when it comes to bullying in the workplace (O'Driscoll et al., 2011). They have the right to work in a safe environment, report bullying without any fear and be provided with confidentiality during investigations. In addition, employees have duties (WorkSafe, 2014). Employees also have a duty to ensure health and safety in the workplace. (WorkSafe, 2014) They are required to behave respectfully and avoid engaging in harmful behaviours, including bullying or harassment (WorkSafe, 2014). If workers experience or witness bullying, they are required to cooperate with investigators to facilitate the management of bullying complaints (WorkSafe, 2014). In summary, a collaborative approach on the part of employers and employees for prevention and management may ensure that both workers' well-being and patient outcomes are safeguarded.

1.9. Research Gap

Regardless of the accounts of widespread prevalence, impacts and antibullying regulation, there is limited data on the role of individual, organisational, and social factors in the management of workplace bullying of NZ junior doctors. Importantly, there is also an absence of theoretical explanations for bullying in this context. Some scholars have suggested workplace bullying research is devoid of a theoretical focus, which supports the assumption that most studies address only a few parts of the bullying phenomenon rather than developing a comprehensive theoretical lens that could potentially explain bullying (Branch et al., 2021). Although several scholars have studied bullying by exploring its impacts, 'a single-theory approach to understanding bullying has not been adopted (Branch et al., 2021). Theories that explain bullying are needed to help identify key antecedents and processes that lead to bullying; understanding these factors can then help to prevent and better manage workplace bullying of NZ junior doctors.

There are several potential theoretical explanations for the bullying of NZ junior doctors. One is the existence of a workplace with damaging leadership styles and interpersonal issues (Gardner & Rasmussen, 2018; Wheeler et al., 2010). Some scholars also claim that workplace culture and power dynamics explain bullying because workplace culture can normalise bullying behaviours, and poor power dynamics lead to an escalation of bullying behaviours, which in turn causes ineffective prevention and inadequate management of bullying (Hutchinson et al., 2006a; Saunders et al., 2007). Similarly, a culture of fear about reporting bullying incidences may be another reason workplace bullying is widespread in NZ healthcare organisations (Darby & Scott-Howman, 2016).

Healthcare organisations' hierarchal structure, strict supervision, increased workload, and different inter-disciplinary teams' priorities may also lead to workplace bullying (Chambers et al., 2018; Montgomery et al., 2020). Healthcare organisations' traditional

hierarchal systems create a power dynamic that encourages bullying through conflicts and role ambiguity (Olsen et al., 2017). Similarly, structurational divergence (SD) theory, which reflects contradictions caused by differences in the rules and resources in various cultural and social units or structures within organisations, may improve understanding of how organisational structures interact (Ford et al., 2022; Nicotera & Clinkscales, 2010). This may be beneficial in understanding specific phenomena, where overlapping of different structures due to structural divergence can be seen—for example, conflicts and bullying. SD theory might be effective in explaining bullying because the bullying process, like conflicts, also involves negative communication and repeated patterns or cycles of abuse.

While there are also several other potential theoretical explanations which describe either the development of bullying or bullying as a process (e.g., Job Demand-Resources Theory, Affective Events Theory and Social Identity Theory), there is a lack of substantive, mainstream research exploring these theoretical explanations of workplace bullying in the healthcare sector (Bakker & Demerouti, 2007; Tajfel, 2010; Weiss & Cropanzano, 1996). Descriptions are often provided post-hoc or as speculative guesses of why bullying occurs. My research addresses this gap in the literature on identifying which theoretical explanations represent junior doctors' experiences of bullying. In addition to identifying which theoretical explanations are relevant, the practical element of this thesis is that understanding the theory behind bullying can aid in its prevention and management. A theoretical explanation of the process of bullying can lead to effective prevention and management of bullying (Blackwood et al., 2017).

1.10. Purpose and Overview of the Chapters

This research aimed to provide theoretical explanations regarding bullying in order to assist in preventing and managing bullying in NZ's junior doctors. This research, therefore, was driven by two research questions:

RQ1: What are the theoretical explanations for bullying of NZ junior doctors?

RQ2: How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?

To answer these research questions, Chapters 2 and 3 present a comprehensive review of the literature on bullying of healthcare workers, theories that can explain bullying in general, and theories that can explain bullying of NZ junior doctors. Chapter 2 includes a scoping review of bullying in the healthcare literature. Chapter 3 takes the theories identified in the scoping review to understand the literature regarding these theories. Chapter 4 describes the methods and methodology adopted for this research to gather qualitative perspectives from participants of this research about their experiences of workplace bullying. Chapters 5 and 6 present the results of the study. Chapter 7 discusses the findings. Chapter 8 details the grounded theory developed from my research. Finally, Chapter 9 provides the study's practical implications, limitations, and future research directions, as well as the conclusion of this research.

Chapter 2: Scoping Review

While workplace bullying may happen in all organisations, there has been an increased focus on bullying of healthcare workers because of the individual, organisational, and social factors that may increase the risk of bullying in this group (Olender, 2017). Researchers argue that bullying is more frequent in some sectors than others, and healthcare employees such as nurses and doctors are at risk of bullying because of strict supervision and work overload (Ariza-Montes et al., 2013).

Despite strong evidence of the antecedents and consequences of workplace bullying in the healthcare sector, there is a lack of focus on the theoretical explanations of bullying (Goh et al., 2022; Hoel & Salin, 2002; Notelaers et al., 2010). Scholars have identified antecedents as explanatory factors for bullying but have failed to systematically theorise these explanations. Theoretical explanations help to systematically coordinate and link particular structures, behaviours, and contexts to the bullying of healthcare workers. These explanations can also contribute to the successful prevention and management of bullying by identifying the critical mechanisms for its occurrence. While there are individual studies using theories (often in a post-hoc manner), currently there is not a comprehensive review of theorising on workplace bullying or the successful prevention and management of bullying (Branch et al., 2013; Hoel & Cooper, 2001). In the context of the healthcare workforce and bullying literature specifically, several systematic reviews and meta-analyses address single-focused issues about workplace bullying definitions, antecedents, and the consequences of bullying (Boudrias et al., 2021; Gupta et al., 2020; Nielsen et al., 2015). However, none of these provides an overarching view of workplace bullying to illustrate how it is explained or prevented and managed. To address this issue and gain a deeper understanding of the theoretical explanation of workplace bullying in the healthcare sector, a scoping review of systematic reviews was undertaken.

A scoping review seeks to offer a detailed, unbiased synthesis of the related literature, using reproducible and rigorous methods (Lockwood et al., 2019). The objective of a scoping review is to retrieve a range of evidence and synthesise relevant studies to assist practice and decision-making (Lockwood et al., 2019). Identifying knowledge gaps by conducting a scoping review may significantly contribute to future research on workplace bullying of healthcare workers because bullying is a critical problem that requires effective prevention and management to enable the provision of quality health services. Therefore, considering the general objectives of scoping reviews, this review focused on identifying knowledge gaps related to the theorising of bullying and mapping the systematic reviews and meta-analyses studies on the workplace bullying of healthcare workers (i.e., doctors, nurses, allied health professionals, and first responders or emergency services workers). This scoping review answers the following research questions: First, how is workplace bullying theoretically explained in systematic reviews of bullying of healthcare workers? Second, how are prevention and management of workplace bullying discussed in systematic reviews of healthcare workers?

In this chapter, the scoping review of the systematic reviews and meta-analyses is presented. The method for conducting the scoping review is described and the findings of the review are then reported. Finally, a discussion of these findings is presented, as well as limitations and future contributions.

2.1. Methods

2.1.1. Protocol Registration

A scoping review protocol is a way to ensure rigour and transparency in the review process (Lockwood et al., 2019)   Lockwood et al. (2019) suggested that the protocol is developed to offer a detailed account of the aims, research questions, inclusion criteria, the basic steps involved in the reviews, and how each step is conducted. Registering a protocol before

conducting the scoping review emphasises that there was a strategy in place before the start of the scoping review, and the analyses are not influenced by the data that emerges during the review process. Protocol registration, therefore, facilitates methodological rigour supports publication, and prevents selective reporting of the scoping review results (Peters et al., 2022). This scoping review protocol was therefore developed and registered on the Open Science Framework (OSF) as a public access document under URL: https://osf.io/zmvdf/ (see Appendix A).

2.1.2. Framework

Two features framed the scoping review protocol. First, the Joanna Brigs Institute (JBI) suggested that scoping review protocols' questions can be formulated by considering the mnemonic "PCC" (Aromataris & Munn, 2020). PCC stands for the population (or participants), concept, and context**.** This scoping review is about exploring bullying (concept) in various healthcare occupations (population and context). By breaking down or aligning the research question with the PCC approach, the potential to miss exclusion and inclusion criteria can be avoided (Khalil et al., 2021). Another crucial step in developing the scoping review methodology is following reporting guidelines, which act as tools for authors to report their research (Tricco et al., 2016). The use of reporting checklists helps readers to comprehend the validity and reliability of the methods and ensures the transparency of the methods (Tricco et al., 2016) The protocol for this scoping review was developed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (i.e., PRISMA-ScR) checklist as a guideline. Using the PRISMA checklist is beneficial because it consists of instructions that assist researchers, policymakers, editors, issuers, publishers, healthcare workers, and reporters to understand the items reported in scoping reviews (Tricco et al., 2016).

2.2. Eligibility Criteria

Systematic reviews and meta-analyses involving healthcare workers were included (relating to doctors, nurses, allied health professionals, and emergency medical workers/or first responders) because they are the critical components of the healthcare system. All eligible systematic reviews and meta-analyses were published between January 1, 2005, and January 1, 2022, in order to cover relatively recent research contributions and knowledge gaps. Non-peer-reviewed literature and narrative reviews were excluded. All reviews were peer-reviewed and in English.

2.3. Information Sources and Search Strategy

The searches involved ProQuest Central, PubMed, PubMed Central, Google Scholar, Scopus, PsycINFO (PsycNet) and Web of Science databases for published systematic reviews and meta-analyses on workplace bullying of healthcare workers. These databases were selected because of their relevance to studies involving healthcare and clinical workers. The search was carried out by using the keywords in the combination of terms from three groupings (using Boolean operations): 1) systematic reviews and meta-analysis with 2) workplace bullying or employee abuse or employee mistreatment with 3) healthcare workers, healthcare employees, doctors, nurses, allied health, first responders, and emergency workers.

2.4. Study Selection

After completing the search, the bibliography and duplicates from all database searches were managed through Endnote software. Duplicate entries were removed. Following this, studies were initially screened for eligibility using the inclusion criteria by keywords in titles and abstracts. After the removal of entries using this initial screen, full texts of the articles were accessed and screened for the final decision on eligibility. The bibliographic content of the articles meeting the inclusion criteria was read to further search for additional reviews meeting inclusion criteria.

2.5. Data Extraction and Data Items

The data extraction process is referred to as charting the results (Aromataris & Munn, 2020). At this stage, a data charting form or extraction table was developed by identifying essential items related to the research question. An Excel sheet was used to develop extraction table for coding the data (see Appendix C for the extraction table). For this review, for each piece of evidence included in the scoping review, a summary of findings in various categories was also presented in a table (See Appendix B).

Data charting involved PRISMA-SCR and JBI guidelines for scoping reviews. The extracted data is presented in categories in the form of a table. According to the JBI Reviewer's Manual (Methodology for Scoping Reviews, chapter 11), key information to chart for each paper includes: Author(s), Year of publication, Origin/country of origin (where the studies were conducted), Aims/purpose, Study population and sample size (if applicable), Methodology/methods, Intervention type/duration, comparator, outcome measures (if applicable) and key findings that relate to the scoping review question/s (Peters et al., 2020). Following the aims of this scoping review and the JBI general principles, the specific data extraction table or an Excel spreadsheet included the following information: a) citation; b) country of origin of the articles included c) healthcare discipline, aim(s) and purposes, number of articles, type of review, methodology/methods and key findings (i.e., definitions, the terminology used for workplace bullying, antecedents and consequences of workplace bullying, theoretical explanation of workplace bullying, prevention, management of bullying, and the type of critical appraisal for the review. A critical appraisal of methodological quality is not required for a scoping review, but it was noted whether the original authors carried out a critical appraisal when conducting their systematic reviews.

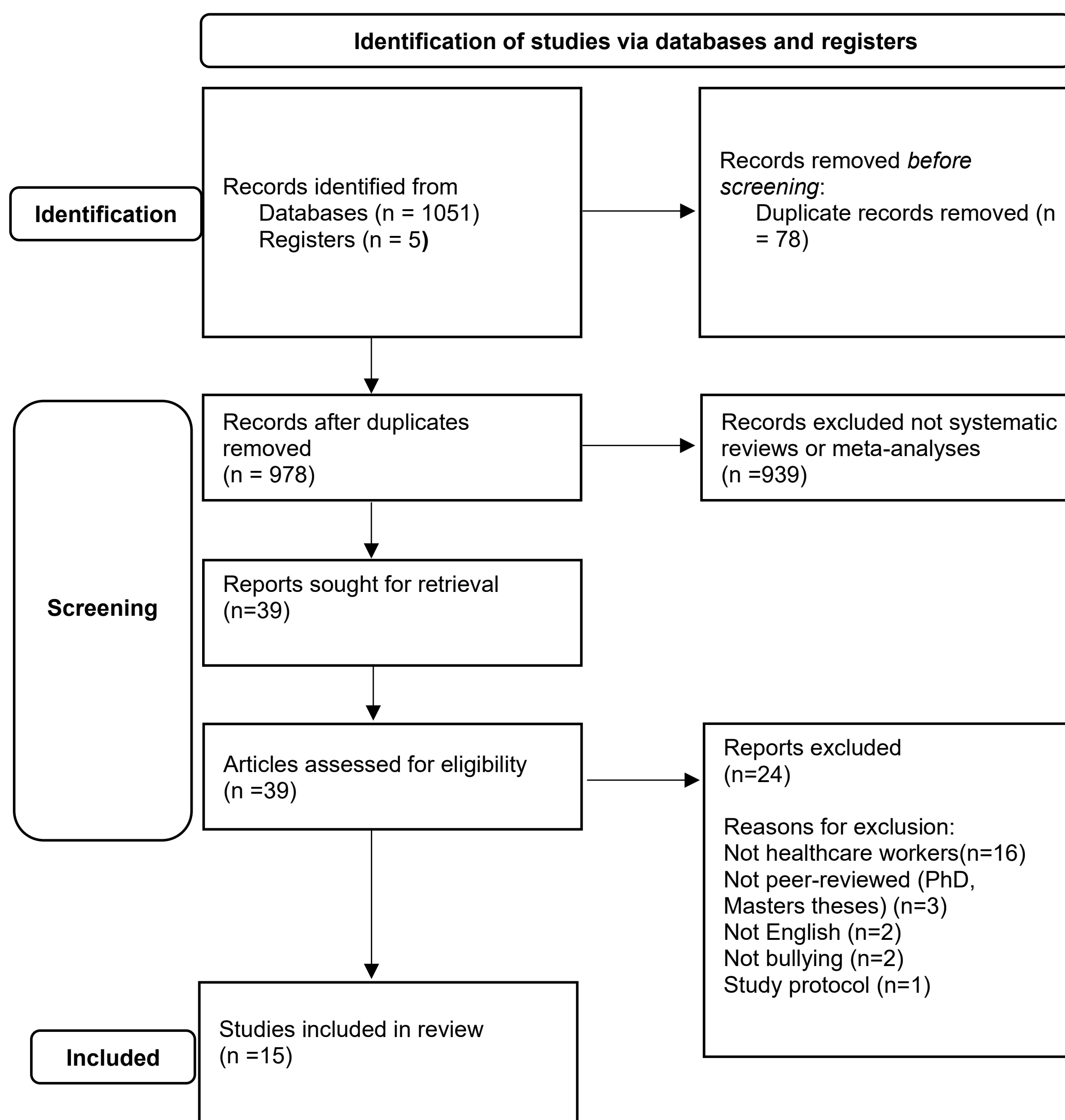
2.6. Synthesis of Results

Studies were sorted into several categories of similar concepts. To analyse the data, the thematic analysis technique was used (Braun & Clarke, 2006; Clarke et al., 2015). Thematic analysis involves identifying, analysing and reporting recurring patterns or themes in the data (Terry et al., 2017). This analysis technique is a descriptive way of reducing data and can be flexibly employed with other data analysis techniques (Braun & Clarke, 2006). For this reason, this approach can be conveniently used to analyse data from a wide range of topics and research questions (Braun & Clarke, 2006; Terry et al., 2017). Braun and Clarke (2006) stated that there are several steps involved in thematic analysis, including: familiarisation, coding, generating, reviewing, defining, naming themes and finally writing the findings (Braun & Clarke, 2006; Terry et al., 2017). The findings from the analysis are coded and discussed in relation to the aims of the scoping review and the research questions (Braun & Clarke, 2006, 2012). Any gaps in the literature are identified and then discussed to highlight the implications for practitioners and researchers (Braun & Clarke, 2006).

2.7. Results

The studies obtained from the initial search of databases were saved and analysed individually based on their titles, keywords, abstracts, and relevance to the inclusion criteria. In total, the search strategy identified 1051 articles from the listed databases. Articles were downloaded to EndNote, and 78 duplicates were removed. A review of the titles and abstracts of the 978 articles using the inclusion criteria resulted in 39 articles being identified for the full-text review. Twenty-four papers were removed after additional screening, resulting in 15 articles for analysis. The study selection is shown in Figure 1.

Figure 2.1 Study Selection: PRISMA Flow Diagram



This scoping review was thus based on 15 studies including 10 solely systematic reviews, 4 systematic reviews and meta-analyses and 1 narrative review. Of the 15 studies included, 5 involved general healthcare sector employees from all units of healthcare organisations without focusing on a particular speciality or profession. The remaining studies included nurses (n=5), surgery units (n=2), midwifery students and midwives (n=1), oral healthcare workers (n=1) and junior doctors (n=1). Regions (or countries of origin) of the

studies included in the reviews included countries in Europe, the Middle East, South Asia, Africa, Oceania, North America and South America.

2.8. Assessment of Bias

This review assessed whether the included systematic reviews had performed a critical appraisal of the studies included in each review. Of the 15 systematic reviews included in this scoping review, 13 reviews had assessed bias. Stagg and Sheridan (2010) and Walker and Stones (2019) did not perform an assessment of bias in their reviews.

The National Heart, Lung and Blood Institute quality assessment tools were used in two reviews (Averbuch et al., 2021; Capper et al., 2020). A mixed method assessment tool (MMAT) for quality assessment for each study was used in one review (Capper et al., 2020). The Newcastle Ottawa or modified Ottawa Scale was used in two reviews (Binmadi & Albowi, 2019; Huang et al., 2018; Samsudin et al., 2018). Quality assessment of the methodological validity of papers using the standard JBI's Critical Appraisal method was used in three reviews (Averbuch et al., 2021; Capper et al., 2020; Serafin et al., 2020). One review performed quality appraisal based on the methodological validity and quality of the studies (Serafin et al., 2020). The Critical Appraisal Skills Checklist was used in one review (Shorey & Wong, 2021). A predetermined assessment criterion of independently reviewing included studies and discussing any disagreements was used by Halim and Riding (2018). A guiding framework for critical appraisal based on sampling, sample size, rate of responses, reliability and validity, and use of statistical methods was used by Lever et al. (2019). Any disagreements were then resolved by discussion between independent reviewers until a consensus was reached (Lever et al., 2019). A similar technique of critical appraisal was used by Johnson and Benham-Hutchins (2020) to assess risk of bias. They performed quality assessment considering sampling size, response rate, reliability, validity, and whether a conceptual model guided the qualitative studies in their systematic review.

2.9. Research Question 1: Theoretical Explanations of Bullying

Four theoretical factors were presented in the literature, to explain what contributes to the presence and process of bullying in the healthcare sector: (1) culture of the workplace; (2) hierarchy in the healthcare organisations; (3) inactive institutional power; and (4) conflict in teams.

2.9.1. Culture of the Workplace

Workplace culture involves shared values, beliefs and norms held by the individuals in an organisation: these shared values and beliefs govern how the members of the organisation behave and practice (Chalmers & Brannan, 2020). Nine reviews included in this scoping review considered how cultural practices in organisations shape and affect bullying in healthcare organisations (Averbuch et al., 2021; Binmadi & Alblowi, 2019; Capper et al., 2020; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Huang et al., 2018; Johnson & Benham-Hutchins, 2020; Shorey & Wong, 2021; Walker & Stones, 2020). Binmadi and Alblowi (2019) stated that most incidences of violence in healthcare organisations are due to the culture of the organisation. They noted that an organisational culture harbouring conditions and norms of physical and verbal violence can escalate bullying. Huang et al. (2018) emphasised that bullying can emerge due to prior teachings and may be accepted as a common tradition in the workplace; bullying issues are endemic to the workplace culture. Halim and Riding's (2018) review of bullying of doctors, nurses, and other staff in surgical workplaces illustrated that bullying was embedded and accepted as part of the workplace culture in the surgical units of healthcare organisations. Capper et al. (2020) highlighted that workplace culture could affect the clinical placements of midwifery students and create a culture that could escalate bullying because midwifery students also feel obligated to maintain the peace in the workplace by conforming to its undocumented rules and regulations. Similarly, Walker and Stones (2020) examined workplace bullying of first responders through an ecological model based on

Bronfenbrenner's (1979) Ecological System Theory. This theory states that human development involves several elements at the micro (directly linked relationships, e.g. friends), meso (interchange of several groups, e.g., family) and macro levels (the broader level that impacts humans, e.g., government) (Bronfenbrenner, 1979, 1992). Walker and Stones (2020) noted that a workplace culture of inconsistency, where managers and leaders in an organisation use contrasting approaches to managing bullying, might promote or allow bullying behaviours. Managers and leaders in organisations may take different approaches to managing bullying or supporting victims based on different societal and cultural values and perceptions about the issue (e.g., some managers may believe that bullying is merely an interpersonal issue between two workmates rather than an actual bullying problem) (Walker & Stones, 2020). Shorey and Wong (2021) found that differences in cultural values impacted the way older nurses behaved toward younger nurses, which in turn created a culture of surrender and compliance to bullying behaviours.

Two studies point more to a specific theoretical explanation of safety culture. Safety culture is a part of workplace culture—it relates to the behaviours, attitudes, and beliefs of the individuals in an organisation regarding practices that involve the health and safety of the employees (Antonsen, 2017). Findings from the review of Johnson and Benham-Hutchins (2020) regarding the influence of bullying on nurses' nursing practice errors suggested that workplace bullying emerged from a compromised safety culture in the perioperative environment of the hospital due to certain cultural practices. They stated that the safety culture in perioperative hospital settings was compromised due to bullying-like communicative practices. For example, negative attitudes concerning communication, including ignoring individual opinions and being yelled at, had negative effects on the safety culture and the environment of the perioperative setting. Further, Chadwick and Travaglia (2017) found that the safety of employees could be compromised due to cultural practices related to bullying

management. For example, management attitudes and behaviours toward employees' safety, such as ignoring employees' complaints and ineffective management of bullying, can lead to employees perceiving that management does not support employees. These cultural practices in the workplace have adverse impacts on employees' safety and may result in workplace bullying.

2.9.2. Hierarchy in Healthcare Organisations

Several studies noted that workplace bullying can happen due to the hierarchies resulting from the bureaucratic structure of the healthcare setting. Nine systematic reviews indicated that healthcare professions such as medicine, nursing, midwifery and dentistry have robust hierarchal systems based on an imbalance in power that can lead to bullying (Averbuch et al., 2021; Binmadi & Alblowi, 2019; Capper et al., 2020; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Huang et al., 2018; Samsudin et al., 2018; Shorey & Wong, 2021; Walker & Stones, 2020). Subthemes identified include bullying of healthcare workers in training, power imbalance and misuse of power.

2.9.2.1. Bullying resulting from hierarchies in the training/apprenticeship model.

Bullying of apprentices by those in the hierarchy is a common phenomenon experienced by junior healthcare employees. Capper et al. (2020) stated that [some] supervisors and nurses were on a 'power trip' and that their hierarchical positions enabled them to bully students. They further suggested that due to this hierarchy, midwifery students did not feel comfortable raising concerns about workplace bullying with their superiors or matrons because of the pressure of getting a position after registration. Shorey and Wong (2021) also found in their systematic review that nurses bully each other to move to higher positions of power in organisations. Further, Binmadi and Alblowi's (2019) review of oral healthcare professionals suggested that bullied employees were afraid to report or complain about bullying behaviour because of the seniority of bullies. Huang et al.'s (2018) review also highlighted that the medical profession

is hierarchal and competitive due to training based on an apprenticeship approach. This system of training and teaching can be the reason for bullying behaviours because those in positions of power may be able to use their authority to fuel bullying behaviours and are more likely to engage in practices that may cause physical and emotional consequences for their subordinates.

2.9.2.2. Power imbalance. Bullying also arises as a result of power inequity and imbalance in the medical training systems. Halim and Riding (2018) explored bullying behaviours in surgical workplaces and found that bullying behaviours develop early in a surgeon's career, and with time, as surgeons move up in their positions, bullying behaviours become a pattern because of strict supervision involving unwarranted efforts to improve the performance of medical trainees (Halim & Riding, 2018). These views were also presented by Samsudin et al. (2018) in their review of workplace bullying of junior doctors. They stated that workplace bullying of junior doctors could be attributed, in part, to a conventional hierarchy and power structure among doctors. Walker and Stones (2020) also suggested that competition and hierarchy in organisations may create a climate where workplace bullying flourishes.

2.9.2.3. Bullying from misuse of power. Seven reviews suggested that the hierarchical system of healthcare organisations leads to misuse of power by people in the hierarchy (Capper et al., 2020; Halim & Riding, 2018; Huang et al., 2018; Johnson & Benham-Hutchins, 2020; Samsudin et al., 2018; Shorey & Wong, 2021; Walker & Stones, 2020). Shorey and Wong (2021) stated that bullying behaviours arise due to an inclination toward control and power by ineffective healthcare leaders. Specifically, they reported that older nurses believe that young nurses should earn higher positions based on experience and job duration rather than education and training, leading to the oppression of younger nurses. Those nurses who were higher in the structure oppressed, silenced, and threatened those in lower ranks to instil fear. Capper et al.'s (2020) review also showed that bullying happens in healthcare organisations because of misuse of power, resulting in unequal power dynamics. Power plays in the workplace can lead to

bullying—this commonly occurs where there is a hierarchy and a struggle for control. Additionally, Serafin et al. (2020) stated that perpetrators mostly target those who are considered weak. They explained that these perpetrators are viewed as having power over their victims either through position or knowledge. Johnson and Benham-Hutchins (2020) also noted in their review that oppression of individuals through the misuse of power over less powerful individuals leads to anger and frustration, which may manifest as bullying of other members of the group. Finally, Averbuch et al. (2012) illustrated that workplace bullying was mainly underreported because of abuse of power: bullies were generally consultants and male, while the bullied workers were frequently female.

These previous studies mention power and control and abuse of power generally. One study included a specific theory to explain power abuse. Johnson and Benham-Hutchins' (2020) systematic review, which explored the influence of bullying on nursing practice, reinforced explanations of workplace bullying through 'oppression theory'. They stated that nursing is an undervalued profession, and oppression theory illustrates that a lack of independence and power may result in individuals behaving badly or bullying others. Johnson and Benham-Hutchins (2020) further described that oppressing powerless parties decreases individuals' self-esteem and causes fright and anger in groups, which may emerge as bullying of one's group over time.

2.9.3. Inactive Institutional Power

Six reviews suggested that bullying can happen due to a lack of management and leadership support (Averbuch et al., 2021; Bambi et al., 2017; Binmadi & Alblowi, 2019; Capper et al., 2020; Shorey & Wong, 2021; Walker & Stones, 2020). Although no particular theories are presented regarding inactive institutional power, there are some explanations of how certain factors contribute to bullying when employees do not feel supported by leaders and those in power due to ineffective institutional policies. For example, Walker and Stones (2020) noted

in their review that at a meso-level in organisations (i.e., involving co-workers, supervisors, or managers), individuals might not take any action—they may actually encourage bullying by not intervening or ignoring the issue. Similarly, Binmadi and Alblowi (2019) suggested that most oral healthcare workers discussed the bullying with managers, family members or peers, but there was no action. Oral healthcare workers, therefore, did not complain because of the belief that reporting bullying was useless. Averbuch et al. (2021) also noted that as a result of not reinforcing antibullying policies in institutions, workers' states of despair and fear of retaliatory consequences can lead to bullying. Capper et al. (2020) also emphasised that most midwifery students tried to seek support from other individuals, such as family, friends, academic staff and counselling professionals, for help regarding workplace bullying rather than seeking advice from individuals in their hospital unit. This is because seeking support from managers was seen as inadequate and not helpful due to a lack of managerial focus on solving the issues. Shorey and Wong (2021) stated that some managers did not address the issue of bullying because managers lacked the abilities and knowledge to address bullying behaviours, resulting in an environment where bullying was encouraged and therefore escalated. Shorey and Wong (2021) emphasised that such institutions had people who were not visible, were uninterested in acting, and ignorant: those who encouraged bullying and 'slip[ped] under the official radar to avoid getting themselves dirty'.

2.9.4. Conflict in Teams

The final theme is that workplace bullying of healthcare workers correlates with conflict and negative team dynamics in the healthcare sector. Five reviews (Bambi et al., 2017; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Johnson & Benham-Hutchins, 2020; Samsudin et al., 2018) emphasised that healthcare workers may experience bullying due to the specific nature of work in healthcare settings: healthcare workers need to work in teams, and when teamwork is not effectively managed, it may cause interpersonal issues.

Three studies discussed conflict in teams leading to bullying as a general explanation of increased bullying behaviours (Chadwick & Travaglia, 2017; Huang et al., 2018; Samsudin et al., 2018). Samsudin et al.'s (2018) review on bullying of junior doctors reported that increased rates of bullying of junior doctors were likely due to junior doctors' lack of skills and experience in reducing and minimising conflicts in the workplace, resulting in a context where conflict continues and escalates to bullying since they cannot resolve the issues. Chadwick and Travaglia (2017) stated that some managers lack interpersonal skills, which may result in conflicts leading to bullying because of a lack of understanding of the issues between employees and managers. Huang et al. (2018) noted that bullying may result from conflict due to group norms: some employees may challenge certain attitudes or complain about behaviours and thus may be victimised by their group.

One study considered a specific theoretical explanation of conflict in teams and subsequent bullying (Johnson & Benham-Hutchins, 2020). Johnson and Benham-Hutchins (2020) pointed out that nursing work in today's healthcare settings has evolved from simple cause-effect processes to more coordinated patient care. Healthcare workers work in teams and involve various departments, and therefore, bullying leads to deliberate counterproductive attitudes at work or conflicts in the organisation. Johnson and Benham-Hutchins (2020) explained that nurses may face situations that pose contradictions between different work structures and units in healthcare organisations. These contradictions inhibit nurses' abilities to comprehend social and work situations, and act accordingly. Underproductive work behaviours resulting from the contradictions between nurses' intended work practices and their actual work practices cause conflicts, which may be called structurational divergence (Johnson & Benham-Hutchins, 2020). The contradictions are usually observable, as they emerge as interpersonal conflicts that may relate to bullying (Johnson & Benham-Hutchins, 2020). Johnson and Benham-Hutchins (2020) noted that Structuration Divergence Theory may be

relevant in the context of workplace bullying and exploring it further may be beneficial in explaining the bullying process in the healthcare settings.

2.10. Research Question 2: Prevention and Management

The second research question (RQ2) focused on the prevention and management of bullying identified in systematic reviews in healthcare settings. Four themes were identified; (1) a comprehensive approach to managing bullying; (2) awareness and effective reporting of bullying; (3) workplace support against bullying; and (4) institutional policies and enforcement of practices.

2.10.1. Comprehensive and Multilevel Approaches to Prevent and Manage Bullying

The findings of ten reviews emphasised that to prevent and manage bullying, a multilevel and/or comprehensive approach should be applied rather than focusing on an individual level or a single aspect (Capper et al., 2020; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Huang et al., 2018; Lever et al., 2019; Lozano et al., 2021; Samsudin et al., 2018; Serafin et al., 2020; Shorey & Wong, 2021; Walker & Stones, 2020). Walker and Stones (2020) examined workplace bullying at micro, meso and macro levels. They mentioned multiple preventive approaches while reviewing theoretical explanations of bullying using Bronfenbrenner's Ecological system theory. For example, the characteristics of bullies may be considered at the micro level to understand bullying and create strategies for prevention and management, while at the meso and macro levels, support from managers and a safe culture may help prevent and manage bullying.

Similarly, Shorey and Wong (2021) highlighted that workplace bullying must be addressed at unit and organisational levels. At the organisational level, organisations can introduce effective antibullying policies to curb bullying and make sure that nurses abide by policy and procedures. At unit levels, managers must foster team-building activities and the exchange of ideas through discussions to strengthen antibullying strategies. Further, Serafin et

al. (2018) pointed out that although many studies have focused on addressing the bullying of nurses, the bullying phenomenon persists and therefore, prevention and management call for a multi-level and comprehensive intervention. Lozano et al. (2021), in their review of workplace violence among first responders, suggested that an institutional and organisational role is critical in designing interventions. They emphasised that institutions must take an approach that focuses both on organisational and individual factors such as a healthy workplace environment, adopting self-effectiveness, intrinsic coping plans, adaptation and strong social support for alleviating workplace violence.

Other reviews also suggested approaches based on multiple aspects, including awareness about bullying, effective practices and procedures, and support from and role of managers and leaders (Averbuch et al., 2021; Stagg & Sheridan, 2010). Stagg and Sheridan (2010) mentioned that there is no single solution, but multiple approaches can be employed to prevent and managing bullying. However, they also emphasised a need for a standardised approach for mitigating bullying to ensure the consistency of preventive measures and suggested that training such as cognitive rehearsal programmes may be the most effective strategy to manage bullying. Averbuch et al. (2021) indicated an organisational-level framework for addressing bullying rather than an individual-level approach because organisational interventions will address the root cause of bullying behaviours and influence the workplace culture. Averbuch et al. (2021) pointed out an approach based on multidisciplinary staff committees, policies, and procedures to curb bullying and develop effective reporting processes, and an education campaign to create awareness about bullying.

2.10.2. Awareness and Effective Reporting of Workplace Bullying

Twelve reviews noted that awareness is a crucial step in preventing and managing bullying. Awareness about bullying behaviours helps bullied workers identify and successfully report bullying behaviours (Averbuch et al., 2021; Bambi et al., 2018; Binmadi & Alblowi, 2019;

Capper et al., 2020; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Huang et al., 2018; Lever et al., 2019; Lozano et al., 2021; Shorey & Wong, 2021; Stagg & Sheridan, 2010; Walker & Stones, 2020). Walker and Stones (2020) stated that awareness and understanding of the scope of bullying issues in healthcare may prevent and eliminate bullying. Lever et al.'s (2019) review noted similar findings. They indicated that awareness about bullying issues may ensure effective reporting to prevent bullying. Averbuch et al. (2021) found that a lack of knowledge about bullying leads to the underreporting of bullying incidents, even in organisations with established policies and procedures around workplace bullying—therefore, a focus on creating awareness about bullying issues is critical for eliminating bullying. Stagg and Sheridan (2010) suggested that bullying can be managed by focusing on employees' awareness of workplace problems and issues and devising a personal action plan. Huang et al. (2018) reinforced the importance of awareness and stated that to curb bullying, some institutions enhance employees' understanding through campaigns, programmes and procedures that aim at developing policies and processes and informing bullied individuals and teams about how to prevent bullying. They also noted that using legal knowledge available online and creating awareness about bullying can change the bullying culture. Shorey and Wong (2021) and Halim and Riding (2018) reinforced that bullying could be prevented by creating awareness by offering education about bullying and conflict management and introducing practical suggestions about addressing bullying in undergraduate curricula for nurses and doctors. Similarly, Bambi et al. (2018) stated that bullying prevention must commence by enhancing awareness in educational settings and the nurses' course curricula.

In addition to awareness, some reviews indicated a need for effective reporting of bullying. For example, Huang et al. (2018) advised that junior trainees should consult with their seniors to ask for advice and support to launch a formal complaint. Averbuch et al. (2018) emphasised that effective reporting results in effective management of bullying. They stated

that underreporting results when addressing bullying problems is perceived as useless. Concerns about maintaining confidentiality while reporting bullying to authorities can also cause underreporting, and eventually, this underreporting may result in ineffective prevention and management of the bullying. Further, Stagg and Sheridan (2010) stated that non-reporting of bullying could result in a lack of focus on the issue of bullying and, thus, poor management of bullying behaviours.

2.10.3. Workplace Support Against Bullying

Ten reviews on workplace bullying emphasised the need for support from leaders in preventing and managing bullying effectively (Averbuch et al., 2021; Capper et al., 2020; Chadwick & Travaglia, 2017; Halim & Riding, 2018; Huang et al., 2018; Lozano et al., 2021; Serafin et al., 2020; Shorey & Wong, 2021; Stagg & Sheridan, 2010; Walker & Stones, 2020). Halim and Riding (2018) suggested that to handle the issue of bullying, providing support in a confidential and accessible manner to bullied employees is essential. Shorey and Wong (2021) stated that nurses suggested providing support against bullying among new nurses who face managers' lack of support and lack the necessary knowledge and skill to deal with bullying behaviours. Chadwick and Travaglia (2017) emphasised that workplace support must be actively provided to all employees, as not all employees will ask for support in cases of bullying. Additionally, some managers may be unable to manage bullying and provide support because of their lack of understanding of the interpersonal issues of employees (Chadwick & Travaglia, 2017).

2.10.4. Institutional Policies and Enforcement of Practices and Procedures

Seven reviews pointed out that an emphasis on institutional policies and enforcement of practices and procedures can assist in preventing and managing bullying (Averbuch et al., 2021; Binmadi & Alblowi, 2019; Chadwick & Travaglia, 2017; Huang et al., 2018; Lozano et al., 2021; Shorey & Wong, 2021; Walker & Stones, 2020). Averbuch et al. (2021) noted a need to focus on effective policies and procedures because workplace bullying may be promoted by

normalising it in the absence of proper implementation of institutional procedures and policies. Walker and Stones (2020) illustrated that crafting organisational strategies and policies with a focus on fostering a safe culture with positive experiences, good communication and support for one another can help prevent and mitigate workplace bullying. Similar findings were reported by Shorey and Wong (2021), who stated that in order to prevent bullying in organisations, relevant codes of conduct, policies and procedures must be implemented and followed effectively. Similarly, Huang et al. (2018) suggested that surgical trainees should take guidance from policies and codes of conduct before reporting bullying. They further emphasised that surgical trainees experience bullying, and establishing standards and procedures to assess consultants for their skills will deal with the problem of those who lack the essential skills and attributes for effectively supervising trainees.

2.11. Discussion

This scoping review aimed to answer two research questions. First, how is workplace bullying theoretically explained in the literature? Second, how are prevention and management of workplace bullying discussed in the literature? The results indicated that workplace bullying is a complex phenomenon, and various aspects of it may be explained from several theoretical perspectives. These theories and theoretical constructs related to the culture of the workplace, hierarchy in healthcare organisations, inactive institutional power, and conflict due to interpersonal and communicative issues, may explain bullying of healthcare workers.

2.11.1. Theories and Theoretical Constructs

2.11.1.1. Organisational culture. Culture was identified as a significant theme that may explain bullying. The findings of this scoping review illustrate that bullying may exist as part of the culture in healthcare professions and organisations where bullying is considered standard practice and is normalised. Culture is related to individuals' hidden values, beliefs, and attitudes, which impact how certain situations are perceived and managed in organisations

(Schein, 1991). The extant literature strongly suggests that the bullying phenomenon cannot be studied separately without considering the cultures of organisations in which healthcare employees operate on a daily basis (Bren & McNamara, 2004; Rahm et al., 2019). Scoping review findings also noted other theories involving culture, which could highlight the phenomenon of bullying: safety culture and Bronfenbrenner's ecological system theory. Safety culture illustrates individuals' shared beliefs and perceptions about practices regarding safety in organisations (Antonsen, 2017). Safety culture impacts how a specific phenomenon, such as bullying, is viewed and managed. The literature points out that organisations with poor safety cultures, where employees' safety is not considered a priority, foster a toxic work environment where bullying behaviours may frequently emerge (Johnson, 2009). The ecological system theory states that humans develop through different layers of micro, meso and macro levels that may pose differences in individuals' values. These differences in values may contribute to an escalation of bullying due to the inconsistencies in workplace culture resulting from differences in individual values. These differences in beliefs and values at various levels lead managers and leaders to take different approaches to bullying prevention and management, making it somewhat more difficult to identify, prevent and manage bullying (Walker & Stones, 2020). Some other researchers also support using this theory (Johnson, 2011). For example, Phelan and Kirwan's (2020) study suggested that the immediate environment of nurses at the micro level, meso (ward, unit level), exo (support level for nurses) and macro (culture and subcultures, overarching rules, policies and regulations) may explain bullying through indicating which factors trigger bullying behaviours at these levels (Phelan & Kirwan, 2020).

2.11.1.2. Hierarchical healthcare system with power imbalance and oppression. The findings revealed that hierarchies in the healthcare sector may potentially explain bullying of healthcare workers**.** Findings indicated that the healthcare sector is hierarchical and complex in nature, with power imbalances: senior staff, supervisors, and those further up in the hierarchy

may abuse their powers as part of the training process for junior staff and subordinates. These findings are similar to what other studies have found (Fnais et al., 2014; Recupero et al., 2005; Subramaniam et al., 2015; Wright, 2020). Oppression theory may be relevant in the context of hierarchy and complex systems in healthcare institutions because it may further explain how some workplaces encourage bullying behaviours through the oppression of individuals (Griffin & Clark, 2014; Johnson & Benham-Hutchins, 2020; Randle, 2003). The hierarchical and complex system of healthcare organisations promotes abuse of power from those who are seniors, and this may lead to oppression of individuals, causing frustration and anger in oppressed individuals that eventually manifests as bullying behaviour towards members of their group or other individuals (Ferguson & Anderson, 2021; Hinchberger, 2009; Johnson & Benham-Hutchins, 2020). The literature identified other similar studies that support the notion of oppression and bullying behaviours in hierarchical systems (Croft & Cash, 2012; Edmonson et al., 2017; Purpora et al., 2015; Simons, 2006). However, some scholars strongly argued that although bullying behaviours are typical characteristics of an oppressed group of individuals, bullying may result from the oppression of individuals in any position, regardless of their place in the hierarchy—for this reason, bullying can be seen both as a result of oppression within the same group or from those in the ranks of power (e.g., seniors, mentors and supervisors) (Edmonson et al., 2017). Edmonson et al. (2017) note that bullying behaviours in hierarchal systems may be learned behaviour patterns; this again points to organisational cultures as an explanation of bullying behaviours. However, further exploration may be required to fully understand how theoretical constructs and theories related to organisational culture, hierarchy and misuse of power all link together to explain the bullying phenomenon in healthcare workers.

2.11.1.3. Inactive institutional power. Although the findings of this review revealed no particular theories concerning inactive institutional power, there were some explanations of

bullying based on how some factors may lead to bullying. Ineffective institutional policies may fail to create and maintain a safe environment for employees in which employees feel supported by leaders and those in positions of power in healthcare institutions. This may escalate bullying behaviours in workplaces. These findings of the scoping review are consistent with the findings of researchers who noted that those healthcare institutions where institutional policies and regulations are ineffective or fail to address the issue of bullying through effective measures are more prone to exhibit workplace bullying (Alahmari et al., 2020; Tuckey et al., 2022). It is important to note that although institutional policies and procedures to prevent bullying may be in place, bullying still continues to happen if the policies are ineffective due to nonenforcement or improper implementation (Bambi et al., 2017; Coursey et al., 2013; Difazio et al., 2019). Although there is some evidence pointing out the role of inactive institutional power as an explanation of bullying, there is a need to explore further what creates inactive institutional power in healthcare organisations and how it may explain bullying. The management literature suggests a gap between the intended and implemented procedures and policies—further exploration is required because this gap is rarely discussed by scholars, and as a result, there are no substantial accounts explaining the effectiveness and significance of implementation processes that will produce the desired outcomes (Woodrow & Guest, 2014).

2.11.1.4. Team conflict: SD theory. This scoping review found that interpersonal issues can result in conflicts between team members. Several reviews (e.g., Chadwick & Travaglia, 2017; Samsudin et al., 2018) indicated that structural contradictions and interpersonal dynamics cause conflicts and even bullying in the healthcare sector. Structurational Divergence (SD) theory may explain conflicts related to these interpersonal issues (Nicotera & Clinkscales, 2010). SD theory states that cultural and social units in organisations with different rules and regulations or different meaning structures may result in poor interpersonal communication and conflict in teams and may lead to bullying (Nicotera &

Mahon, 2013). Some scholars suggest that there are conceptual links between conflicts, bullying and structurational divergence, so identifying where conflict and bullying diverge and, most importantly, converge, may offer beneficial insights into the bullying process and its management (Baillien et al., 2017; Keashly et al., 2020; Malterud & Nicotera, 2020; Nicotera et al., 2014; Zapf & Gross, 2001). Thus, studying the bullying process through SD theory may be beneficial in explaining bullying that results from conflicts and structurational divergence in healthcare organisations. This may also help prevent and manage bullying in healthcare organisations where the nature of the work revolves around teamwork.

2.11.2. Prevention and Management of Bullying

RQ2 aimed to explore how prevention and management of bullying was discussed in the literature on healthcare workers. The identified themes included a comprehensive approach to managing bullying, awareness and effective reporting of bullying, workplace support, and enforcement of organisations' policies, practices and procedures.

2.11.2.1. Comprehensive interventions for bullying prevention and management. This review showed a need for comprehensive interventions in organisations, including multilevel interventions at individual, organisational and institutional levels. The extant literature illustrates that antecedents of bullying exist at multiple levels (Chipps & McRury, 2012; Pope & Burnes, 2009). The systematic review found that prevention or management should involve multifaceted interventions based on both individual and organisational components (Einarsen et al., 2002; Plimmer et al., 2022).

The review suggested workplace bullying of healthcare workers is significantly related to culture, hierarchy and inactive institutional power, which are the critical elements of the work environment of healthcare workers (Roscigno et al., 2009; Salin, 2003). However, some interventions or approaches have been proposed that focus on the behaviours of individuals, for example, teaching coping strategies to individuals or emotional management techniques for

perpetrators and victims (Aquino & Thau, 2009). In a workplace where bullying is normalised, and hierarchy is operative, focusing on interventions that aim to change or target negative behaviours may be an ineffective approach to bullying prevention and management. This is because it may not address the root cause of the bullying but only the symptoms of bullying, such as stress and mental health challenges of the victims (Nielsen & Einarsen, 2012). Addressing behaviours or individual approaches can alleviate immediate symptoms of bullying. Still, such approaches may not necessarily address or resolve systemic issues, such as lack of organisational support or hierarchy-related power imbalances, which provide a breeding ground for a culture where bullying thrives (Sheehan et al., 1999). Effective prevention and management, therefore, can involve comprehensive strategies that not only focus on addressing misconduct or changing abusive behaviours but also seek to offer a safe work environment where healthcare workers are supported and respected (Vessey et al., 2009).

Comprehensive strategies and interventions can create a safe environment for healthcare workers by providing practical workplace support, fostering awareness, and enforcing anti-bullying policies (Abdullah et al., 2021; Fricke et al., 2023). By doing so, the focus can shift from behavioural intervention to proactive strategies that can target underlying systemic and organisational issues, ensuring a more sustainable, healthier and bullying-free workplace.

2.11.2.2. Effective workplace support. The scoping review noted that workplace support, such as support from leaders and managers, may help to prevent and manage bullying. Several authors support these findings (Cleary et al., 2010; Djurkovic et al., 2021; Harrington et al., 2012). However, some scholars argue that organisations may not be able to support bullying victims because of the leaders' and managers' lack of training in preventing and managing bullying (Gardner & Cooper-Thomas, 2021; Sullivan, 2010; Vartia & Tehrani, 2012). Scholars suggest that workplace support can be ensured in such circumstances by

training staff and management around bullying prevention and management, so they are able to identify and address bullying issues (Gardner & Cooper-Thomas, 2021; Macintosh, 2006; Randle et al., 2007; Sullivan, 2010). Leaders must consider bullying reports as a means of understanding the issue, rather than viewing these reports as a 'waste of time' (Crawford, 2001). Leadership abilities have the potential to eradicate bullying (Laschinger & Fida, 2014). However, there are differences in leadership and managerial styles of managers and leaders. which may also impact how bullying is prevented and managed in workplaces (Hutchinson & Hurley, 2013). Nevertheless, organisations must respond to bullying reports to create a supportive workplace (Bentley et al., 2012; Randle et al., 2007).

2.11.2.3. Increased awareness. Another finding furthering the notion of workplace support for preventing and managing bullying is awareness and effective reporting of bullying. As noted, workplace support must be present to encourage the reporting of bullying when it occurs. Awareness of bullying behaviours may potentially assist workers in recognising bullying (Samsudin et al., 2018). Bullying prevalence rates may be seen as low because bullying remains unidentified and under-reported (Allen, 2015). This likely results in poor bullying management because it cannot be managed if it is not recognised or reported. Effective interventions can only be designed and introduced to prevent and manage bullying if there is a thorough awareness of what may cause bullying and what steps need to be taken by organisations to address bullying (Allen, 2015; Georgakopoulos et al., 2011). Further, and linking with the first theme, awareness campaigns, cognitive programmes, and measures must be introduced at multiple levels (i.e., at organisational, social and individual levels) to effectively reduce bullying (Han & Ha, 2016). Previous research illustrates that a comprehensive programme of cognitive rehearsal programme resulted in 70% of nurses indicating that they changed their own behaviours, and 40% declared a decrease in workplace bullying due to increased awareness (Stagg et al., 2013).

2.11.2.4. Effective implementation of policies and procedures. The scholarly literature argues that while policies and procedures are present in organisations, these policies and procedures must be aligned with the prevention and management of bullying (Pope & Burnes, 2009). It is the responsibility of institutions and healthcare workers to create a culture of safety through the effective implementation of policies and procedures on bullying management. Both institutions and healthcare workers should work together to prevent safety issues (Majrabi, 2022). Policies must provide guidance for prevention and management from an organisational perspective: they may include a definition of workplace bullying for clarity, but they must also promote organisational, individual, and societal awareness of the impacts and prevalence of bullying. However, although crafting effective policies is critical for bullying prevention and management, implementation of antibullying policies is a challenge that organisations must focus on to prevent and manage bullying incidents successfully (Sheehan et al., 2020). Human resource departments and personnel in organisations can play a significant role in making sure that antibullying policies are implemented effectively (Cowan et al., 2021; Fox & Cowan, 2015; Salin, 2008). To do so, human resource personnel and managers must consider reports of bullying seriously and take action to prevent and manage bullying (Cowan et al., 2021; Fox & Cowan, 2015). Managers must also have expertise in understanding and interpreting policies to ensure procedures are followed promptly and policies are implemented accurately (Cowan et al., 2021; Fox & Cowan, 2015).

2.12. Conclusions, Limitations, and Future Directions

In conclusion, the scoping review aimed to address two research questions relating to theoretical explanations of bullying in healthcare workers and the prevention and management of bullying. The workplace culture, hierarchy in healthcare organisations, inactive institutional power, and conflict may potentially provide an explanation of bullying behaviours in healthcare workers. A comprehensive approach involving both individual and organisational level factors

can be adopted to prevent and effectively manage workplace bullying. This comprehensive approach may include a greater focus on addressing the root cause of bullying by creating a safe work environment for healthcare workers through providing organisational support, addressing policies and procedures, creating awareness about bullying to promote effective reporting of bullying behaviours, and running programmes and training that could help raise awareness around workplace bullying. The role of leaders and managers is also critical in ensuring that healthcare settings are bullying-free.

This review has some limitations because the search was restricted to systematic reviews and meta-analyses, articles published in English only, and peer-reviewed studies. Non-peer-reviewed studies may offer additional insights and theoretical explanations.

There are significant gaps in the literature regarding the explanation of workplace bullying of healthcare workers. Further exploration is required to understand how the theories, theoretical constructs, and explanatory factors indicated by this scoping review relate, complement, and overlap each other.

Chapter 3: Theories Explaining Workplace Bullying

The previous chapter identified the predominant theoretical approaches for understanding bullying in the healthcare sector in the literature through the scoping review. Most of these explanations were briefly introduced within the reviews. This chapter provides an in-depth review of these theories and the theoretical constructs to explain workplace bullying in healthcare settings. The chapter explores the literature on significant themes and the relevant theories identified by the scoping review, and how they explain workplace bullying and its prevention and management. The theories include organisational culture (specifically safety culture), power imbalance (specifically oppression theory), ecological systems theory and structurational divergence theory. In addition, some other theories that have been identified in the extant literature (Job Demands-Resources Theory, Affective Events Theory and Social Identity Theory) are also discussed to explain how literature offers accounts of the development of bullying and bullying process.

3.1. Organisational Culture

Empathy, kindness and care are the primary attributes of healthcare, yet the stories and experiences of many healthcare employees lack these attributes (Chakravorty et al., 2022)

The scoping review findings suggested peoples' perceptions, attitudes and beliefs in organisations or organisational culture are a theoretical explanation of bullying behaviour. Evidence indicates that the healthcare sector must focus more on organisational culture to understand and explain the bullying process (Bremert, 2021; Chakravorty et al., 2022). Evidence also suggests that culture contributes to bullying behaviours and exploring it further may help to understand how bullying is prevented and managed (Bremert, 2021; Foster et al., 2004; Riley et al., 2021).

All organisations have their own cultures to guide workers in their work structures and systems (Rajalakshmi & Gomathi, 2016). Culture consists of shared beliefs learned by

individuals when they solve their problems via adaptation to external issues and integrating internally (i.e., by incorporating these external concerns into one's decision making operations); this phenomenon has worked effectively to be considered valid, and thus organisational culture is taught to new individuals as an accurate way to comprehend things and feel in relation to problems (Schein, 2010).

One of the themes in the scoping review was that organisational culture can be associated with how bullying happens and how it can be prevented and/or managed in healthcare workers. Rajalakshmi and Gomathi's (2016) study also found that organisational culture shapes the way workplace bullying emerges and is addressed in organisations. They further emphasised that organisational culture impacts the attitudes and behaviours of employees in an organisation, which introduces widespread effects: the environment of the workplace, policies and procedures, leadership styles and finally, how decisions are made, are all governed by the culture of an organisation (Rajalakshmi & Gomathi, 2016).

A culture of bullying not only impacts individuals but also affects organisational performance and productivity. Leisy and Ahmed (2016) found that bullying in medical settings emerged because of the culture of medical training settings and the repetitive nature of bullying in that workplace culture. Workplace bullying of junior doctors and nurses commences as soon as they start their training and are in their first year of professional placement. The culture of bullying they experience promotes teaching through bullying (Hoosen & Callaghan, 2004; Timm, 2014). A survey by the British Medical Association concluded that doctors are less likely to report bullying than any other healthcare professional because of a tolerance of bullying behaviours that leads to a culture of bullying (Hoosen & Callaghan, 2004; Timm, 2014). Several authors explored organisational cultures to investigate the bullying of healthcare professionals and suggested that the bullying process is strongly linked to the culture of healthcare organisations (Edmonson & Zelonka, 2019; Elewa & El Banan, 2019; Lewis, 2006).

The following subsections include accounts of what creates an organisational culture of bullying and looks at the construct of safety culture—a specific type of organisational culture. The prevention and management of bullying through culture and safety culture approaches are also discussed.

3.1.1. An Organisational Culture of Bullying

The behaviours of individuals in an organisation shape that organisation's culture (Schein, 2010). This configuration of organisations by the behaviours of individuals may lead to organisational culture influencing the prevalence and management of bullying (Lipsinki & Crothers, 2014)). Lewis (2006) reported that bullying behaviours are substantially a learned process rather than simply a psychological dilemma between victims and bullies. Scholars further suggest that organisations with a culture where equality is rejected, power is misused, and oppression is promoted, encourage bullying behaviours (LaGuardia & Oelke, 2021). For example, in medicine, bullying primarily happens because of a culture where medical teaching is practised by intimidating and humiliating individuals (Mistry & Latoo
, 2009).

Although most bullying situations are not intentional in medical settings, a bullying culture is still created by the traditional system of these workplaces that initiates a cycle of bullying, starting with junior doctors and passing on to subsequent groups of junior doctors (Mistry & Latoo, 2009). A survey conducted by the British Medical Association found that in general healthcare systems, doctors who were bullied by their seniors would pass the bullying onto their juniors (Vogel, 2018). Wild et al. (2015) noted that a culture of bullying stops junior medical trainees from expressing their problems in a system where seniors are not paying attention and not responding to juniors' issues. They further added that such a culture makes it especially tough for doctors who are in smaller specialities or are in specialities that have geographically alienated training settings to report bullying: they do not want to report bullying

because of the culture and do nothing in order to avoid being another target of bullying (Wild et al., 2015).

Evidence strongly suggests that organisational culture is a significant factor in workplace bullying, and employees' perceptions that nothing will be changed constitute a substantial barrier to reporting. Employees do not wish to be perceived as 'troublemakers' and they are doubtful about the implementation of policies to manage bullying (Carter et al., 2013). The role of the culture in shaping the behaviours of the people in organisations with regard to identifying and addressing bullying translates into the construct of safety culture, which is discussed in the next section.

3.1.2. Safety Culture

An organisation's safety culture relates to people's attitudes and behaviours toward workplace safety (Roughton et al., 2019). Safety culture is an essential element of organisational culture (Roughton et al., 2019; Schein, 2010), and refers to the shared beliefs, values and behaviours of the members of an organisation concerning the organisation's practices around health and safety (Cooper et al., 2014). Safety culture addresses the degree to which organisational workers prioritise, support and practice safety. Health and safety in organisations are reflected directly by the safety culture; this is why management research emphasises a safety culture (Antonsen, 2017). Safety culture in workplaces may contribute to managing risks, injuries, accidents, and hazards, and enhancing behaviour that promotes health and safety (Roughton et al., 2019).

Healthcare settings are influenced by various factors that influence the work environment and make it challenging to address the safety requirements of medical employees (Ford et al., 2022). The healthcare sector is a complicated system where different units overlap and this may cause healthcare workers to be stressed by being presented with specific demands and responsibilities to fulfil; for example, licensing institutions and regulating policies with

legal requirements for medical professionals suggest particular needs of hospital workers, and this may sometimes have negative implications due to the obligation of fulfilling multiple responsibilities at the same time to maintain professional alliances and registrations (André et al., 2016; Ford et al., 2022).

Management literature suggests that healthcare workplaces with a culture of disruptive behaviours such as bullying, humiliation before fellow workers, verbal abuse, and intimidation impact the safety culture by negatively affecting and destabilising team members' psychological safety and well-being (Rehder et al., 2020). In such a scenario, junior doctors' workload and working conditions may make healthcare workers even more stressed or exposed to other bullying behaviours (Riley et al., 2021). An Australian survey of 30 organisations, including 220 employees, pointed out that safety culture related to workers' perceptions of psychological health and safety was negatively associated with workplace harassment and bullying (Law et al., 2011). Low levels of harassment and bullying are observed in workplaces with a safety culture and a climate where workers feel psychologically safe (Law et al., 2011).

The literature also explains bullying by exploring its links to peoples' perceptions of safety, which are shaped by contextual factors (Escartín et al., 2021). For example, bullying is processed through the bully and bullied employees' reports. Bullying involves an emotional process and leads to exhaustion. Escartin et al.'s (2021) study of 54 work units examined how bullying operated in various work units within an organisation. They found that bullying was operationalised by integrating target and perpetrator reports, which led to emotional exhaustion and an escalation in bullying (Escartín et al., 2021). A safety culture that is also moderately centred around some degree of organisational support and a moderate level of goal-oriented leadership style may provide fewer chances for bullying behaviours to emerge (Samsudin et al., 2020). Several other studies exploring the links between safety culture and bullying highlighted that it is a risk factor for bullying (Bond et al., 2010; Dollard et al., 2017; Dollard

& McTernan, 2011; Zadow et al., 2019). This may be due to the notion that a safety culture that does not address employees' stigma around reporting stress-related issues may foster the risk of bullying (Klinefelter et al., 2021). When such stress-related concerns at the workplace remain unreported, bullying escalates (Klinefelter et al., 2021).

The literature illustrates that the Safety Culture is closely related to healthcare workers' Psychological Safety Climate (PSC) (Reason, 2016). Safety culture reinforces PSC, which is characterised by a work environment of support and safety where psychosocial hazards such as bullying can be safely reported (Dollard et al., 2017). When a safety climate lacks accountability for bullying behaviours, employees are unable to report bullying, and there is a potential for further escalation of negative behaviours and abuse in the workplace (Dollard & McTernan, 2011; Law et al., 2011). This is because an absence of PSC not only impacts the psychological health of healthcare workers, but it may also serve as an antecedent of psychosocial hazards, including bullying, as well as a moderator of the negative impacts of bullying (Law et al., 2011).

A study aimed to explore the role of culture and safety climate in junior doctors' exposure to workplace bullying indicated that bullying incidents take place within hierarchal workplaces with an unsupportive culture for employees; bullying has a lower chance of appearing in a culture that creates a PSC marked by a moderate level of hierarchy, and a positive and supportive team culture (Samsudin et al., 2020).

3.1.3. Preventing and Managing Bullying through Organisational Culture

The traditional healthcare system is centred around handling bullying through prevention programmes aimed at training individuals on how to be resilient, which influences individuals rather than focusing on organisations taking efficient steps to address bullying behaviours (Benmore et al., 2018). However, organisational culture management researchers argue that all features of an organisation can influence healthcare workers' risks of bullying (Samsudin et al.,

2020). Therefore, the prevention and management strategies must encompass individual and organisational approaches (Samsudin et al., 2020). A lack of focus on practices that foster a safety culture can result in inefficient prevention and management of bullying (Hald et al., 2021).

Bullying behaviours may not prevail in workplaces with a culture of wellbeing and safety (Carlasare & Hickson, 2021). Creating a safe culture where bullying is reported effectively is critical to managing bullying (Riley et al., 2021). The literature indicates that an organisational (safety) culture is based on four elements: (1) involvement, (2) consistency, (3) adaptability and (4) mission (Denison & Mishra, 1995). The first two elements illustrate a flexible culture of openness and receptivity, while the latter two elements indicate an organisation's alignment, aims and intentions (Denison & Mishra, 1995). These findings are supported by Vogel’s (2018) study, which showed that the British Medical Association wants National Health Services to prevent and manage bullying by creating a culture of openness where people are allowed to speak about bullying and managers and leaders are responsive, and can identify and address issues related to bullying behaviours.

A study involving medical staff working in South Korean hospitals indicated that an organisational culture based on positive behaviours of employees and leadership might help prevent and manage incidences of bullying (Yun & Kang, 2018). Yun and Kang (2018) argued that organisational and individual factors must be considered when formulating a strategy addressing bullying. This is because successful management of bullying in organisations greatly depends on eliminating employees’ negative behaviours to improve organisational culture (Cleary et al., 2009; Jenkins et al., 2012). In addition, transformational leadership, management support, work ethics, and the presence of effective policies regarding safety in workplaces may also contribute to the management of bullying (Ferris et al., 2021; Jenkins et al., 2012; Naseer et al., 2018).

Thus, creating a healthy and safe culture is crucial for preventing and managing workplace bullying (Duffy, 2009). This also points to the fact that for effective bullying prevention and management, there should be a sound focus on fostering an antibullying workplace culture by changing employees' behaviours, attitudes and values through training and by developing antibullying strategies that will incorporate effective policies and regulations: this will create awareness about what actions must be taken to prevent and mitigate bullying (Rajalakshmi & Gomathi, 2016). To support this, Martin (2008) recommended a framework for healthcare organisations. He suggested that safety can be fostered by creating a physiologically and psychologically safe workplace by offering managerial support to healthcare workers during safety related concerns, which also assists with quality patientcare (Martin, 2008). Studies further indicate that when psychological safety is prioritised, workplaces can foster a culture of trust and respect where bullying is less likely to happen (Majrabi, 2022). Workers feel safe to verbalise their concerns about safety. A PSC can act as a mediator against the development of bullying because it provides workers with a sense of belonging and trust as they have a safe space to report workplace safety issues such as bullying and seek resolution (Kwan et al., 2016; Tsao & Browne, 2015).

Other approaches are also mentioned in the literature to address the issue of workplace bullying through organisational culture. The first and most important approach is redesigning the culture to ensure a violence-free or bullying-free workplace by practising no-tolerance policies (Cleary et al., 2009; Meloni & Austin, 2011; Oade, 2018). Although creating a safe culture through these policies may be a practical first step towards managing bullying, researchers argue that such policies may not be implemented effectively because policies do not consider bullying occurrences as unusual events or significant issues; they are more centred around exploring what has already happened or the incidents rather than paying attention to actual management or introducing effective interventions (Smith et al., 2020). Another

approach is focused on encouraging the voicing of concerns about bullying behaviours. This leads to the resolution of bullying attitudes in workplaces where the safety culture is not supportive of employees, who tend to ignore and accept the situation and exit the organisation without protest because of the unresolved bullying issues (Kwan et al., 2016). This approach suggests that fostering a safety culture in a workplace by providing organisational support to bullied workers is critical in shaping the coping strategies and choices available to them—strategies based on policies that foster safety culture may be a potentially effective intervention for preventing and managing workplace bullying (Kwan et al., 2016). Overall, safety culture is an organisational resource that can eliminate or lower the occurrence and prevalence of bullying (Hamre et al., 2023).

In summary, the bullying process and its management have been explored through the theories and theoretical constructs of organisational culture in general and safety culture specifically. To prevent and manage bullying fostering a safety culture by providing workplace support and practising strategies based on zero-tolerance policies may help prevent and manage bullying. The following section addresses the role of power dynamics in explaining the bullying phenomenon.

3.2. Power Imbalance

The scoping review findings suggested that power imbalance is a significant theme explaining bullying behaviours in healthcare settings, particularly amongst doctors. The healthcare sector is predominantly governed by the idea of power (Logan & Scott, 1996). Despite the high risk of bullying in the public sector and healthcare organisations and its adverse consequences, little attention has been paid to exploring bullying that may happen based on power and professional knowledge (Hutchinson & Jackson, 2015). Scholars argue that it is critical to consider the construct of power to understand and explain bullying. Power is the capability of an individual or a group of individuals to affect and change the attitudes of other individual/s (Sneed, 2001).

Power imbalances in various professions in healthcare can impact coordination and communication, eventually compromising patient safety (Rogers et al., 2023). Coordination between different professions results in division within teams due to power imbalances and conventional beliefs, such as doctors being the leaders in healthcare organisations while other professionals are considered only passive contributors to patient-centred decisions (Rogers et al., 2023). Therefore, an approach based on investigating power as part of the human connections in healthcare professions is critical in several contexts: for example, in terms of relationships between nurses, doctors, therapists and even patients and their families (Sneed, 2001). Specifically, the constructs of power and relevant approaches to explaining bullying argue that power dynamics or imbalance of power result in bullying or negative behaviour (Saunders et al., 2007).

Bullying has a feature of power imbalance comprising a victim-perpetrator element (Salin, 2003a). Specifically, a target is bullied to the extent that they feel powerless in defending themselves against the bully (Salin, 2003a). Conflicts among individuals of equal authority may not be labelled bullying unless power dynamics and differentials are involved and the victim and the perpetrator have unequal power (Baillien et al., 2017; Salin, 2003a, 2003b). Power imbalances not only relate to differences in power or dynamics concerning positional or hierarchical power but may also be present within relational power. Relational power illustrates that people can influence others without playing a role in a hierarchy (Soga et al., 2022). For example, a junior executive in an organisation may effectively influence their seniors by offering their services for a new initiative, although it might require more resources and time on the part of the junior executive as compared to the junior executive's colleagues (Soga et al., 2022). Relational power is different from hierarchical power, which relates to the position of an executive and the authority embodied in that role or position (Soga et al., 2022)

Thus, power imbalance may be observed within both positional (i.e., pertaining to hierarchy or authority) and relational power (i.e. outside of hierarchical order) in organisations. For example, power imbalance may be observed among colleagues (relational) or in groups where various individuals may team up to bully a supervisor who has authority over these individuals (positional) (Salin, 2003a). Such power imbalances escalate with time, and the bullying phenomenon further increases power imbalances because of its repetitive nature (Salin, 2003a). Both relational and positional power imbalances are discussed in the fundamental theories and theoretical constructs of power imbalance in the following sections. These constructs include power dynamics, hierarchy, misuse of power and oppression theory. The following section further discusses how the constructs of power dynamics, hierarchy, and power misuse may help in understanding bullying.

3.2.1. Power Dynamics

Bullied individuals consider themselves powerless and unable to defend themselves against bullies (Berry et al., 2016). Some scholars suggest that this power imbalance is also associated with societal views about who is more powerful. Ultimately, these societal views about the powerful shape the culture of organisations (Berry et al., 2016; Salin, 2003a). For example, doctors and nurses in the healthcare sector are bullied by seniors and supervisors who are considered more powerful (Somani et al., 2022). This is why understanding the power dynamics in a healthcare organisation is critical for understanding the bullying process (Somani et al., 2022). Power dynamics refers to how various elements relate to the power play in organisations (Somani et al., 2022)

The literature suggests that poor power dynamics arise as a result of inequality caused by disparities in the nature of work, differences in socioeconomic status, autocratic workplaces, and social dominance due to popularity or higher status (Somani et al., 2022; Volk et al., 2014). However, power dynamics are influenced by poor implementation of social policies around

power, which renders workers insecure and vulnerable in workplaces with poor power dynamics (Somani et al., 2022). To further understand the concept of power dynamics and how power works in healthcare organisations, the following accounts related to hierarchy are presented.

3.2.2. Hierarchy

Management literature points out that bullying behaviours due to power imbalance are associated with the hierarchical structures of an organisation (LaGuardia & Oelke, 2021). Organisations are structured social units with systems of coordinated activities related to external environments (Patterson et al., 2018; Schneeweiβ, 1995). Hierarchy is the formal authority structure and decision-making within an organisation. This structure consists of levels, orders or ranks that are arranged in a specific way, with employees at lower levels reporting to employees at higher levels within the order (Diefenbach, 2013; Lambe, 2014).

The hierarchy in an organisation facilitates direct outlines of responsibility, authority, and accountability. Hierarchy can also facilitate efficient and effective coordination and communication between different departments or units or sections of an organisation (Diefenbach, 2013; Lambe, 2014). The rules and regulations and positions of workers in the hierarchy describe the way workplaces function and create power processes and frameworks for power (Patterson et al., 2018).

Power processes in organisations involving hierarchies or hierarchal systems may explain the bullying phenomenon. Those sitting higher in the hierarchy may have the power to show bullying attitudes towards the individuals below them in the hierarchy because of their position (LaGuardia & Oelke, 2021). Perpetrators often have specific traits; for example, they have positions of authority and power, and an ability to impact the division of resources. They may be senior professionals with strong personalities and have substantial experience in their specialities and areas of practice. They may also have control over functions and organisational activities (LaGuardia & Oelke, 2021). A study exploring bullying attitudes in the nursing

profession in the UK indicated that the primary perpetrators who bullied junior nurses, new employees and students were well-established nurses in senior positions (Wilson, 2016). A study involving two large hospitals indicated that most perpetrators of bullying of junior doctors were consultants in senior positions (Imran et al., 2010).

Hierarchies in organisations relate to positions of power arranging people and groups depending on their access to valuable social resources (Vanstone & Grierson, 2022). The hierarchal role of an employee in an organisation is visible in the place where an employee's job fits (Wech et al., 2020). Similarly, an individual's position within the medical profession's hierarchy is affected by several factors, including the type of speciality (surgical or medical), the sex of the healthcare worker, personality type (passive or aggressive; introvert or extrovert), level of skills, and local or foreign educational background (Green et al., 2017).

Historically, hierarchal organisations in the healthcare sector included professions such as medicine and surgery where male dominance was evident: individuals with strong personalities, high-level competencies and strength were high in the hierarchy, ruling the disciplines of medicine and surgery (Green et al., 2017). A male-dominated healthcare sector is a history now (Green et al., 2017). However, healthcare organisations still face hierarchal challenges in many other ways. (Green et al., 2017). Competition to rise in the hierarchy commences at medical school and remains present throughout the career of medical professionals, giving conventional teaching strategies a chance to foster bullying (Vlăduț et al., 2023). In a highly competitive and hierarchal system of healthcare organisations, recognition of academic qualifications is not an easy task and therefore, some healthcare professionals may resort to bullying behaviours and mistreating other employees, affecting junior doctors under training through the use of traditional abusive teaching strategies (Vlăduț et al., 2023).

Several studies have indicated that junior employees who belong to a minority group in an organisation are bullied more than the majority members or those further up the hierarchy

(Bergbom & Vartia, 2021). A study involving participants from Irish hospitals showed that immigrant non-European junior doctors in training were bullied more than European doctors because non-immigrant doctors were more senior and established than the immigrant doctors, who needed to establish themselves (Mendonca & D'Cruz, 2021).

The hierarchy in various healthcare professions and individuals' professionalism may also impact employees' behaviour in hierarchal organisations (Green et al., 2017). Healthcare organisations are characterised by a hierarchy of perpetrators who may promote one another's bullying behaviours (Hutchinson et al., 2008). Another reason for bullying behaviours in hierarchical systems is the notion that changes in the hierarchy lead to conflicting changes in affiliation and loyalty of some employees towards others in the hierarchy—some employees may show an inclination and loyalty toward seniors and those who had higher positions because seniors can help them move up in the hierarchy by giving favours and career opportunities (Felblinger, 2009).

Most medical apprenticeship is done in highly structured and hierarchal healthcare organisations with conventional teaching strategies based on abuse, humiliation and intimidation (Hoosen & Callaghan, 2004). This leads to a cycle of bullying of juniors who sit lower in the hierarchal order, similar to a cycle of abuse. Those who are bullied and abused continue to be bullies and abuse juniors when they become seniors (Hoosen & Callaghan, 2004). An increasing number of doctors are reporting to the British Medical Association about the abuse and bullying encountered from seniors who faced bullying behaviours and abuse as victims when they were juniors (Hoosen & Callaghan, 2004; Vogel, 2018).

The hierarchal healthcare system is a hierarchy of power (O'Shea et al., 2019). This also means that in healthcare organisations, individuals are positioned in the hierarchy based on their social power, which is governed by access to resources and social support. Healthcare professionals work in multidisciplinary teams of people from different hierarchical positions

(Noyes, 2022). In instances when interdisciplinary groups of healthcare workers work together to alleviate hierarchy-based power differences, this form of coordination disappears over time, and the differences in power reappear (Noyes, 2022). Those who were bullied by their seniors would pass this behaviour of bullying on to their own juniors (Vogel, 2018).

Bullying is encouraged and remains unaddressed due to bullying management via hierarchy, where a lack of empowerment is seen. Silencing workers' concerns and inaction by leaders and fellow workers are common responses to bullying attitudes and bullying management (Wilson, 2016). For example, a study found that for immigrant doctors in the UK, the rewards of staying quiet and not reporting bullying outweighed the outcomes of addressing bullying (Hoosen & Callaghan, 2004). The foreign doctors who were bullied were considered less likely to fight bullying than local doctors facing bullying; this is because immigrant doctors have often invested a lot in getting trained in the UK and are dependent on other doctors for references (Hoosen & Callaghan, 2004). Thus, they put up with bullying attitudes to avoid the risk of alienating doctors who could provide them with references for work (Hoosen & Callaghan, 2004).

While much of the literature about bullying in hierarchical systems points to bullying behaviour directed towards a junior by those further up in the hierarchy, some scholars have explored the concept of upward bullying or bullying of senior staff and managers by their subordinates (Branch et al., 2004; Gaudine et al., 2019; Parchment & Andrews, 2019). This type of bullying is seen because of the misuse of power by subordinates. Those lower in the hierarchy abuse the power given to subordinates under organisational rules and regulations around specific processes, which can lead to upward bullying (Branch et al., 2021). For example, grievance and formal and informal strategies can be used to target seniors through false allegations of bullying. In summary, hierarchy or hierarchal order in an organisation may

foster power dynamics based on the misuse of power. This concept of power misuse is further discussed in the next section.

3.2.3. Misuse of Power

Misuse of power is a crucial feature of bullying (Schumann et al., 2014). As discussed earlier in the section on power dynamics, power-based relationships are a part of the social group based on strength, age, size, socioeconomic status, likability and social ties of those involved (Schumann et al., 2014; Somani et al., 2022; Volk et al., 2014). These power-centred relationships and power differences can lead to abuse or misuse of power, manifesting as bullying (Dhar, 2012; LaGuardia & Oelke, 2021; Vickers, 2014). Some scholars have explored the misuse of power in association with the concepts of predatory bullying and dispute-based bullying (Karabulut, 2016; Reilly, 2006). Predatory bullying entails the misuse of authority or power abuse along with aggression, while dispute-based bullying emerges as a result of conflicts in workplaces (Karabulut, 2016). Destructive leadership, inefficient leadership styles, preconceived notions, and blame-assigning staff meetings can lead to predatory bullying (Karabulut, 2016). Bullied individuals often state that bullying started as a result of raising a concern or showing a different point of view to that of their seniors or influential colleagues (Karabulut, 2016). What started as a conflict soon escalated to the bullying of the weakest individual involved in the conflict (Karabulut, 2016).

Several studies have indicated that misuse of power leads to bullying of employees (Vickers, 2014). Unlike formal hierarchy-based systems, bullying may occur within informal workplace connections and networks. A study exploring predatory bullying in nurses pointed out that informal workplace systems can act to enable a form of bullying that is characterised by predatory, collaborative and planned bullying behaviours (Hutchinson et al., 2006b). In such predatory bullying, associations in workplaces conceal bullying behaviours by protecting and facilitating the bullies (Hutchinson et al., 2006b). In such cases of bullying, power is often

misused to socially isolate, undermine and harm the victim in front of other workers (Bren & McNamara, 2004; Martin & Martin, 2010). Misuse of power further relates to oppression. The scoping review findings indicated that the oppression theory might explain the bullying phenomenon involving misuse of power.

3.2.4. Oppression Theory

Oppression theory suggests that nurses are oppressed by dominating medical and gender aspects in healthcare organisations (Duffy, 1995; Hutchinson et al., 2006a). The history of the nursing profession illustrates deep-rooted beliefs about women carrying out the role of nurses through nurse education and their social and professional interactions (Duffy, 1995; Simons, 2006). Oppressed nurses interact through structures of unequal power dynamics, which in turn results in the oppression of fellow workers (Hutchinson et al., 2006a). Nurses' perceptions that they are inferior emerge from the traditional belief that they lack power in the healthcare sector, which impacts how they function in healthcare organisations (Gillespie et al., 2017; Hutchinson et al., 2006a). The ideology that nurses are an oppressed group provides a framework for understanding bullying (Croft & Cash, 2012; Duffy, 1995; Griffin & Clark, 2014; Williams, 2016). Such beliefs can initiate a repetitive pattern of refusal and denial of oppressing behaviours from and towards fellow workers, fostering the traditional power system (Hutchinson et al., 2006a). This view further supports the notion that the nursing profession harbours a culture of oppression, where nurses are perceived as subordinates. This is one of the reasons why nurses behave in ways similar to the individuals of an oppressed group; for example, low self-confidence and passive-aggressive attitudes towards fellow workers are vital characteristics of nursing (Hutchinson et al., 2006a), Oppression due to socio-political beliefs about nurses, manifests as bullying or violence toward workmates in nursing (Hutchinson et al., 2006a).

Oppression theory has been used extensively to study horizontal bullying, involving attitudes of the oppressed group where employees on the same level in organisational hierarchy, or members of the same group, bully one another (Hutchinson et al., 2006a; Simons, 2006; Weaver, 2013; Yun & Kang, 2018). A study that explored the oppression of nurses stated that nurses show oppressed group behaviour because of the low self-esteem that comes from their position within the healthcare system and professions-based hierarchy—the medical profession being at the top compared to nursing (Roberts et al., 2009). In such hierarchal systems, nurse leaders may consider themselves marginalised because leaders might be selected based on the references and approval of senior physicians and more powerful administrative executives in the workplace—thus, some nurses may facilitate the agenda of the stronger parties rather than their nursing profession (Roberts et al., 2009)

Bullying that involves oppression of the same group members is sometimes due to perceptions of low self-esteem by the members and their inability to associate with the group or the group identity (Hutchinson et al., 2006a). However, oppression theory mostly lacks a focus on upward or vertical bullying or bullying behaviours by professionals other than nurses (Hutchinson et al., 2006a). The literature involving oppression theory also does not effectively draw on a workplace's internal functioning, which may contribute to bullying (Hutchinson et al., 2006a). Because of the oppression theory's substantial consideration of nurses being a social group, and a perspective that bullying manifests as a result of the unique social interactions of nurses and the practices of oppression, oppression theory has little focus on the organisational practices and the nature of workplace transgressions that may lead to bullying (Hutchinson et al., 2006a).

Despite some attention to the systems and practices of oppression in organisations, some scholars argue that oppression should not be explored as a single construct but could be investigated with other aspects such as exploitation, marginalisation and lack of power

(Zutlevics, 2002). Some scholars argue that bullying behaviours are not individual to nurses, who do not merely bully the members of their group because they are part of an oppressed group; instead, there may be other organisational factors in play which may cause bullying of nurses and other staff in healthcare organisations (Johnson, 2009).

Oppression is a type of injustice that emerges as a result of the compliance and conformity of one group, instilled into them by another group which is socially more advantaged (Taylor, 2016). For example, some scholars argue that nurses have been oppressed in healthcare organisations for many years because of being female; as a result, they may have low self-esteem and therefore are subjected to bullying and workplace violence by their male colleagues who are superior to them (Boyle & Wallis, 2016). Similarly, there is evidence of the oppression of migrant doctors in British medical institutions where non-whites, immigrant medical trainees and doctors forcibly enter into a liberator-outcast type of relationship with the other white, non-immigrant and senior members, whom they believe will support their career progression in their institutions, contrary to the guidelines set by British Medical Association (Kyriakides & Virdee, 2003).

Bullying involves pressuring individuals by misuse of power, fear and oppression (Normandale & Davies, 2002). Several other factors, including social values, institutional policies and stereotypes, may also play a role in sustaining oppression in organisations (Taylor, 2016). A study on the relationship between power and emotion in medical trainees found that medical training works by exercising power through fear and intimidation (Crowe et al., 2017). The literature also highlights that medical students' career prospects and development mainly depend on their abilities to withstand and tolerate intimidation and abuse without challenging the misuse of power (Lempp, 2009). Many medical students function by portraying an illusion of control to avoid being seen as incompetent (Crowe et al., 2017). These findings are further supported by some studies, which indicated that post-graduate medical trainees' relationships

with their seniors and those who supervised them are guided by frustration, fear, intimidation, oppression and acceptance of hierarchy (Crowe et al., 2017; Lempp, 2009). The next section discusses how the literature identifies several strategies for the prevention and management of bullying through a focus on the power dynamics, hierarchy and misuse of power.

3.2.5. Prevention and Management Through Power

The literature identifies that exploring how power is practised in healthcare institutions has implications for strategies and reform that may prevent and manage bullying of healthcare workers (Branch et al., 2004; Hutchinson & Jackson, 2015). A study by De Ceiri et al. (2019) suggested that healthcare employees do not merely practise the organisational policies concerning prevention and management; they also consider their experiences, their group and workplace while working. When managers and supervisors fail to practise their power in a way that protects staff from workplace bullies, bullying can escalate (De Cieri et al., 2019). For this reason, supervisors and managers can play a critical role in preventing and managing bullying by setting rules and regulations that are socially appropriate and accepted (De Cieri et al., 2019). Participants of a study investigating power dynamics concerning bullying and organisational failures to prevent and manage bullying indicated that managers were unable to practise their power effectively—rules, regulations and guidelines to prevent and address bullying were unclear and distorted in a way that was not beneficial (Hutchinson & Jackson, 2015). Participants in the same study also stated that the reporting system was inefficient and was designed to reflect the outcome that the manager and those with positions of power wanted (Hutchinson & Jackson, 2015). Some authors suggest that increased managerial and leadership attention to the disciplinary measures in the organisation – for example, quality assessment of the workplace systems, performance management (reward for good behaviours and consequences for bad behaviours), case management (attention to addressing individuals' issues) – can promote the efficacy of rules and regulations in organisations by enforcing their

application (Hutchinson et al., 2006a). Such laws, rules, regulations, and disciplinary measures provide a framework for practising power and control to protect nursing professionals from being targeted by those in positions of power (Hutchinson et al., 2006a).

Bullying is rooted in the forms of power in organisations, and the way these powers are exercised, learnt, supported, and formalised in a workplace where people and institutions are the producers, users and regenerators of these forms of power (Mannix-McNamara, 2021). Therefore, while understanding preventing and managing bullying, it is critical to examine the individual and organisational aspects of bullying (Mannix-McNamara, 2021). Hierarchy in organisations promotes the bullying phenomenon because people in the hierarchy possess power. How power is practised within the order in healthcare institutions impacts the prevention and management of bullying. This is because people who have power in organisations or are sitting higher in the hierarchy may think that they do not have to abide by the organisational policies and formal procedures (Rockett et al., 2017).

Flattening the hierarchy by the distribution of power among the organisation's members may change the power dynamics, foster positive communication and improve patient care (Escartin et al., 2011; Green et al., 2017; Wright, 2020). The literature identifies that in medical specialities higher within the medical hierarchy, such as surgery, receiving feedback from seniors may be fear-inducing for trainees. In such circumstances where hierarchy influences concerns, flattening the hierarchy by facilitating open communication and fostering respectful practices around feedback processes can prevent bullying (Munro & Phillips, 2023). Further, encouraging open communication will also enable effective reporting to facilitate the management of bullying (Munro & Phillips, 2023)

Scholars also suggest a more realistic analysis of the duties and roles of both workers and organisations, and creating power and management of workplace bullying to design the most successful interventions (Hodgins et al., 2020). Approaches based on shared

responsibility, which may impact the values of the groups and teams, are underdeveloped (Hutchinson, 2009). Assuming that bullied employees will actively ask for help is not a practical approach. Therefore, it is critical to cultivate trust by offering genuine support to victims of bullying. This also means that bullying behaviours must be addressed at an individual level, and those who exercise misuse of power and senior positions and are involved in training and teaching must be aware of the effects of being a role model to their junior staff members (Hoosen & Callaghan, 2004).

There is a substantial amount of management literature that identifies the positive impact of workplace assistance in the form of support from those who have power, such as seniors and managers, in the prevention and management of bullying (Hoosen & Callaghan, 2004). For example, psychiatry units in healthcare organisations involve trainees being supported and supervised regularly, which may provide them with an opportunity to share their concerns regarding bullying and provide support to other staff members (Hoosen & Callaghan, 2004)

Recurring incidences of bullying behaviours can be changed by recognising that bullying is taking place in an oppressed group. For instance, in nursing, educational programmes should include accounts of how oppressed groups behave, and of the prevention and elimination approaches (Chan, 2009). Bullying prevention and management strategies must also explain how to seek support from fellow workers rather than opting for showing bullying behaviours in response to bullying and 'oppressing the oppressor' (Chan, 2009). Without proactive approaches and effective interventions to stop this phenomenon, bullying will continue to pass on to generations of healthcare employees (Chan, 2009).

The scoping review in Chapter Two indicated multiple themes recognising power imbalance, and relevant theories and theoretical constructs beneficial for explaining the bullying process. The section on power imbalance in this chapter includes theories and

theoretical constructs related to power, including power dynamics, hierarchy, misuse of power and oppression theory. The accounts in this section illustrated how power imbalance, hierarchy and misuse of power might lead to oppression and bullying within groups of healthcare workers who are at the same or different levels in the healthcare organisation's hierarchy---the accounts explained that misuse of power could take the form of predatory bullying of healthcare professionals such as nurses or doctors. In summary, bullying may be caused by power-imbalances leading to the oppression of power within the same group or by the oppression of different people such as juniors, migrants and non-whites, females, and interns. The following section focuses on Structurational Divergence theory, which was indicated in the scoping review as one of the theories that could potentially explain bullying.

3.3. Structurational Divergence Theory

Interpersonal conflicts emerged as one of the themes of the scoping review for explaining the bullying phenomenon. Conflict is an unavoidable and persistent problem in healthcare teams (McKibben, 2017). Despite all the conflict resolution training for healthcare professionals, leaders and managers, issues concerning interpersonal relations of staff, employee retention and stress remain unresolved (McKibben, 2017). Changes in staff, leadership and management can lead to interpersonal conflict in healthcare teams (McKibben, 2017). Conflicts can happen because of contradictory and opposed interests, aims and expectations of individuals (Kim et al., 2017). Conflicts can be destructive or constructive (Kim et al., 2017). While constructive conflict might lead to better decision-making, improved judgment, better performance of teams and an enhanced understanding of other individuals' perspectives, destructive conflict can adversely impact team cohesion, communication and problem solving among employees (Kim et al., 2017).

Interpersonal conflicts can lead to bullying if not managed effectively. The difference between conflict and workplace bullying is the magnitude of power (Baillien et al., 2017).

Some researchers have labelled bullying as an unresolved conflict that crosses the boundary of no return (Baillien et al., 2017). Evidence points out that bullying is not an instant but a consistent process that escalates over a while, and interpersonal conflicts and organisational changes may act as precursors of bullying phenomena. Thus, what might start as a conflict may lead to bullying or violence (Einarsen, 1999; Skogstad et al., 2007). For this reason. a framework used for understanding conflict, such as Structurational Divergence (SD) theory, may help to understand and explain the bullying process and contribute to the prevention and management of bullying (Baillien et al., 2017).

The scoping review findings in Chapter Two indicated that Structurational Divergence (SD) theory, used previously for understanding conflict in healthcare workers, might help in understanding bullying. SD theory and its significance in preventing and managing bullying are discussed in this section. The following sections explain SD theory, its foundational elements, evidence supporting SD theory, and its significance in bullying prevention and management.

3.3.1. SD Theory and Foundational Elements

SD theory is rooted in the structuration theory developed by Anthony Gidden (Canary & Tarin, 2017; Nicotera & Clinkscales, 2010). Structuration theory explains the relationship between human agency (i.e., human capability to make a change) and social structures (Lamsal, 2012). Social structures are the resources, rules, norms, patterns of social relations and macro systems that determine individuals' behaviours (Lamsal, 2012). Nicotera & Clinkscales (2010) defined structures as unobservable resources and rules that produce observable systems or behaviour patterns. Any principle or way of doing things that governs individual action or behaviour is a rule, while resources are what individuals use during their activities. Resources can be tangible (e.g., currency, instruments) or nontangible (e.g., individuals' professional expertise or skills, education, and/or experience) (May & Mumby, 2004).

Structuration theory states that human behaviours or actions are not solely driven by outside forces but also occur because of continuous social interactions among individuals. Many structures are generated continuously through individuals' interactions and may be observed through several interaction patterns (Nicotera et al., 2010). Structures are, therefore, created and maintained throughout the ongoing actions of individuals and groups or by the process of structuration (Giddens, 1984). Structures may be constraining or enabling human actions and provide a framework of understanding and meaning to individuals to enable them to navigate their social world, within which individuals take various measures (Giddens, 1984a, 1984b)

Continuous changes in structures occur because humans have the freedom to create their living environment, and the structures (or institutions) in which people exist are therefore, shaped by humans voluntarily (i.e. human agency) (Lamsal, 2012). This also means that individuals are both shaped by and have the capability (i.e. agency) of shaping and reshaping structures over time. For example, power structures in organisations have specific rules to practice power; however, human agency describes how humans practice the rules of power in organisations (Stinchcombe, 2000).

In summary, structuration theory signifies the complex relationship between human agency (freedom) and determination (i.e. structure), where the choices of the individuals are somewhat constrained; however, they still remain individuals' choices (Oppong, 2014). For this reason, agency and structures are both critical and equally essential for influencing individuals (Giddens, 1984b)

3.3.2. Explaining Structures in Healthcare Organisations.

In organisations, structures are seen as the arrangement of roles, responsibilities, positions, communication patterns, decision-making, and authority (Tolbert & Hall, 2015). Structures in an organisation describe how specific tasks are divided, including the flow of information, the

decision-making, and the grouping and management of employees (Tolbert & Hall, 2015). For example, power or authority structures offer a framework for control and coordination (Tolbert & Hall, 2015).

Distribution of structures in the organisation is seen at all levels from micro to macro, involving individual, organisational and social contexts (Tolbert & Hall, 2015). Structuration theory does not perceive organisations as independent institutions; rather, organisations can be formed and supported by human activities and transformed through human interactions scattered within various structures (May & Mumby, 2004). This is why multiple systems and processes in organisations can be observed by analysing various factors acting as structures; for example, the power and authority structures in the process of structuration can be observed to explore how power works in organisations (Thompson, 1956). Similarly, hierarchy and the effects of the values, individuals' perceptions and beliefs concerning hierarchy can help observe how hierarchy operates in organisations (Grigoroudis et al., 2012; Pilgrim et al., 2020). Thus, understanding power and hierarchy structures can assist in observing phenomena related to hierarchy and power, such as workplace bullying (Salin, 2003a).

The healthcare sector involves distinctive structures characterised by social expectations that must be taken into account, meaning that particular sets of values or cultures may exist for other structures (Graber & Kilpatrick, 2008). Social relationships within organisations are regenerated or transformed via the multi-level impacts of certain practices of individuals in particular positions within structures (Tolbert & Hall, 2015). Organisations can be regarded as having many structures that are sustained and transformed when individuals engage in social interactions, depending on their specific 'position practices' at different levels in the social organisation. This may also illustrate the points of interaction or overlap between the human agency (i.e. influence) and the structure (Tolbert & Hall, 2015).

In healthcare organisations, various external structures, including religion, culture, and gender, may influence societal expectations from employees that could lead to multiple organisational outcomes (Graber & Kilpatrick, 2008). The workplace culture, professional education and training, and interpersonal relationships of the employees in healthcare organisations also contribute to the organisations' multidimensional structures and guide specific actions (Graber & Kilpatrick, 2008). This complexity of organisations' value systems may pose a challenge for healthcare employees, managers and leaders because of contradictory values in a department, unit or throughout the organisation (Graber & Kilpatrick, 2008).

Hospital staff have to play many different roles using various social structures at once. These multiple social structures may include workplace culture, professional codes of conduct, community worldviews, hierarchal structures of healthcare organisations, and power structures and technology-related regulations (Nicotera & Clinkscales, 2010). Personal ethics, organisations' regulation, group identities and practical rules around various specialities in healthcare settings are also social structures that may impact workers' choices and actions (Nicotera & Clinkscales, 2010). Further, in healthcare systems, workers are conventionally embedded in a nexus where different social structures merge and interact together, pressuring individuals to fulfil various responsibilities related to multiple systems of rules or 'meaning structures' (Nicotera & Clinkscales, 2010). This leads to a phenomenon called Structurational Divergence (SD), which is explained in the following section.

3.3.3. SD Theory Explaining Conflict Leading to Bullying

While corresponding and non-conflicting structures can lead to productive communication patterns, unobservable resources and rules corresponding to a particular meaning structure may present a contradiction of values and cultures, known as Structurational Divergence (SD) (Nicotera & Clinkscales, 2010). For example, the violation of identity structures by opposing or contradicting personal ethics, as a result of organisations' regulations, or contradictory

structures of other group identities and practical rules, may occur as a result of SD in healthcare organisations (Nicotera & Clinkscales, 2010). SD theory recognises that social actions generate and regenerate structures and that structures act as the sources and are seen as the results of social interactions (Ford et al., 2022). SD theory also supports the notion that human agency imparts a degree of control to social relations. Through this control, individuals can transform the social world they navigate (Nicotera et al., 2015).

While structuration theory mentions how humans are constrained and enabled by structures, SD theory focuses on situations where humans are bound by conflicting or contradictory structures (Ford et al., 2022). SD manifests when several different meaning structures overlap and contradict the rules and resources of other structures. This overlapping of structures results in them being intertwined such that any action will reject and oppose single or multiple meaning structures, leaving individuals without agency or empowerment to act, and leading to unresolvable and persistent conflicts that can negatively impact relationships, prevent the achievement of goals and adversely affect individual and organisational development (Ford et al., 2022; Nicotera et al., 2015). These overlapping social structures result in workers facing situations that generate negative communication cycles in employees, leading to unaddressed conflicts (Nicotera & Clinkscales, 2010; Nicotera et al., 2010). Workers are challenged by demands to frequently interpret and take specific actions that are contradictory and incompatible across various social structures in the organisation (Nicotera et al., 2010). For example, when different rules for patient-oriented support and bureaucratic management are in place for healthcare workers, they lead to interpersonal conflicts and repeated negative communication patterns (Nicotera et al., 2010).

SD may occur at the unit, individual, social and organisational levels (Conway-Morana, 2012; Nicotera et al., 2010). In a workplace with contradictory structures, workers facing SD handle various demands by interpreting multiple-meaning structures and engaging in numerous

actions simultaneously. This also means that when SD is present, individuals cannot use resources coherently or apply the rules effectively, because the rules and resources of one structure violate another structure's rules and resources (Nicotera & Mahon, 2013). It then becomes difficult for individuals to act within several different structures, creating incoherent interactions leading to ineffective communication patterns that further relate to conflict and bullying (Nicotera & Mahon, 2013).

SD manifests at the organisational level but may be observed at an individual level (Ford et al., 2022; Nicotera & Clinkscales, 2010). For example, impotent agency, or individuals' incapacity to deal with contradictory structures, may result in profound anger that may present itself as bullying at an individual level. At an organisational level, it may manifest as ineffective policies and procedures, and unaddressed discrepancies or conflicts (Ford et al., 2022; Nicotera & Mahon, 2013). The following accounts of the SD cycle and SD nexus further explain how SD operates at the individual and organisational levels, and its role in explaining conflicts and bullying.

3.3.3.1. SD nexus and SD cycle. Two major features of SD are the SD nexus and the SD cycle. (Ford et al., 2022; Nicotera & Clinkscales, 2010). A nexus represents the institutional position where several structures overlap or permeate; that is, a situation where an individual feels forced to meet obligations or obey rules relating to several different systems or social structures (Nicotera & Clinkscales, 2010). Contradictory or different-meaning structures often have rules that determine which structure surpasses another. However, there is no rule for determining the right or most appropriate action in an SD nexus; structures contradict one another simultaneously with opposing obligations or demands on individuals (Nicotera & Clinkscales, 2010). This does not imply that in an SD nexus, individuals have no empowerment or agency to fulfil the demands and take action. Instead, in the SD nexus, one structure sabotages or overrides the other structure, so acting within one structure may strip individuals

of their agency or empowerment to take action elsewhere, leaving them immobilised or unable to take any action due to a persisting problem (Ford et al., 2022; Nicotera, 2018; Nicotera & Clinkscales, 2010).

This immobilisation because individuals cannot take any action to address the contradiction or inconsistency (known as impotent agency) results in a negative communication pattern or downward spiral that leads to a repetitive and consistent cycle known as the SD cycle, which is an unresolved conflict resulting from different meaning structures (Ford et al., 2022; Nicotera, 2018; Nicotera & Clinkscales, 2010). The SD cycle intensifies and becomes more potent after the destruction of any development that may address conflict—the SD cycle merely aggravates the unresolved conflicts because of the opposing structures (Ford et al., 2022; Nicotera & Clinkscales, 2010). Some examples of conflicts caused by contradictory structures, and SD cycles in healthcare organisations, are given below.

3.3.3.2. Examples of Structurational Divergence. A simple example of such contradictions is a request by a nurse to reconsider a dosage regime. The nurse tries to ensure that safety protocols taught during safety training are being followed (Nicotera et al., 2010). However, the request is perceived by a doctor as an action that undermines his professional authority. This interaction is a typical example of structural divergence in healthcare contexts where doctors follow organisations' conventional authority structures (Nicotera et al., 2010). At the same time, nurses should follow doctors' orders and might perceive this process differently (Nicotera et al., 2010). This type of negative interaction indicates a non-coherent structure of power or authority and culture, where healthcare workers show negative communication patterns based on frustration and blame, which may affect patient care quality. (Andre et al., 2016; Nicotera et., al, 2010).

A further example occurred during the COVID-19 pandemic. The guidelines in US hospitals required healthcare staff to wear protective gear such as N95 masks while seeing

patients (Antommaria et al., 2021; Livingston et al., 2020). Hospitals had limited protective equipment, yet disciplined healthcare workers for bringing their own masks (Ford et al., 2022; Livingston et al., 2020; Tirupathi et al., 2020). In addition, as new information emerged about COVID-19, the hospitals constantly altered strategies, rules and regulations that were related to protective gear, including mask-wearing (Antommaria et al., 2021; Ford et al., 2022; Tirupathi et al., 2020). This situation resulted in hospital workers being trapped in an unresolved conflict where any actions would contradict either the hospital rules or regulations about not bringing their own masks, or the organisational policies surrounding the use of protective gear, including masks, to prevent the spread of pathogens in the air. This resulted in immobilisation or impotent agency, leading to a persistent unresolved conflict or an SD cycle.

A similar example is a healthcare worker dealing with various structures in a hospital in the early days of COVID-19. While the Centres for Disease Control and Prevention (CDC) required mask-wearing while treating a patient, many US hospitals made mask-wearing outside of treating a patient a punishable or disciplinary offence (Ford et al., 2022). This led to a situation where any act by hospital workers either opposed the organisational rules and regulations of using masks provided by hospitals only, or policies surrounding the use of personal protective equipment and wearing their own masks to avoid spreading the pathogens (Ford et al., 2022). This contradiction fuelled impotent agency, leaving workers immobilised as they could not make decisions or take any actions regarding mask wearing. This scenario even escalated into a situation where some workers protested in hospitals (Ford et al., 2022).

Several studies have identified that contradictions posed by rules and regulations concerning safety and safety protocols in hospitals during the COVID-19 pandemic led to bullying of healthcare workers (Ananda-Rajah et al., 2020; Ayton et al., 2022; Somani et al., 2022). Ayton et al. (2022) noted that Australian healthcare workers faced bullying behaviours due to constantly changing rules and regulations around protective gear and safety during the

pandemic. Changes in rules caused contradictions between various work units and structures, which left healthcare workers confused and unable to take action (Ayton et al., 2022).

To summarise, the incapacity to take action due to the immobilisation of individuals leads to a cycle of persistent conflicts (or an SD cycle), which negatively impacts organisational growth because of diminished trust between healthcare workers and employers over health and safety rules (Ford et al., 2022). Profound SD is an unresolved conflict caused by overlapping or contradictory structures in an SD nexus, which generates, sustains and fuels a repetitive SD cycle (Nicotera & Clinkscales, 2010).

3.3.4. Evidence Supporting SD Theory

The literature suggests that bullying and conflict are common phenomena in healthcare professions (Malterud & Nicotera, 2020). Scholars have suggested links between SD and bullying because bullying may be an outcome of conflict posed by SD (Malterud & Nicotera, 2020; Nicotera & Mahon, 2013; Nicotera et al., 2015). Researchers have use SD theory in relation to nursing; however, it can be applied to a range of organisational settings (Nicotera & Clinkscales, 2010; Nicotera et al., 2014).

The SD nexus in healthcare organisations results in ineffective communication that may lead to conflict and bullying within teams (Nicotera & Clinkscales, 2010). Evidence also suggests that ineffective communication is an organisational determinant of workplace bullying (Arnetz et al., 2019). Because of the nature of work in the healthcare sector, healthcare professionals operate in multidisciplinary teams and coordinate to provide quality patient care (Epstein, 2014). They resolve complicated issues and create plans for quality patient care (Epstein, 2014). Multidisciplinary teams have members from several disciplines, including physicians, surgeons, nurses, pharmacists, and other healthcare professionals (Ruiz-Ramos et al., 2021). SD hinders healthcare professionals' ability to navigate the various structures of healthcare organisations. Healthcare workers may not effectively provide feedback, recognise

and discuss boundaries, and manage their workloads: these issues can result in interpersonal and organisational conflicts, which may eventually escalate into bullying behaviours (Anderson, 2015; Malterud & Nicotera, 2020; Nicotera et al., 2015)

Several studies have explored organisational factors that can lead to ineffective communication and SD cycle (Ford et al., 2022; Nicotera & Clinkscales, 2010; Nicotera et al., 2014). Some scholars have used the concept of SD with organisational dissent, which refers to declaring disagreement about contradictory points of view in response to actual or perceived problematic workplace operations, practises and procedures, and policies (Zanin & Bisel, 2022). Further, regulations and policies serve as social structures in workplaces that are created and recreated, and enforced by organisations' employees; sometimes, employees also voice their concerns about their seniors or managers. The presence of an SD nexus might even invite voice and behaviours that could either resolve or aggravate the SD Nexus. SD, therefore, may at times silence employees about their views on their leaders (Zanin & Bisel, 2022). Such a situation shows immobilisation or an individual's inability to act, which manifests as frustration over navigating different structures and creates adverse outcomes, such as employees intending to leave, and increased burnout among employees (Zanin & Bisel, 2022). In addition, the SD nexus may generate role conflict, elevated turnover and workplace bullying (Conway-Morana, 2012; Ford et al., 2022; Nicotera & Mahon, 2013; Zanin & Bisel, 2022). It can be concluded that contradictory structures may cause healthcare employees to lose their agency in the SD nexus, thus creating a persistent SD cycle that may lead to conflict and, eventually, bullying,

3.3.5. Prevention and Management of Bullying Through SD Theory

Bullying involves interpersonal aspects and acts between various workers at all organisational levels compared to interpersonal violence or aggression, which may include outsiders (Salin, 2003). Bullying may be present in the workplace as a result of the organisational factors that

are 'power structures' (i.e., about authority) in organisations (Liefooghe & MacDavey, 2001). This may also imply that intervention is needed at the organisational level.

To prevent and manage bullying, it is critical to examine not only organisational structures and practices that will enhance various processes at work, but also those that will create negative processes that lead to bullying (Kramer et al., 2008). Mackay (2014) argued that individual agency in the people at the bottom of the hierarchy in an organisation is centred around maintaining accountability standards and efficient practices. (McKay, 2014). Therefore, organisations with highly bureaucratic systems or hierarchies must take initiatives that strengthen individual empowerment or agency; for example, giving employees a platform to share their concerns about the rules and various structural processes. Doing so may effectively balance the severe effects of the different structures (McKay, 2014). Nevertheless, there is a need to strategically develop and sustain structures such as power, hierarchy and relevant procedures and regulations, which will increase organisational effectiveness by eliminating negative behaviours, providing quality patient care and facilitating employee job satisfaction (Kramer et al., 2008).

A healthy workplace results from effective interpersonal relationships between healthcare employees (Andre et al., 2016). SD theory emphasises that a disruption in communicative relationships can be caused by contradictory structures where the rules and resources of one structure overlap with the rules and resources of another structure, which can escalate to bullying behaviours. Making structures explicit and regulations and resources clear so that individuals' meaning-making is concrete may be beneficial for alleviating contradictions that can lead to conflict and eventually bullying. The desire to change the rules and resources around structures needs to be communicated openly; managers and administrators must consult healthcare employees to know which structures require change if something is not working (Kramer et al., 2008).

It is crucial to identify the structures that can create healthy workplaces to create a bullying-free workplace (Kramer et al., 2008). Education and training can help to prevent and manage bullying by making structures explicit and identifying which structures take precedence to manage contradictions (e.g., patient safety is primary) (Bloisi & Hoel, 2008). Further, evidence suggests that assertiveness, stress management, and dispute resolution training can help to prevent and manage bullying (Martin & Martin, 2010). Training for managers, human resources executives, leadership and administration that outlines clear and comprehensive guidelines about the effective prevention and management of bullying may also be useful (Fox & Stallworth, 2009a).

Prevention and management of bullying in a particular organisation also depend on the organisation's specific policies, rules and regulations, and legal technicalities (Allen, 2015). Healthcare organisations have professional settings that are influenced by organisational, institutional, and professional factors, which affect the work environment and make it challenging to address the safety requirements of medical employees. For example, licensing institutions and regulating policies with legal requirements for medical professionals present specific demands to hospital workers (Ford et al., 2022; Riley et al., 2021). Therefore, policies and regulations concerning licensing requirements must be communicated to healthcare employees so that healthcare workers are not exposed to bullying behaviours from individuals supervising licensing requirements.

Workload, working conditions, and psychological distress among junior doctors expose them to bullying behaviours (Imran et al., 2010**.** A culture of blame and shame may represent a structure overlapping with healthcare organisations' health and safety policy structures. Workplace bullying is a complex issue that needs to be prevented at individual, social and organisational levels. Several factors produce positive health and social outcomes at multiple levels, such as better communication between healthcare workers, and workers' relationships

with management. These aspects of social and personal networks may provide a healthy workplace by addressing issues arising within contradictory structures, and providing a platform for exploring phenomena that may result from SD (Malterud & Nicotera, 2020; Nicotera et al., 2014; Nicotera et al., 2015).

In conclusion, the section noted that interpersonal and team dynamics in healthcare organisations can cause conflicts, which may lead to bullying. SD theory, rooted in structuration theory, may explain bullying through the SD nexus and SD cycle constructs, where healthcare employees' inability to take action may leave them immobilised because of contradictory structures with different rules. Making healthcare structures plain, so that healthcare employees can understand the rules of various structures at all levels within a healthcare organisation, can help prevent and manage bullying.

3.4. Ecological System Theory

The focus of management literature on workplace bullying has primarily been on collecting empirical evidence to describe bullying through the lens of target-perpetrator dynamics and its consequences (Berlingieri, 2015). Scholars also highlight that bullying may stem from an organisation's culture, where individuals' behaviours relating to safety guide their attitudes. Researchers also argue that all forms of violence, including bullying, must be explored in terms of the interplay of social processes and the connections between different forms of oppression (Berlingieri, 2015). Workplace violence needs to be examined through a framework where the constructs of power are not considered in isolation from social aspects both inside and outside of the workplace (Berlingieri, 2015).

In addition to the oppressing and bullying behaviours of individuals in efforts to establish power dynamics in workplaces, contextual or environmental factors may have significant impacts on both victim and perpetrator. This is considered an under-explored area because not much is known about how community-related aspects relate to bullying in the adult

population. It requires an approach that explores the interplay of social factors with community associations that may contribute to cultivating power dynamics relating to victims and perpetrators (Schumann et al., 2014). The ecological system theory is a theoretical approach that may explain bullying by taking into account both individual and contextual or social factors, and was the final theory identified in the scoping review.

Ecological system theory (EST) explains bullying through several interconnected social factors at various levels, both within and outside of the workplace. EST emphasises the contextual factors and differences in human development (Darling, 2007). EST has its foundation in the socio-ecological framework and is often used interchangeably with it (Binder et al., 2013). Urie Bronfenbrenner first used the socio-ecological framework as a conceptual framework to explore human development, which later emerged as a theory in the 1980s (Kilanowski, 2017). Despite the focus on context in Bronfenbrenner's early accounts, his later work is characterised chiefly by attention to the role of a developing individual, patterning and drawing connections between the various determinants of human development (Darling, 2007). EST theory views an individual's development as a complicated system of relationships that are affected by several levels or layers of the surrounding environment, including immediate family, educational institution settings, and broader cultural beliefs, legal aspects, and traditions (Bronfenbrenner, 1992).

EST has two primary features. First, humans shape their environment and are impacted by their environment. Second, human behaviour can change and is changed by the environment (Phelan & Kirwan, 2020). EST has been widely used in the fields of education, human development, social work, healthcare, and multidisciplinary research to describe how the well-being of individuals is shaped by and interacts with both distant and immediate social aspects, which overlap and affect one another (Elliott & Davis, 2020; Neiterman et al., 2021; Paat, 2013; Phelan & Kirwan, 2020).

This theory reinforces the notion that workplace incidents are not associated with a single system and are not isolated events to which individuals are exposed; instead, most workplace phenomena may be understood by considering several systems nested together (Yang & Sanborn, 2021). The earlier accounts from Bronfenbrenner described an individual placed in an orbit with several surrounding systems (Kilanowski, 2017), and thus EST offers an interactive system of five layers: micro, meso, exo, macro and chrono.

The system closest to the individual or the microsystem relates to the connections and interactions with the immediate surroundings and exerts the most substantial impact on human development (Elliott & Davis, 2020; Kilanowski, 2017). The meso-system is the second layer, which explores beyond the close interplay and associations and comprises those who may have direct contact with individuals, including schools, churches, and neighbours. The exo system illustrates the interaction between elements of the microsystem (Espelage, 2014). The exo system may not impact individuals as directly as the microsystem but may produce positive and negative effects on individuals in communities and social circles (Kilanowski, 2017). The exo system relates to the remote social setup, which only indirectly impacts individuals, including the neighbourhood, wider society and the individual's support network (Paat, 2013). Culture, society, and religion-related beliefs make up the macrosystem of the socioecological framework (Kilanowski, 2017). Finally, there is an additional layer, the chronosystem, which comprises the aspects related to history and time, such as major transition points in individuals' lives and changes in individuals' environments over time, which may impact policies; for example, relocation, family-related changes and death (Espelage, 2014; Kilanowski, 2017; Neiterman et al., 2021).

The elements of EST relating to individuals, communities, and internal and external environments contain components that are physical, social and political (Kilanowski, 2017).

The literature identifies that all aspects of the EST are critical for understanding the bullying process (Jones-Bonofiglio, 2020; Sharma et al., 2021; Song et al., 2023). These aspects may involve society at the macro system level, the organisation at the exo system level, and the colleagues and managers of the bullied individuals and the perpetrator at the microsystem level (Hong et al., 2014; Johnson, 2011). Single-level approaches may not be practical in understanding bullying because several different factors at each level may act as antecedents of bullying behaviours; outcomes of bullying may also be visible at multiple levels (Sharma et al., 2021). For example, the literature points out that organisational factors may facilitate the process through which bullying becomes part of organisational cultures. Although individual factors, such as certain personality traits, may be the reason behind escalated bullying behaviours, the role of managers and leaders in the bullying process, as well as in preventing and managing bullying, is still essential: organisations play a vital role in creating an environment that is free of bullying behaviours and leadership plays a crucial role in addressing bullying (Ahmad et al., 2022; Samsudin et al., 2020), Thus, adopting a multifaceted approach to explaining bullying through factors at various levels is critical to effective bullying prevention and management. The significance of each layer of the EST in explaining the bullying of healthcare organisations is further discussed in the next section.

3.4.1. Evidence Supporting Ecological System Theory

Workplace bullying is a phenomenon that involves a broader behaviour pattern (D'Souza et al., 2017). Various bullying behaviours and violence may be occurring in organisations simultaneously at multiple levels with multiple victims, which has the potential for harmful outcomes of bullying manifesting at more comprehensive levels (i.e., at the micro or individual level; at the meso levels or at the organisational/industry level and; at the macro level or at a level outside the organisations, for example, broader society) (D'Souza et al., 2017; Flynn & Mathias, 2023). This further emphasises why considering all dimensions is critical for

effective planning, evaluation, and interventions for preventing and managing bullying (Hong et al., 2014; Johnson, 2011; Song et al., 2023).

Studies indicate that at the microsystem level of the ecological system theory (related to family, friends and immediate circle), perpetrators or bullies show a diverse range of ages and genders. Perpetrators may also range from coworkers and supervisors to managers (Espelage, 2014; Walker & Stones, 2020). Individuals who bully at the microsystem level of the ecological system are driven by a sense of competence in their social setup, may have ineffective leadership skills and hold a micro political agenda, such as goals of getting promotion or recognition in the workplaces, and moving up in the hierarchy (Einarsen et al., 2002; Glasø et al., 2009; Walker & Stones, 2020). At the meso-level, bullying can be explained by observing the bullied individual, the perpetrator's colleagues and the manager of the bully and the bullied (Walker & Stones, 2020). Bullying can escalate at the meso level due to the behaviours of peers or colleagues, who can facilitate bullying behaviours by ignoring or encouraging the perpetrator (Walker & Stones, 2020).

At the meso level (related to the interactive features of the microsystem), role conflict, confusion about one’s role, aggression, and inappropriate working conditions can trigger bullying behaviours (Walker & Stones, 2020). Ineffective communication processes in the organisation can also contribute to bullying because individuals point to their colleagues or managers and ask them about their response to bullying behaviours (Lutgen-Sandvik & Tracy, 2012). Evidence indicates that gossip and blame-shifting are responses to bullying at the meso level (Razzante et al., 2018; Walker & Stones, 2020).

At the exo level (environments that are impactful although they may not have a direct effect on individuals—for example, peer networks, community groups, workplaces, regulatory bodies and mass media), the absence of efficient regulations and interventions at the group level can lead to an escalation in bullying. Chaotic organisational factors (such as competitive

work, restructuring, downsizing, and unclear and inadequate policies around operations) can act as triggers for an escalation in bullying (Chaiwuth et al., 2020; Johnson, 2011). Several scholars have identified that the competitive nature of healthcare work can lead to an increase in bullying behaviours because employees are in a race to acquire the organisational resources to advance in the organisation (Barua & Verma, 2021; Gkagkanteros et al., 2022). Similarly. evidence also suggest that lack of effective regulatory mechanisms can lead to the encouragement of bullying because unclear policies do not provide adequate guidelines for managers and leaders in such organisations (Einarsen et al., 2020; He, 2022).

The literature highlights that the macro level is essential for understanding bullying because it may involve a broader societal context (Walker & Stones, 2020). This is because, at the macro system level, the organisation must be considered as a whole system. Organisations are highly structured institutions governed by power, hierarchy, extremely competitive workplace cultures, complicated operating systems, restructuring of systems, and consistently changing reforms (Walker & Stones, 2020). At the macro system level, people in the hierarchy misuse their power to silence those who raise concerns about bullying behaviours (Walker & Stones, 2020). Studies exploring bullying through EST illustrate that at the macro level, bullying does not occur because of conflict between individuals; instead, bullying attitudes emerge as a result of the misuse of power by individuals and the hierarchy (Walker & Stones, 2020). Cultural and societal norms regarding workplace bullying, and laws that are relevant to bullying and abuse, can influence bullying at the macro level (Johnson, 2011). For example, gender roles and the attitudes and behaviours of individuals toward accepting and responding to bullying can shape the way bullying is received in the wider society and in organisations (Favaro et al., 2021; Johnson, 2011; Lutgen-Sandvik & Tracy, 2012). Culture, societies and systems where bullying behaviours are neglected can encourage further bullying of individuals (Berlingieri, 2015; Harvey et al., 2006; Johnson, 2011; Lutgen-Sandvik & Tracy, 2012). This

is similar to the oppressed group behaviour discussed earlier in this chapter, where members of an oppressed group bully one another (Johnson, 2011).

At the chrono level, studies have indicated that the significant decisions healthcare employees make during their time in an organisation (e.g., decisions to stay in a profession) are associated with bullying and related behaviour (Neiterman et al., 2021). A study using EST investigated several factors at the chrono level that shaped midwives' decisions to stay in the profession of midwifery. Specifically, the time spent in the profession and the timing of the midwifery profession's regulations shaped the behaviours of the midwives toward staying or leaving the profession (Neiterman et al., 2021). In terms of bullying, transitions at the chrono level, such as changes in the family, death and divorce, can escalate peer aggression (Espelage, 2014).

In conclusion, the literature indicates that in healthcare organisations, factors present at each layer or level of the social-ecological framework act as antecedents of bullying (Johnson, 2011). The impacts and outcomes of bullying are also observed and experienced at every level of EST (Espelage, 2014; Johnson, 2011). Several scholars have used the applicability of micro, meso, exo and macro systems to investigate workplace bullying of healthcare professionals (Johnson, 2011; Neiterman et al., 2021). Sharma et al. (2021) used Bronfenbrenner's EST to study workplace bullying of nurses and associated factors. They stated that the educational system for nurses is complicated and is impacted by interactions of many factors, which include interactions with families, parents, work, fellow workers, and other student nurses, as well as with management, the location of their organisation and concerns about policies and laws (Sharma et al., 2021). The study found that nurses' race and educational levels affected workplace bullying at an individual level. In contrast, at the organisational level, workplace bullying was influenced by nurses' invitations to and involvement in corporate meetings

(Sharma et al., 2021). The following section focuses on how EST can contribute towards addressing bullying.

3.4.2. Prevention and Management of bullying through Ecological System Theory

The previous focus on theorising bullying as an isolated event or explaining it at the individual level has resulted in bullying management through treatment, and reactionary rather than preventive approaches (Berlingieri, 2015). To prevent and manage bullying and to support healthy social connections in workplaces, it is imperative to consider the complex nature of human experience and aspects such as risk and protective factors, characteristics of individuals, and their background and course of participation in the bullying process (Espelage et al., 2013; Swearer & Hymel, 2015).

Although bullying may happen as a result of individual factors, the context or environment is a vital enabler of bullying behaviours (Adeniran, 2016). Without a supportive environment, educating employees to enhance civility may not be effective (Adeniran, 2016). Therefore, an emphasis on all-inclusive, multilevel or comprehensive approaches and programmes involving not only individuals but social and organisational elements is essential for sustainable change to facilitate a civil culture and an environment of respect (Espelage, 2014).

Several scholars have argued that a carefully articulated theory such as EST may be beneficial to identify which element of prevention and management programmes or strategies can be most effective in invoking a change or attaining desired outcomes (Espelage et al., 2013; Gillespie et al., 2015; Hawley & Williford, 2015). Multilevel approaches based on factors at micro, meso, exo, macro and chrono levels need to be considered while designing the prevention and management of bullying strategies, because the factors causing bullying are present at each level, and outcomes of the bullying process are also observed at each level

(Espelage, 2014; Flynn & Mathias, 2023). Thus, EST can be used as a framework to guide interventions and prevention and management.

EST has been used extensively to explore school bullying and its prevention and management (Dresler-Hawke & Whitehead, 2009; Espelage, 2014; Flynn & Mathias, 2023; Holt et al., 2013). Gillespie et al. (2015) studied the prevention and management of bullying through micro, meso, exo and macro levels to identify approaches and offer suggestions that could protect healthcare employees from the adverse effects of workplace violence and bullying. They suggested that at an individual level, preventive techniques may involve personal harm reduction strategies for healthcare employees. Issues of bullying between employees and co-workers, patients and visitors were discussed at the relationship level (Gillespie et al., 2015). At the organisational or community group level, a multilevel approach to prevent and manage bullying was recommended; at the societal level, a need for a health policy for preventing and addressing bullying was identified (Gillespie et al., 2015).

Another study by Smith et al. (2020), which explored strategies for bullying prevention and management among nurses, analysed nurses' accounts using EST. At the individual level, the need for communication training and having an open mind and respectful attitude towards the values and beliefs of others was recommended by the nurses as a preventive and management strategy. At the relationship level, focusing on relationships with colleagues, seeking support and help from colleagues to address bullying behaviours, and actively stopping the bully by calling the bully out on their attitude were identified as critical preventive and management measures (Smith et al., 2020). At the community level, the study identified two types of approaches. The first type related to the prevention and management at the unit or organisation level through strengthening the team environment by supporting other nurses rather than belittling them, and through measures focused on unit-level prevention and management (Smith et al., 2020). The second type of community-level prevention and

management involved making use of current resources and creating new resources to prevent and manage bullying; for example, a zero-tolerance policy to bullying, education and training programmes aimed at prevention and management of bullying, and management considering bullying behaviours and eliminating staff shortages at unit levels so bullying due to increased workloads could be prevented (Smith et al., 2020).

A study of New Zealand nurses' experiences of workplace bullying and the effect of workplace environment used the ecological system approach and suggested several factors at multiple levels of the ecological system that impacted workplace bullying-related interventions (Blackwood et al., 2017). These factors were identified over the four system levels (societal, organisational, industry, and community and location levels) (Blackwood et al., 2017). The factors involved two aspects: (1) willingness and individuals' abilities to intervene, and (2) the victim's and perpetrator's responses to the alleged bullying behaviours (Blackwood et al., 2017). The study indicated that bullying prevention and management strategies could be driven by these aspects (Blackwood et al., 2017).

To summarise, EST recognises several factors in the human environment that may cause bullying behaviours. These factors occur at micro, meso, exo, macro and chrono levels and involve individual, organisational, and social elements that could explain bullying and facilitate the prevention and management of workplace bullying.

3.5. Other Theories Which Explain Bullying

As indicated by the theories presented earlier, workplace bullying is evident as a pervasive challenge that has profound implications for individuals as well as for organisations. It is influenced by several theoretical and contextual aspects that may assist in understanding how bullying progresses in healthcare organisations. Thus, a comprehensive conceptualisation of bullying necessitates further exploration of both specific and general theories that could potentially offer insight into the bullying phenomena. Literature indicates that some of the other

theories that may be relevant in the context of the bullying process include Job demands-Resources (JD-R) Theory, Affective Events Theory (AET) and Social Identity Theory (SIT). These theories may illustrate how individual, group and organisational aspects and factors intersect in addition to explaining the origin, dynamics, development and impacts of the bullying behaviours.

3.5.1. Job Demands-Resources (JD-R) Theory

Arnold Bakker and Evangelia Demerouti presented the JD-R Theory in 2006 (Bakker & Demerouti, 2007). The theory illustrates that stress and burnout are heightened when job demands are high and job resources or positives are low; in contrast, more job positives can regulate the increased job demands, therefore decreasing stress and burnout. (Bakker & Demerouti, 2007). JD-R theory provides a concrete basis for explaining workplace bullying by highlighting the role of internal stressors in organisational work environments (Van den Broeck et al., 2011). Several studies suggest a work environment characterised by increased job demands, for example, excessive workloads and time pressures coupled with inadequate job-related resources (e.g., support to complete a task or job or autonomy to perform a job or task) may create stress or strain developing conflict among healthcare workers (Ariza-Montes et al., 2013; Livne & Goussinsky, 2017; Nel & Coetzee, 2020). Frustration due to increased job demands may create situations with the potential to provide a fertile ground for bullying, as the organisational stressors increase frustration among employees and reduce workers' capabilities to manage work-related stress and interpersonal issues such as conflicts (Livne & Goussinsky, 2017). The healthcare sector is known to have a lack of resources due to skill shortages, and in the absence of ample resources, the competition heightens, which may trigger negative behaviours, including bullying as a maladaptive mechanism to claim control over organisational resources or dominate in the workplace (Demerouti & Bakker, 2011).

JD-R theory can provide a platform for prevention and management of bullying by considering how job demands, and workplace resources may influence the wellbeing of healthcare workers. Jobs that involve excessive workloads, immense time pressure, emotional labour and role ambiguity can increase healthcare workers' stress levels (Abdullah et al., 2021; Gabr & El-Shaer, 2018). Therefore, a reduction in job demands by ensuring that there is no role ambiguity and tasks are transparent and manageable can address the stress and, in turn, prevent conflicts and bullying (Abdullah et al., 2021). Additionally, a lack of resources, including support from supervisors and work colleagues that may leave employees feeling frustrated and stressed and making them more vulnerable to workplace abuse and bullying can be addressed by providing healthcare employees with workplace resources such as social support, job autonomy, organisational justice where all employees are treated equally and effective communication channels (Livne & Goussinsky, 2017). Such coping resources can mitigate the adverse impacts of high job demands (Livne & Goussinsky, 2017). In addition, balancing job demands with ample workplace resources will keep employees more engaged rather than burned out, eventually mitigating workplace tension. Regular assessment of job demands and resource availability can effectively address burnout and the potential of negative behaviours and bullying in the workplace (Van den Brande et al., 2016). In summary, the principles of job demand theory can help organisations address the negative behaviours and bullying while managing the resources and decreasing the job demands.

3.5.2. Affective Events Theory (AET)

AET, proposed by Howard M. Weiss and Russell Cropanzano, offers a platform to further explain the bullying phenomenon by particularly analysing the emotional experiences of healthcare workers (Weiss & Cropanzano, 1996). This theory explains that affective events (i.e., circumstances or situations) may cause emotional experiences for employees (Weiss & Cropanzano, 1996). AET explains that negative behaviours may result from negative emotional

responses caused by particular incidents, events or interactions in the workplace, which can then have a further escalation of bullying and a negative impact on job satisfaction and the performance of the employees (Christensen et al., 2023). The emotional responses to unfavourable circumstances or events often initiate a cycle of abuse or bullying where the perpetrators and the victims are involved in emotionally charged situations or negative interactions, making workers feel intimidated and intending to leave the organisation (Ciby et al., 2021). Literature supports the role of AET in explaining bullying. For instance, a negative interaction such as being humiliated publicly or exclusion of a worker in the workplace can give rise to the feelings of humiliation, exhaustion, frustration or anger, which has the potential to escalate into further abuse and bullying dynamics (Peng et al., 2016). A study found that affective events, for example, situations of passive leadership that do not support workers and avoid addressing workplace issues, can compromise healthcare workers' wellbeing and initiate bullying (Islam et al., 2022). This evidence is further supported by a study of 436 employees from the public sector of Malaysia that suggested that adverse events, such as coworkers not helping one another, were mediated by feelings of hurt and stress, which triggered workplace incivility (Ismail et al., 2018). Thus, examining the emotional responses in organisations may provide a platform for explaining a behavioural intention including negative responses such as incivility and bullying (Ismail et al., 2018).

As indicated earlier, bullying may emerge as a result of the negative events that may trigger emotional responses; in order to prevent bullying, AET can help recognise, address and mitigate the emotional triggers that may cause hostility and bullying behaviours (Christensen et al., 2023). The prevention and management strategies, therefore, have been identified as involving minimising internal stressors in organisations, such as stress and burnout due to workloads and time pressures. A study conducted by Naseen & Ahmed (2020) suggested that minimising emotional reactions to unwanted events through regulating the work climate can

help address bullying. They argue that bullying can be managed by preventing emotional exhaustion, providing a work environment, and creating a climate where conflicts are effectively addressed to avoid stressful situations for employees (Naseem & Ahmed, 2020).

The work environment and climate aspect related to AET is based on addressing stressors in employees' workplaces to accelerate safety and address bullying. Scholars have also indicated the role of AET in recognising how individuals' emotions and moods can be regulated by creating an environment of social support, recognition of the employees' work through rewards and recognition of their achievements (Luo & Chea, 2018). By doing so, individuals may be less likely to indulge in harmful behaviours resulting from stress, burnout and frustration or anger— the adverse emotional reactions triggering bullying (Wheeler et al., 2010). Because negative behaviours and bullying in the workplace are visible when negative emotions build up over some time, management strategies may consider focusing on early interventions at the time of the development of emotional progression and reaction processes (Mohr, 2020). For example, by introducing techniques for emotions management, providing support and resources to employees through providing additional job resources, social support, counselling, and conflict resolution (Ferris et al., 2021; Keashly et al., 2020; Wheeler et al., 2010). Negative responses to difficult circumstances and internal stressors can be prevented from turning into harmful behaviours and bullying (Mohr, 2020).

3.5.3. Social Identity Theory (SIT) and Self-Categorisation Theory

While JD-R theory and AET describe the development of the bullying process by describing workplace and organisational factors that may cause bullying, SIT focuses on the individual aspects that are discussed in the literature as factors that may be associated with bullying behaviours in organisations. These factors may be related to individual or group dynamics (Ojala & Nesdale, 2004). Several studies suggest individual group dynamics can influence bullying (Escartín et al., 2013; Ojala & Nesdale, 2004). Henri Tajfel first offered SIT in the

1970s as a framework to explain the dynamics of social categorisation (i.e., self-categorisation or how individuals categorise themselves in groups) and intergroup behaviours (Tajfel et al., 1971). The framework was later developed into SIT, which was effectively used to study intergroup dynamics and individual behaviours in group settings, particularly individual behaviours toward discrimination and prejudice. (Tajfel, 2010; Tajfel et al., 1971).

The SIT posits that individuals in a group or team perceive a sense of belonging and self-esteem through their participation and membership in teams and social group settings (Tajfel, 2010). In such a case, professional roles or departmental or workplace clicks can interfere with or impact the work environments in a way that distinctions can be seen among group members based on differences in professions, social rules, genders or ethnicities because people self-categorise themselves among members of the group they identify with depending on aspects related to age, gender, ethnicities and social norms (Spears et al., 1997; Tajfel, 2010). This self-categorisation phenomenon, which SIT also explains among groups, is closely related to another theory called self-categorisation theory, which builds on the SIT by describing the negative or positive behaviours people might exhibit during self-categorisation. (Glambek et al., 2020). Both the Self-Categorisation theory and SIT have been used to explain bullying as a process (Abrams & Hogg, 2010; Glambek et al., 2020). Self-categorisation can sometimes be associated with individuals engaging in negative behaviours and workplace bullying when they stereotype others or try to reinforce the dominance of the individuals or the group that they identify with or belong to while excluding the out-group members or rejecting the group they do not associate with (Gini, 2007; Tajfel, 2010).

Literature provides evidence of how the process of workplace bullying can be studied by SIT (Branch et al., 2004; Greacen & Ross, 2023). People may derive their sense of belonging and self from their perceived group (Abrams & Hogg, 2010). Thus, their behaviours may lead to a favouritism dynamic toward those who they think belong to their group. Additionally,

based on their social identity, individuals decide whether they would like to separate or associate with the solidarity of the group (Abrams & Hogg, 2010; Spears et al., 1997). More negative behaviours, discrimination, bullying, or aggression may be observed in workplaces where individuals set themselves apart and favour the exclusion of the members of the perceived outgroup (Abrams & Hogg, 2010). In conclusion, a workplace environment of favouritism for some members and discrimination for others may arise in workplaces, triggering abuse and bullying.

Bullying may arise when individuals strongly identify with members of the ingroup and view other colleagues as different or members of the outgroup. Thus, promoting a shared identity in organisations may foster respect by emphasising a sense of belonging for all. Individuals may be less likely to behave negatively toward people of different races, gender and sexual orientations (van Dick & Haslam, 2012). Fostering unity through shared goals and similar values and experiences may minimise the emergence of discriminatory or aggressive behaviours and bullying toward out-group members (Kay, 2015). Additionally, by reducing the distinction between ingroup and outgroup members by introducing shared activities in the workplace and encouraging interactions between different teams and groups by introducing a shared group project, team-building activities may foster positive intergroup relations so that individuals may perceive one another as equals, whether as a means of through exhibiting negative behaviours or reinforcing in-group preferences (D'Cruz & Noronha, 2012; Zapf & Vartia, 2020).To prevent bullying, it is essential to foster understanding across different groups.

By sharing experiences and mitigating stereotypes. Individuals may be able to see things from the perspective of other people, which may reduce conflicts or bullying, and diversity training, anti-bullying campaigns have been reported to help individuals recognise their own biases and understand the adverse impacts of prejudice (Saam, 2010; Zapf & Gross, 2001). By eliminating stereotypes, people are far less likely to marginalise or abuse those they

perceive as different to them. Emotional support encourages victim empowerment and provides opportunities for victims to re-reclaim their role. Counselling and peer mediation programs can help victims regain confidence and restore their social identity (Ferris et al., 2021; Lassiter et al., 2021). In the context of SIT, empowering bystanders could be beneficial because they often play a critical role in the bullying dynamics (Lassiter et al., 2021; Paull et al., 2012). According to SIT, bystanders may either reinforce negative behaviours or bullying by either supporting the bully or they may help address bullying by challenging the bully or defending the bullied workers (Ullah et al., 2024). Thus, educating bystanders and empowering them to support the victim by speaking out against negative behaviours in the workplace can potentially prevent bullying from further escalating (Paull et al., 2012). If bystanders support the victim, rather than being passive, it may shift group norms to zero tolerance to negative behaviours (Mazzone, 2020).

Both SIT and self-categorization theory offer valuable insights into the explanation of bullying, as well as its prevention and management. By considering the group identity, in-group/out-group dynamics, and the social structures that promote inclusivity for all genders, ethnicities and backgrounds in the workplace, bullying can be addressed effectively. Through the application of Social Identity and Self-Categorisation theories, safe work environments can be fostered where bullying is discouraged, and respect and inclusivity are central to group identity.

In conclusion, workplace bullying is a complex phenomenon influenced by individual, group, and organizational factors. JD-R theory, AET, SIT and Self-Categorisation theory provide valuable insights into its causes and consequences. The interplay of gender, immigrant status, and professional hierarchy further highlights the need for targeted interventions to address bullying in diverse workplace contexts. Organisations must prioritise creating inclusive

cultures, fostering open communication, and implementing robust policies to mitigate the prevalence and impacts of bullying.

3.6. Summary and Focus of Current Study

Workplace bullying is a widespread phenomenon in healthcare organisations. Several scholars have offered significant accounts of bullying prevalence and its antecedents, yet the explanation of bullying processes is an under-explored area. Exploring the theories that may help explain the bullying phenomenon is crucial for designing and implementing effective preventive and management interventions. To date, there seems to be an absence of exploratory studies that focus on explaining workplace bullying and its prevention and management in New Zealand junior doctors by looking at the theories that could explain the bullying process.

The current study is based on exploring theories explaining bullying. The theories and theoretical constructs described in this chapter include organisational/safety culture, power dynamics including oppression theory, structurational divergence theory, and ecological system theory. In addition, other theories in the extant literature that have been identified to explain the development of bullying and bullying as a process, such as JD-R theory AET, SIT and Self-Categorisation theory, are also presented in this chapter. This study aimed to explore the theoretical explanations of bullying of junior doctors to assist in the prevention and management of bullying in New Zealand's hospitals. This chapter was guided by investigations into which theories or theoretical constructs explain bullying and its management. The next chapter includes the methods and methodology adopted to gain qualitative perspectives of NZ junior doctors' explanations of bullying, using several theories.

Chapter 4: Methodology and Method

This research aimed to explore the theoretical explanations of bullying of junior doctors to assist in preventing and managing bullying among New Zealand's junior doctors. The following research questions guided this research:

> ***RQ1: What are the theoretical explanations for bullying of NZ junior doctors?***
>
> ***RQ2: How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?***

This chapter describes the methodology and methods used for this study. The research design is explained in this chapter, along with the philosophical assumptions guiding the study. Data collection and analytical procedures are also discussed.

4.1. Research Design

Research design is the framework of actions that strategically align the research aims and questions with the methodology or data collection techniques to guide the research process (Blanche & Durrheim, 2006). An effective strategy for developing a research design is aligning the research aims with a methodology that helps attain the research aims (Vanderstoep & Johnson, 2009). This was a qualitative study that included an interpretive research design. Interpretive approaches are inductive in nature and are applied in qualitative research because they are beneficial for exploring new concepts, understanding complicated problems, and explaining individuals' interactions, behaviours and beliefs (Hennink et al., 2020).

In addition, a qualitative approach is suitable when researchers examine a sensitive issue or aim to understand a particular process, because qualitative approaches can facilitate the cautious exploration and explanation of the research topic. Qualitative approaches are also important for studying individuals' interactions, shared values, and beliefs (Hennink et al., 2020).

This research design aligned with the aim and research questions of this study for several reasons. Considering the aim and objectives of this study, it was crucial to adopt an approach that

encouraged and described the perspectives of the individuals involved in the study. Also, during the research, there was potential for identifying some sensitive experiences and challenges for individuals (e.g., elements of the healthcare workplaces for junior doctors). Therefore, a qualitative approach was selected to facilitate the research process and guide the enquiry, even of such sensitive circumstances.

A qualitative approach may explain how various patterns or events happen over a period in a particular context (Bell et al., 2022). Thus, it was used to explore aspects of bullying that could explain theoretically, and prevent and manage bullying of NZ's junior doctors. A qualitative approach could unravel specific processes to help participants identify and describe factors relevant to the process of bullying and how bullying is managed in NZ's junior doctors' workplaces.

A study's research design differs from research methodology (Bell et al., 2022). While the research design explains how to approach a problem, research methodology illustrates how to apply the research design (Bell et al., 2022). The research methodology of this study is constructivist grounded theory (CGT). CGT seeks to generate new theories through inductive analysis of data collected from study participants. CGT was first developed by Kathy Charmaz (2006) as an adaptation of the grounded theory proposed earlier by Glaser and Strauss (1967).

Methodologically, CGT is interpretive because the idea of a shared and co-created reality is interpreted by the researcher. Through interaction between the participants and the researcher, the reality is discovered through exploration of various contexts, including structural, cultural and temporal aspects (Charmaz, 2000). The CGT methodology starts early in the research process with the research question and sampling. Data are collected using approaches that align with CGT. Further accounts of CGT methodology and the rationale for using CGT for this study are discussed in the next section, which also describes the philosophical underpinnings of the study.

4.2. Philosophical Underpinnings

Before starting a study, researchers must assess the philosophical underpinnings or worldviews they will use (Creswell, 2017; Rieger, 2019). The philosophical underpinnings of research refer to the conceptual and metatheoretical aspects that guide the research process, and they also must include researchers' assumptions (Creswell & Poth, 2016; Duberley & Johnson, 2015). These assumptions include the following features: (1) the procedure to conduct the research (methodology), (2) how the researcher knows what is known (epistemology), (2) how the researcher perceives reality (ontology), and (3) the value stance or what is valued by the researchers in the research (axiology) (Creswell, 2017). All these assumptions inform the inquiry through a 'set of beliefs' called paradigms or worldviews. The worldviews or paradigms are applied through interpretive frameworks in qualitative studies (Creswell & Poth, 2016).

4.2.1. Methodology: Constructivist Grounded Theory

Understanding a study's paradigms or philosophical assumptions begins with comprehending how these align with the overall research process and where they fit within a study (Creswell & Poth, 2016). The philosophical underpinnings of CGT methodology relate to the constructivist paradigm. Constructivism reflects the subjective interconnection between the research participants and the researcher, and the co-construction of the meaning (Mills et al., 2006b). Researchers are a part of the research process, rather than being notetakers or observers of objective reality (Guba & Lincoln, 1994; Mills et al., 2006b). Therefore, researchers' ideas and values must be considered by them and others as a critical part of the research (Guba & Lincoln, 1994; Mills et al., 2006b).

CGT branches away from Glaser and Strauss's (1967) traditional GT and adopts a constructivist approach that illustrates how realities are constructed (Charmaz, 2006; Lauridsen & Higginbottom, 2014). Glaser and Strauss applied an inductive method to their study of dying individuals' treatment and allowed for theory development without the guidance of a pre-existing

theory (Charmaz, 2006; Glaser & Strauss, 1967; Lauridsen & Higginbottom, 2014). While most social sciences and management accounts have described how theories can be tested based on accurate facts, Glaser and Strauss argued that ideas discovered from the data—carefully obtained and systematically analysed—can be offered and extended (Glaser & Strauss, 2017).

Researchers' beliefs and assumptions or philosophical underpinnings guide the research questions and affect the interpretations and recommendations made during the research (Creswell, 2017). However, a study may also be driven by theories or theoretical positions that frame the research process (Creswell, 2017). These theoretical positions define the methodological beliefs or approaches that address the research questions (Creswell, 2017). Unlike the traditional grounded theory version, CGT illustrates the research process and the outcome in social, historical and situational contexts (Charmaz, 2006, 2017). This study required interpretive frameworks such as CGT because interpretive frameworks can answer research questions through methodological approaches that are inspired by inquiry.

Many methods can be used in theory testing (deductive) or theory building (inductive) approaches (Alemu et al., 2015). CGT is an approach that does not rely on testing a particular theory; rather, it depends on the researcher and the participants to construct the meaning and identify the theoretical approach from the perspective of the participants (Alemu et al., 2015). This research focused on exploring which theories or theoretical constructs explained bullying of NZ junior doctors. While existing theories might provide an explanation of bullying, a clear picture of the exact process behind the bullying of NZ junior doctors was missing. Rather than testing a pre-formed hypothesis or theory through a deductive approach to discover whether the theory might work, this research focused on an inductive, interpretive approach to exploring the bullying phenomenon and finding the explanations for the bullying process through empirical data gathered from interviewing participants. It provided a platform for cocreation with participants and reflexivity during the data collection and analysis stages, which is vital

for CGT. A CGT approach in this study, therefore, could lead to either the development of existing theories or the building of theories of bullying, relevant to the context of NZ's junior doctors.

4.2.2. Epistemology

Epistemology, a branch of philosophy, deals with exploring the nature, origin and methods of acquiring knowledge, and the limits of human knowledge (O'Connor et al., 2018). A researcher's epistemological stance, therefore, has a vital influence on their choice and use of research methodology (O'Connor et al., 2018). Recent epistemological changes and methodological extensions to CGT provide a platform for integrating grounded theory with critical inquiry and upgrading it through the research process (Charmaz, 2017). As a methodology, CGT fits within the frames of subjectivism (epistemology), where it shapes the interaction between the researcher and the participants. While doing so, it offers the idea of the researcher being an integral part of the research process (Charmaz, 2006). Subjectivism points to the notion that knowledge is constructed socially, and people's experiences and interpretations illustrate their understanding and knowledge of the world around them (Gewirth, 1954). Subjectivism states that meaning is not embedded in the data but arises from the interactions and viewpoints of the individuals (Gewirth, 1954). It is through subjectivism that researchers seek to explore multiple perspectives to construct knowledge (Gewirth, 1954).

4.2.3. Ontology

CGT has an ontological position (i.e., nature of reality) in relativism. A relativist ontology assumes that because of the scarcity of absolute truth, the researcher might not be able to comprehend the 'single' reality existing out there, because this single reality might not exist around us but may be present beyond ourselves (Creswell, 2017; May & Mumby, 2004). Researchers who do not accept the presence of an objective reality affirm a relativist position regarding ontology. This is because relativists believe that ideas such as truth, objectivity, reality, norms, right and good

are to be explored and understood relative to a particular conceptual system or a theoretical framework--a paradigm, culture, society, or a lifestyle. The plurality of these ideas and concepts cannot be reduced. In short, the world can be understood via several individual realities (Guba & Lincoln, 1994; Mills et al., 2006b). CGT provides a platform for interaction between the researcher and the research participants, exploring their understanding of the world around them. It finally leads to the co-creation of a shared reality.

4.2.4. Axiology

The philosophical aspects related to the role of values (i.e., value stance) concerning researchers are described as 'axiology' or 'axiological position'. This has implications for researchers' perceptions of values and their roles in the research process. Axiology examines the values and illustrates managing issues and dealing with right and wrong. It observes developmental levels and emotional bias. In CGT frameworks, researchers' biases should not be portrayed in the study; there is a need to control and address the researcher's biases (Creswell & Poth, 2016). The CGT approach argues that a dialogue is present between the researcher and the participants of the research (Bryant, 2003). To co-create the reality, a neutral stance must be taken. During this research, I took a neutral stance, focusing on recognising and eliminating my biases.

4.3. Sampling and Participants

In CGT, data is collected through in-depth interviewing until saturation is reached (Charmaz, 2006). Participants are recruited continuously until no new information results from current samples during data analysis (i.e., the point when theoretical saturation is reached) (Bryman & Bell, 2015). A purposeful sample selection strategy was used in this research to provide rich data exploration (Edmonds, 2019).

This study's participants were either junior doctors who experienced or witnessed bullying, or senior doctors familiar with bullying in their workplaces. The latter had an awareness of larger issues relating to bullying junior doctors in the workplace, were involved in bullying prevention

and management, or experienced bullying when they were junior doctors. After considering the scope of this study and the relevant time constraints, recruiting 20-30 participants was initially considered. Participants were first recruited through purposeful sampling (i.e., selecting participants based on their knowledge, experience and characteristics) (Bell et al., 2022). Then, snowball sampling (i.e. a recruitment approach in which research participants identify other potential participants) was used to extend participant recruitment (Bell et al., 2022).

Participants of this study were accessed via the junior doctor's unions, the Speciality Trainees of New Zealand (STONZ) and the New Zealand Resident Doctors Association (NZRDA) and through personal networks. First, I contacted STONZ and NZRDA via email and phone respectively and briefed their representatives about the aim and objectives of this research. The broader implications and benefits of the study were also explained to the union representatives. After the initial coordination and discussions, union representatives distributed participant information sheets (see Appendix D). STONZ published posts on their social media network to inform their members so that potential participants could contact me about the study. After distributing the participant information sheets and social media posts, some junior doctors contacted me directly by email or phone and scheduled interviews.

Recruiting participants through doctors' unions was beneficial because these unions had junior doctors (e.g., post-graduate year or PGY2, resident medical officers or RMOs and senior house officers or SHOs) as members. I recruited participants through doctors' unions because of the assumption that junior doctors and doctors under training are familiar with bullying. They may have seen it happening to other junior doctors or experienced it themselves. They might also have been involved in managing bullying. These participants could potentially help explain the process and provide explanations of bullying in their workplaces or organisations where bullying might be happening.

STONZ and NZRDA were significant sources of participant recruitment. However, due to doctors' busy schedules and several cancellations, personal contacts and networks were also used to recruit additional participants through a snowballing approach. Senior doctors such as general practitioners (GPs) and consultants were also included as eligible because they had gone through speciality training and were aware of the work environment of junior doctors and their training process. There were numerous advantages to having a broader pool of participants. First, senior doctors could provide accounts of bullying of junior doctors both from their previous and current experiences. They had undergone extensive training as junior doctors and were aware of bullying during their early years of speciality training. Second, consultants and GPs were more willing to participate as they were relatively senior in their roles. Therefore, they were comfortable offering their accounts on the sensitive topic of workplace bullying. During the recruitment and data collection process, I noticed that some junior doctors cancelled mentioning that they were vulnerable due to their training status and therefore scared to share their experiences openly.

Some cancellations also resulted from doctors being over-worked, particularly in the COVID-19 phase in hospitals. Recurring waves of COVID-19 in NZ affected participant recruitment and the process of interviewing because of the high workload and on-call requirements. The recruitment time for this research was therefore extended to keep recruiting participants until saturation was reached. Similar patterns and themes emerged in the data after seven to eight interviews. Saturation was reached at 20 interviews, and therefore, recruitment stopped.

To protect the privacy and confidentiality of the participants, the demographic details of the participants are given in this thesis in the form of descriptive accounts rather than as a table. All 20 participants worked at healthcare organisations under several different DHBs (District Health Boards) in both the North and South Islands. Most participants were affiliated with DHBs in the North Island. Participants identified as either male or female, with 13 participants

identifying themselves as male and seven as female. All participants were in the age range of 20-70 years. Five participants were in the age range of 20-30 years; five were aged 30-40 years; two were aged 40-50 years; six were aged 50-60 years; and two were aged 60-70 years.

Participants were from a range of specialties and departments including geriatrics, medicine, general surgery, psychiatry, vascular surgery, radiology, emergency medicine, gynaecology and obstetrics, neurosurgery, neonatal/paediatrics, and orthopaedics, providing rich and diverse data. Roles identified by the participants included house officer, senior house officer (SHO), PGY1 (postgraduate year 1), PGY2 (postgraduate year 2), PGY3 (postgraduate year 3), resident medical officer (RMO), registrar, clinician, consultant, surgeon and senior surgeon, senior medical officer, and clinical director.

4.4. Data Collection Approach

4.4.1. In-depth Interviews

Qualitative methods such as CGT often employ in-depth, intensive or one-on-one interviews (Charmaz, 2006). In-depth interviews are beneficial for collecting, exploring, and interpreting data from individuals, including when individuals with similar attributes see the world differently (Bell et al., 2022). Due to the significance of personal interactions in generating rich data, in-depth interviews were a suitable method for this study. In-depth interviews were suitable for this study to support participants share their views with ease, and also to protect privacy and confidentiality (Bell et al., 2022). Workplace bullying is a sensitive topic for some participants. One-on-one interviewing ensured that participants shared their thoughts with ease and without worrying about identity and privacy issues. In other methods (e.g., focus groups), participants may hesitate to share their ideas; also, their responses may be influenced by other individuals in the focus group (i.e., the group effect) (Bell et al., 2022). Consequently, the credibility of the collected data may be affected (Bell et al., 2022).

4.4.2. Semi-structured Interviews

Qualitative research offers various data collection methods, including focus groups, face-to-face interviews, ethnography, and case studies (Creswell, 2017; Hennink et al., 2020). However, for this study, semi-structured interviews were chosen. Semi-structured interviews allow the participants to participate in the research process and discuss their views about the specific topics essential to individuals working in a particular environment (Creswell, 2018). NZ junior doctors could offer meaningful data by examining the bullying process in their specific work environment or healthcare organisation. Therefore, semi-structured interviews were chosen for this study.

Qualitative researchers often use semi-structured interviews for data collection because they enable the use of both structured and unstructured interviewing techniques (Roulston & Choi, 2018). Semi-structured interviews help the interviewer to probe deeply, allowing flexibility, as seen in unstructured interviews (Bell et al., 2022; Roulston & Choi, 2018). Interpretive designs often employ semi-structured interviews as a data collection technique because they offer some structure to participants, who may comfortably convey their views and concerns (Bell et al., 2022). As a result, the researcher can receive meaningful information (Bell et al., 2022).

A semi-structured interview should last between 60-90 minutes to ensure the quality of the collected data (Bell et al., 2022). To estimate the duration of the proposed interviews for this study, two pilot studies were conducted with one medical student and a senior doctor. These interviews lasted between 45 and 90 minutes. The average time for the rest of the interviews for this study was 65 minutes.

Consideration was given to exploring policy documents and organisational databases. However, considering the fact that this research involved exploring lived experiences of bullying of NZ junior doctors, policy documents might not have captured the individual perspectives on bullying. They may also fail to show how bullying could escalate in the world of the participants. Further, bullying is a sensitive topic, and victims could be reluctant to report it because of the fear

of retaliation. The possibility of underreporting in organisational databases and policy documents could be a concern. More importantly, ethical considerations related to accessing the policy documents and organisational databases could challenge the effective progression of the research. Thus, it was decided that data would be collected through in-depth interviews only.

4.5. Data Collection Procedures

4.5.1. Interview Guide

The interview guide typically consists of (1) an introduction involving a brief introduction of the researcher, a brief explanation of the aims and the objectives of the study, protection of privacy, confidentiality, and the outcome of the research (e.g., research report or article etc.); (2) opening questions, which are broader but still relate to the topics in the study; (3) core questions which are critical questions designed to collect the most relevant information to answer the research questions. 'Probes' are also used during core questions to dig deeper, get detailed information, understand the hints and subtle variations in meanings of what is shared, and explore the problems from a participants' perspectives; and (4) closing questions, which lead to the end of the interview (Bell et al., 2022; Hennink et al., 2020). Effectively closing interviews is essential when the study involves a sensitive topic, and therefore, additional questions may be required to close the interview process safely (Hennink et al., 2020). Following these criteria, an interview guide was developed, including an introduction, and opening, core, and closing questions.

The interview guide consisted of opening questions Q1-5 that enquired about the roles/ positions of the junior doctors within their organisation, their working hours and length of employment, and their general views about why the junior doctors (i.e. PGY2, RMOs, HOs and SHOs or doctors under training) decided to take part in this study (see appendix E for interview guide). Clarifying the interviewees' roles or positions was important because participants could offer different views depending on their roles, experiences, and characteristics. These questions further explored to what degree participants were familiar with bullying, its prevention and

management and in what role (i.e., as bystanders, bullied or involved in managing bullying). Q4 enquired about participants' responsibilities regarding their role. This was to ensure that the recruited participant was related to the sample. Q5 asked what made participants take an interest in the study. It helped explore multiple viewpoints from participants to address the research aim.

Core questions, such as Q6, investigated how the participants were familiar with bullying. This provided insights into each participant's position in a detailed way (i.e. a victim, bystander or involved in bullying management). Probes about the causes of bullying in their workplaces offered understandings and explanations of bullying in particular departments, specialties or workplaces. Q7 was intended to inquire directly about participants' perceptions of their work environment's specific characteristics and associated factors that led to bullying behaviours in their workplace. General core questions and probes about individual, social, and organisational factors encouraged discussion around perceptions of these layers and their role in bullying prevention and management in participants' organisations.

Q8 was intended to gather participants' views about culture, hierarchy, and power dynamics. Probes about rules and regulations and opposing structures were used. Similarly, Q9 focused on participants' views on how contradictory cultural and social units could lead to bullying. Indirect probes were used to facilitate the sharing of ideas around these concepts. I used indirect probes to facilitate participants' understanding of unfamiliar concepts. Participants offered examples of workplace units with opposing structures that resulted in patterns leading to workplace bullying. Q9 was an efficient way of positioning the researcher as the participants' partner in the research process rather than as an objective analyst of subjects' experiences, which is vital to developing a CGT research design.

Q10 was intended to identify the specific aspects of bullying prevention and management (including individual, social and organisational factors for prevention and management, trainings for bullying management, and managers' support) for NZ junior doctors. Q11 asked participants

to offer suggestions around prevention and bullying management to help identify the role of managers, leaders, and rules and regulations in organisations in managing bullying effectively. In conclusion, the interview schedule specifically involved questions that were intended to find answers to the research questions and achieve the aim of the research. All interviews were conducted following an open-ended approach to get the most relevant information. Participants were asked if they had any questions for the researcher or if they wanted to share any further accounts of the topic. Interviews were closed following the participants' permission.

4.5.2. Data Collection Mode

Interviews were conducted in-person or online (via Zoom) according to the preferences of the participants due to post-COVID schedules and the workloads of the participants. Studies suggest that online interviews are the most satisfactory and preferred qualitative interviewing method by participants from the healthcare sector because of convenience, security features, cost-effectiveness, and time-saving options (Archibald et al., 2019). Online interviewing ensures timesaving because of the absence of travel requirements, as in the case of in-person, face-to-face interviews (Gray et al., 2020). Further, online interviewing was provided because it could facilitate collecting data from participants at different geographical locations (Gray et al., 2020).

In qualitative interviewing, recall bias may happen, which means the participants may find it challenging to recall certain events accurately due to time lapses, memory issues, or their current emotional states (Bengo, 2006). This could have implications for the data quality and reliability of the qualitative research. In order to address the recall bias, a comfortable and trusting environment was created. Time was taken to build rapport with the participants. Participants were asked probing questions to help them remember the relevant situations thoroughly and accurately. Additionally, participants were offered the transcripts of their interviews if they wanted to add something. Participants were given the opportunity to choose a location for the interviews, which

also helped them stay comfortable during the interview so they could share the events in their preferred environment,

Choosing a location for interviews is vital in qualitative studies to minimise disturbances; disturbance can be avoided by selecting a site in a quiet environment (Bell et al., 2022). In-person interviews were conducted in many different locations based on participants' choice, confidentiality, privacy and availability of a calm and quiet environment. Most in-person interviews were conducted outside of the participants' workplaces.

4.5.3. Recording

In-person interviews can be recorded for documentation and analysis by audio and videotaping (Bell et al., 2022). All interviews were audiotaped. Before the interview, I informed all participants that interviews would be recorded. All participants consented to be audiotaped. During research, it is essential to protect the recordings of interviews to ensure participants' privacy and maintain confidentiality (DiCicco-Bloom & Crabtree, 2006). All recorded interviews were saved on my password-protected laptop. No one had access to the audiotaped interviews other than the interviewer. Later, the recorded interviews were transcribed. Interviews were transcribed soon after they were recorded.

4.5.4. Transcribing

Transcribing the interviews is an essential step before CGT data analysis. Professional transcription services were used for six participants who allowed professional transcription. For the remaining 14 participants who did not allow professional transcription, I transcribed the interviews myself. Professional transcribers may have problems during the transcription process due to misunderstood words in lengthy interviews, which may impact the accuracy of the transcribed interviews (Al-Yateem, 2012; DiCicco-Bloom & Crabtree, 2006). However, professional transcription saves time. To avoid issues related to the interpretation of transcribed data, such as misunderstanding of content and meaning, I listened to the audio tapes of all 20

interviews and read the corresponding transcripts simultaneously. This ensured the accuracy of the interpreted interviews to a greater degree. The transcripts of all interviews totalled 351 pages.

4.6. Ethical Considerations

Before starting this study, all aspects of research ethics were discussed with my supervisors. Accordingly, ethics approval was sought from the University of Waikato research ethics committee. The study was approved by the University of Waikato Human Research Ethics Committee under approval HREC2021#56 (see Appendix G).

This study involved no direct physical harm to the participants. However, there was a possibility of participants feeling stressed or anxious while sharing their views and experiences. When a participant seemed stressed or anxious during or after the interview, I encouraged them to take a break and contact their Employee Assistance Programme (EAP) or private counsellor if needed. It was also considered that I seek therapy if overwhelmed or stress emerges while listening to participants' experiences. The primary ethical considerations concerning this study were confidentiality, informed consent, voluntary participation, and participants' protection rights. Accordingly, participation in the study was voluntary and based on informed consent. When a participant required additional information, I answered the participant's inquiry through an email or talked to the participant on the phone or in person, depending on the participant's availability and preferred way of contact. Before starting the interviews, I explained the aims of the research to all participants. Participants were assured of privacy and confidentiality. I also mentioned participants' rights to withdraw from the study and provided the information sheet (see Appendix D) and consent form (see Appendix F). Following this, I asked participants to provide formal consent if they wished to participate in the study. If participants were willing to participate in the study, I asked them to sign the consent forms before starting the interviews. Alternatively, participants also had the choice of providing their consent via email or verbally on the audio recording before the start of the interviews. To protect participants' identities and privacy,

pseudonyms were allocated to all research participants (e.g., P01, P02, and P03). Participants' identities were not revealed during any stage of the study.

4.7. Role of Researcher

In qualitative studies, it is essential to describe the researcher's values, perceptions, and biases at the beginning of the study because the researcher is the primary data collection tool (Creswell, 2017). Charmaz (2006) and Mills et al. (2006b) suggested that in CGT, the researcher plays the role of an author because the CGT develops an interactive process between the researcher and the study participants. Thus, the researcher's position is that of a partner in the research process; researchers' ideas are valued.

Researchers' perceptions and contributions to a study influence the research setting positively rather than unfavourably (Creswell, 2017). Therefore, I tried to take a neutral stance throughout the research process. Participants were not judged based on their personal views and choices. I consulted with my supervisors throughout the research to eliminate bias and ensure the validity of the findings. I shared the transcripts and interpretations with participants for feedback after the interviews, which is an essential step in procedures relating to CGT research (member checking). In CGT the researcher's potential for bias is recognised. Researchers are advised to stay impartial during the analysis; rather than relying on their own judgement to interpret the data, researchers must follow the logic and points of view of the participants. Due to my previous experience of observing female healthcare workers being bullied frequently, I had a bias that female healthcare employees are bullied more than male healthcare employees. I was aware of my bias during the analysis. I maintained a neutral stance to facilitate the data analysis. Further accounts about addressing my bias are provided later in this chapter in the theory development section.

4.8. Data Analysis

Data analysis aims to find meanings in the data collected during the research (Ghauri et al., 2020). For this study**,** the inductive method of CGT) was used, where research is a repeated process and results from data collection and continuous analysis (Charmaz, 2006). In CGT, the data analysis phase progresses along with the other steps of the research process—with steps that were previously taken during the research (e.g., data collection) and are designed to obtain meaning from the data to address the research questions (Creswell, 2017; Creswell & Poth, 2016; Ghauri et al., 2020). The steps of CGT analysis are explained below.

4.8.1. Steps in Constructivist Grounded Theory Analysis

CGT analysis involves the steps of the traditional grounded theory including theoretical sampling, memo writing and coding (Charmaz, 2017; Mills et al., 2006b). Theoretical sampling was discussed in the participants and sampling section. The other steps of CGT analysis – member checking, memo writing, coding (initial and focused coding) and theory development - is described in the following sections.

4.8.2. Member Checking

Member checking, also known as respondent validation or participant validation, is a step in CGT procedures that is used to enhance the collected data's trustworthiness. This is a process in which the researcher checks the accuracy of the transcript (Barker et al., 2010). After the data is collected and transcribed, the data or results are returned to the study participants to ensure accuracy and to determine whether the data gathered offers accounts that resonate with the study participants. By doing this, participants are offered an opportunity to add or subtract material that does not resonate with their recollection of the discussion. After the data was transcribed, I provided each participant with their transcripts to validate them. Only one participant offered additional material that built on their views provided in the interview.

4.8.3. Memo-Writing

Memo writing includes note-taking during the interview, coding, and analysis. It allows the researcher to observe participants' actions and experiences and engage with the data to see connections, similarities, patterns, or contrasts. It also provides a platform for developing an understanding of the phenomena being explored or studied, accurate participants' accounts and stories.

There is no one way to write a memo. Memos can be in any form, written or digital. Memos are essential in the CGT analysis to enable the constant comparison of the data and codes identified through the transcripts. During every interview, I took notes and wrote memos. Memos were written at the time of the interviews and before, during and after. Memos helped me to recognise data patterns and facilitated further concept development during constant comparison. This practice aligns with the constructivist grounded theory approach, emphasising the co-creation of reality with the participant. An example of a memo about one of the participants is given below.

Table 4.1 An example of Reflective Memo (P08)

Codes: Hierarchy, workload, training structure, culture leading to bad behaviours, micropolitical agenda of individuals, bullying due to culture, variation between cultures of different healthcare setups, female and male bullying dynamics, work pressure, team dynamics escalating bullying, acceptance of bullying, cultural norms of the medical departments,
The participant is a relatively senior doctor under higher level surgical training (PGY3 above). They are working in a team where they facilitate PGY1 and PGY2 doctors. They are a trainee in a large public hospital in the North Island. They hold qualifications in a critical surgical speciality. The participant completed some of their medical training in Ireland and Australia. They had significant accounts to offer about bullying in the NZ healthcare sector; They seemed a bit distressed a couple of times while sharing their thoughts. I asked them if they felt okay and comfortable sharing their views further or if they wanted me to stop asking them any questions. I encouraged them to take a break if they felt upset. They told me that they were okay and wanted to talk for a while about this topic. I stopped the interview two times at the participant's request. The participant experienced bullying during their training. They were quite sensitive because of what they had experienced. They also observed other junior doctors being bullied and talked about the culture of their department and how junior and immigrant doctors experienced bullying more than local doctors. The participant had some exciting stories about their experiences in rural healthcare facilities in NZ.

4.9. CGT Analysis

4.9.1. Initial Coding

In CGT, the analysis process begins after conducting the interviews, transcribing the interviews and writing memos. Charmaz (2014) stated that coding creates a vital link between collected data and analysis. CGT analysis transforms the raw data into meaningful concepts or theories describing the relevant social processes. Data were transcribed after the completion of each interview. After transcription, I read each transcript line by line and paragraph by paragraph to separate the first or initial set of codes. Coding involves two phases, the early, *initial coding* phase and then *a focused, selective* phase. Initial coding involves labelling every word or sentence in the qualitative data and breaking them down into distinct segments (Charmaz, 2006). Open coding, as implied by the name, opens the researcher to many different possibilities of theoretical concepts. I coded the data manually because it was an opportunity to look deeper into the data (Charmaz, 2006). Focused coding comprises sorting, synthesising, integrating and arranging data to recognise various themes and find the relationships between these themes (Charmaz, 2006).

The initial coding process was centred around open coding, i.e., recognising and labelling the data considering the participants' actions and experiences. I also took copies of the transcripts and coded them word by word, and line-by-line with gerunds (coding using verbs ending in letters 'ing'). This helped with identifying distinct processes in the data. I also listened to interview recordings when coding to understand the participants' worlds and experiences. This allowed me to fully immerse myself in the data.

4.9.2. Constant Comparative Analysis

During the constant process of listening to interviews and reading transcripts, I kept referring to previously read and coded interviews, ensuring constant comparison of data and codes while coding. This process of constant comparison or constant comparative analysis is a critical aspect of CGT analysis and the focused coding process. The ongoing comparative analysis results in the core categories where discrete data are seen as initial or open codes, categories, and themes. Different parts of the data are constantly compared to discover similarities and variations, recognise interrelationships, and generate connections.

Going back to the initial codes identified in several transcripts and comparing them to the other transcripts, helped me recognise the recurring patterns of concepts in the data. I then separated these sets of codes or initial codes as open codes. The open codes are listed in Table 4.2.

Table 4.2 The First set of Open Codes from all Interviews

Bullying is a norm in healthcare workplaces.	Command and control system	Intradepartmental variations in rules and regulations	Interdisciplinary competition among doctors	Ineffective bullying prevention and management
The normalisation of bullying behaviours	Fear of retribution	Gender-based bullying	Immigrant vs local medical trainees and practitioners	Ineffective policies
Bullying is a teaching practice.	Professional competition	Training requirements of junior doctors	Organised bullying	Lack of preventive measures
Culture of compliance	Lack of trust in managers and leaders	Professional development system	Inefficient reporting system	Lack of staff training
Interdepartmental variations in cultural values indicating the degrees of bullying	Poor-communicative practices escalate bullying	Favouritism	Shame concerning bullying behaviours	Poor organisational support
Professional expectations and pressure causing bullying	Workload causing bullying	Poor interpersonal relationships	Ignorance	Oppression by seniors
Internalisation of bullying	Micropolitical agenda of hierarchy—Personal aspirations	Bullying personalities	Doctors' resistance to speaking up against bullying	Systemic issues impacting bullying management
Bullying as a repetitive cycle of abuse	Culture of blame and shame	Scapegoating	Active role of the victim in preventing and managing bullying	Cooperation and coordination of leaders in preventing and managing bullying

After separating the initial codes, I reflected on the whole process of initial coding and wrote memos about what was happening in the participants' worlds. How did they experience the bullying, and what were their thoughts and reflections in response to my questions during the interview? I had also written memos when I captured interviews. I also referred to the notes I wrote during the interviews. I read those notes again while going through each transcript and separating initial codes.

4.9.3. Focused Coding

Focused coding is the next step of CGT analysis after the initial coding. It also initiates the theoretical coding process which is the development of a relational framework connecting all significant codes to the relevant themes and generating core category. Charmaz (2014) encouraged researchers to be innovative in the CGT analysis approach. Determining the core category is the process which facilitates generating themes from the available data as the analysis proceeds. I developed multiple core categories considering Charmaz's (2014) recommendation to be transformational during the analytical process. An advantage of developing multiple core categories was a thorough interpretation of the data. In addition, developing multiple core categories provided a concrete view of the themes that resulted in a particular core category. A supra-core category was also developed through open and focused coding, which had themes from other core categories. Core categories are recognised and integrated into groups with various concepts during the focused coding stage. To integrate the core categories, I chose a core category and then redescribed the story of that core category using the other concepts and categories during the analysis. Properties or themes of each core category were separated and grouped with their relevant subthemes.

The researcher needs to consider several aspects and questions to proceed to the theoretical stage from the initial coding stage. For example, what makes the participants think, feel or act in a particular manner? What could be the participants' experiences or thoughts towards the phenomena or topic under research? What are some of the consequences of participants' perceptions or actions? Once I started considering these questions along with constant comparison of data and memo writing, codes appeared consistently as recurring patterns among the initial codes. These codes resulting from focused coding process were more precise and significant. During focused coding, the emerging codes are filtered, organised, synthesised, and analysed from the enormous amounts of data (Charmaz, 2014). I continued

the constant comparison during this stage and wrote memos as I did in the first stage of initial coding. As the analysis continued, I wrote notes in my research journal to understand my steps during the various data analysis stages. Open codes and focused codes were developed (see Table 4.3 for open codes and focused codes).

Table 4.3 Open Codes and Focused Codes

Open Codes	Focused Codes
Personal traits and social characteristics	Individual and social attributes of bullies and victims
Favouritism, Competition, Conflict, Differences in rules and regulations	Team dynamics
Individuals higher in the hierarchy foster bullying, power-dynamics, an imbalance of power, misuse of power, command-and-control, fear of retribution.	Hierarchy
Bullying as a norm, Blame and shame culture, Denial, Ignorance, the cycle of bullying.	Culture
Inadequate policies, ineffective policies, training system, Lack of consequences for bullies,	Systemic issues
Acceptance due individual personalities and social characteristics, hierarchy, culture, and systemic issues	Acceptance of bullying
Flattening of hierarchy, role of leaders, senior doctors, and junior doctors, effective reporting system	Bullying prevention and management

During the analysis, initial and focused coding was done manually. Therefore, words and sentences were highlighted, labelled, and pulled out of the transcripts that helped organised the participants' data through different themes and categories. Data was sorted into different core categories and their relevant themes which made recognising relationships between various categories and themes easier during the write-up of findings.

4.10. Evaluating CGT: Trustworthiness

Charmaz (2006) suggested that in CGT, the criteria for evaluating research are based on the purpose of the study and who, as a researcher, invokes this purpose. Trustworthiness points to the accuracy of the study. In CGT, it depends on three key aspects.

4.10.1. Credibility

Credibility reflects whether the researcher has achieved familiarity with the research topic and the setting in which it was conducted. Comparisons and engagement with the data to indicate logical, concrete links between the data and analysis are also critical to assess the credibility of the CGT research. For this study, all analyses and findings resulted from participants' narratives. The research question guided coding, categorising, and explaining the themes and processes relevant to the core categories. I also used memo writing and made constant comparisons throughout the analysis. Memos were shared and discussed with my supervisors to ensure the accuracy of the process emerging from analysis.

4.10.2. Originality

According to Charmaz (2018), the originality of CGT research is indicative of the theoretical contribution of the study. Charmaz (2006) emphasised observing whether the categories offer new insights, how the analysis introduces a new conceptual end to the data, and how the research reflects theoretical and social importance. Observing how the CGT refines, challenges, or extends the current viewpoints is critical. The findings of this research (Chapters 5 & 6) present the current processes related to the explanations of bullying among NZ's junior

doctors. Robust CGT analysis of the data effectively explains the bullying process, to assist in effectively preventing and managing bullying. Future directions for practitioners about the prevention and management of bullying of junior doctors point to the theoretical and social significance of the study. The findings of this research also add to the extant literature by providing theoretical explanations of the bullying process among NZ junior doctors that can improve outcomes for the medical workforce in terms of prevention and management.

4.10.3. Resonance

Resonance refers to whether the categories reflect the richness of the studied experience (Charmaz, 20026). Resonance also relates to how effectively the researcher observed and revealed the 'taken for granted' and liminal meanings in the data. Researchers also need to consider the links between the participants and their settings; for example, the larger institutions and participants' lives, and whether the CGT analysis makes sense to the participants. To ensure that the gathered data in this study was genuinely reflective of the participants accounts and their clinical settings, all participants were offered the interview transcripts and an opportunity to update or change the accounts if the narratives did not resonate with them. One participant chose to add to the transcripts. Participants were also offered the findings of the study to further allow them to express their thoughts.

4.11. Theory Development

For CGT, Charmaz (2001) provided a guideline for constructing meaning from the data and incorporating participants' experiences into theoretical interpretations. Charmaz (2014) recommended that researchers using CGT analysis should consider the questions around how to address the issues related to concept development from participants' accounts and experiences while maintaining an aspect of participants' presence in the written accounts. CGT emphasises building a theory that is grounded in the research data. It should be a mutual process between the researchers and the participants (Mills et al., 2006a). In order to co-construct the

reality and share the meanings with my research participants, I built my theory by proceeding to an assumptions and propositions approach. Assumptions provide a foundation for theory—or for building a structure that is not driven systematically but offers a concrete ground for establishing the observable and testable propositions. Management scholars view a theory as a set of propositions, which are supported by theoretical assumptions. Propositions are a set of testable statements that are rooted in assumptions.

Assumptions and proposition-based theory development offer the researcher an opportunity to perform theoretical triangulation of dat. This also means that bias can be eliminated during the process of creating assumptions and propositions because the researcher has to thoroughly explore the participants' accounts to develop assumptions and construct propositions (Cornelissen, 2023). I developed my assumptions considering the purpose of my enquiry. I considered how I could find meanings in participants' accounts. Data were thoroughly explored to find critical concepts and to ground assumptions.

Propositions that emerged from the CGT were an outcome of my interpretations of research participants' experiences—the findings, and the assumptions. I remained theoretically sensitive through the creation of assumptions and propositions and questioned the assumptions considering the fact that my position as a researcher could impact the direction of the interpretation theorised by the process of organising the concepts and foundational elements of the theory. The concepts and foundational elements of my theory are discussed in chapter 8. During the final stages of theory development, I continuously validated my assumptions by going back to the data and interpretations of participants' accounts. I also refined the propositions several times in response to any dissenting ideas or new insights. Finally, I created a model that represented the core aspects of my theory (see chapter 8).

4.12. Summary of Chapter 4

This chapter describes the methodology and methods used for this study, and the philosophical assumptions guiding the study. The study's qualitative, interpretive research design involved a Constructivist Grounded Theory approach. CGT holds its philosophical positioning in subjectivist epistemology and relativist ontology. Data were collected from 20 participants through intensive interviewing. CGT analysis was used to analyse the data. Several core categories resulted from the CGT analysis (i.e. through initial and focused coding with constant comparison), which explained the bullying processes affecting NZ's junior doctors. The next chapters report the findings of the study resulting from CGT analysis. Chapter 5 addresses RQ1 and Chapter 6 addresses RQ2.

Chapter 5: Findings: Theoretical Explanations for Bullying

This research aimed to provide theoretical explanations relating to bullying, and therefore support recommendations for effective prevention and management of bullying among New Zealand's (NZ) junior doctors. The research was framed by two research questions (RQ):

RQ1: What are the theoretical explanations for bullying of NZ junior doctors?

RQ2: How do these theoretical explanations support the prevention and management of bullying of NZ junior doctors?

Chapter 5 addresses RQ1. The findings are sorted into core categories. Core categories are defined, and their relevant properties or themes are discussed under each core category. Some themes relating to a core category are further categorised into sub-themes.

CGT analysis of the data revealed six core categories that provided theoretical explanations for bullying. These core categories indicate processes linked to explanations of bullying. The six core categories addressing RQ1 are: (1) Individual and social characteristics of perpetrators and victims, (2) Team dynamics, (3) Hierarchy in healthcare organisations, (4) Workplace culture, (5) Systemic issues and (6) Acceptance culture. The six core categories and their exemplar quotes are given in the table 5.1.

Table 5.1 Core Categories, Themes and Exemplar Quotes for RQ1

Core Category	Theme	Example Quotes
1.Individual and Social Characteristics	Individual Personalities and Social Attributes of the Bullies	But you can see on the other teams with some of the other bosses, especially the older ones, who have a certain style, you know, they've been brought up through that bullying culture, and they sort of pass it on. (P12)
	Individual Personalities and Attributes of the Victims	I notice that doctors who moved here from other countries, like immigrants…and like, those who want to do specialty training, get it [bullying] more than others, it is just a usual thing that they face on most workdays. (P 20)
2. Team Dynamics	Competition	…it [bullying] is in its worse form when there is competition between senior and junior doctors… toxic people win the game by bullying junior doctors in their surroundings…everybody in the group wants to win the competition. (P17)
	Favouritism	I have noted that the more you're on the closer you are to a senior doctor or attending the more likely you are to get favour out of. (P02)
	Team Conflict due to Friction Between Team Members	We always have something going on in the team, people do not get along very well, there are challenges…people always have something to disagree upon. (P19)
	Team Conflict due to Difference in Rules and Regulations	The juniors were not trusted to make decisions [due to different intra-departmental rules] even though they'd make the right ones most of the time. (P01)
3. Hierarchy in NZ Healthcare Organisations	Hierarchy System Encouraging Bullying	…they can do whatever because the entire system runs on seniority and authority; consultants know they are higher in the system and have senior positions, so they exploit house officers. (P03)
	Misuse of Power: Command and Control Approach	I think the serious bullying starts later on…when you've got these supervisors and those supervisors, they don't just control you at your hospital; they control you at every hospital because they are part of the training programme, so you're always having to interact with them. (P12)

4. Culture	Bullying as a Tradition or Norm	I had been bullied, and it was the norm at that point in time. As a junior doctor you're bullied, you're asked to do things you can't just say, 'That's not what I thought.'…It was a norm…it was already becoming obvious it [bullying] was a wrong thing. (P14)
	Culture of Ignorance and Denial	I think for me, I do quite well in just ignoring the assaults, the abuse, you know, like the verbal abuse… (P12)
	Culture of Doubt, Shame and Blame	They didn't think that it was a minor mistake, a misjudgement; they would blame us for their mistakes and made me feel like I was the black sheep; consultants would run a show for residents by calling us useless and lazy. (P08)
5. Bullying due to Systemic Issues	Increased Workloads and Understaffing	I think the stress, the hours worked, the understaffed. I think all of that really does relate to the bullying and is probably a big driver of it even if you managed to fix all the other systemic issues. (P12)
	Training Structure of the Junior Doctors	Most of the time it was during my training when my colleagues and I experienced it [bullying]. We couldn't actually do anything during training because bullies were our own bosses…they supervised us. (P03)
	Issues Regarding Policies for Bullying Prevention and Management	They [policies] are sort of implemented as a tick box…but what they don't do is change the cause of the root problem, is not ever solved. It's not in that policy. (P15)
	Ineffective reporting process for doctors in training.	It was frustrating because I didn't find a channel to report the abuse. They expected us to speak to the supervisors, which was not an option for me in that situation because I was reporting verbal abuse and bullying directed to me from him [the bullying senior]. (P18)
	The Absence of Consequences for Bullies After Bullying Complaints**.**	They [bullies] evade the consequences because they are aware of the loopholes in the system. They take advantage of the system…that system will justify their behaviours, there is accountability for them. (P17)
6 Acceptance Culture	Acceptance due to Individual and Social Characteristics.	… the general perception is that we must agree to everything. We must do what we are asked to do. We agree to biases and opinions, and um, and bad attitudes because we have agreeableness in our personalities. (P20)

	Acceptance due to Hierarchy	Most doctors will let it slide when they see it happening…just because *they've absorbed* [emphasis added] the hierarchical nature of bullying and the hierarchical nature of the medical profession…they think that whatever comes from the seniors to the juniors is tolerated. *It's, it's okay* [emphasis added] (P01)
	Acceptance of Bullying as Part of Workplace Culture	It's sort of, um, usual for everyone to get used to it. It [bullying] has always been there, and it is a culture…and it is natural for us to accept it when it never goes away. (P06)
	Acceptance of Bullying due to Systemic Issues	Then, he [the junior doctor] said, 'oh, it is better if I *get on with it'* [emphasis added] because if I don't, I can get into trouble… they [administration] are not going to hear my story anyways; this is how it works over here… (P03)

5.1. Core Category 1: Individual and Social Characteristics

The first core category that emerged relates to the individual and social attributes where bullying happens, escalates, or is experienced by junior doctors in NZ healthcare organisations. The medical workforce in the NZ healthcare organisations is diverse. It comprises individuals who have different personalities, ages, cultural backgrounds and genders. Individual and social characteristics are linked to how bullying happens and how the victims experience bullying. There were two subthemes identified under this core category in relation to the individual personalities and social attributes of the bullies and of the victims.

5.1.1 Individual Personalities and Social Attributes of the Bullies

Research participants pointed out that workplace bullying was linked to the personal qualities and traits of the individuals they worked with. Perpetrators had specific personal and social characteristics that were described as triggering their bullying behaviours toward coworkers. P07, a resident medical officer in gynaecology and obstetrics, noted that bullying incidents in a speciality or department depended on the people who worked there. They said: “It [bullying] depends upon, you know, the type of people you have in your area”. According to P07, bullying in several departments related to individuals who had bullying personalities; if a medical speciality employed individuals with negative personalities, there were greater chances of bullying in that speciality.

Participants believed that if the clinical leader of a speciality was generally a good person and respected their juniors, there was less chance of bullying. P11, a senior surgeon, stated that departments where seniors had positive personal attributes with a focus on people did not harbour bullying. However, a culture of bullying emerged when a supervisor with a bullying personality joined the department. P11 said: “In some departments, we never heard

about any bullying because the director was very good. He used to keep people together, and when he retired and other one took over, we could see the culture change".

When a person with a negative personality joined, juniors had no choice but to agree to whatever the bully was saying or doing because of the bully's forceful personality. P15, a consultant who worked in a public hospital, also validated that the bullies were those with a negative personality, which made it difficult for other people to cope. They said:

> I think he [the bully] is a bit of a narcissist. You can't really say no to him for anything; if any of you disagree with his plan, he makes it look like you're the bad person. I suppose with a narcissist, you can't really say anything to them.

Bullied individuals believed that rejecting bullying, because of the bully's negative personality, would make them look bad as well, so they did not retaliate, and perpetrators kept bullying them. If individuals were more aggressive and hostile due to negative personal attributes, there was a greater likelihood of bullying.

Social characteristics were also described as important by participants. The age of the perpetrators was particularly identified as another marker of bullying in junior doctors' workplaces. Older bosses were described as set in their ways with certain styles of managing their younger trainees. If things did not go as planned, trainees and junior doctors were mistreated and bullied by them. P12, a PGY1 trainee, said that an older doctor mistreated them and other trainees over minor things. They said:

> The old person's in [name of a department] at the moment…he has a very set mindset on what each individual person does in the team and if you step outside of that you will get pushed back into your role, you will be yelled at.

P12 described an experience with a senior and older boss in their team who had a rigid and inflexible approach toward the responsibilities of the junior doctors. If a junior doctor tried to deviate from the expectations of the older boss, he or she would encounter verbal abuse and

bullying. Participants indicated that older doctors' bullying of junior doctors was because of negative beliefs and biases toward juniors. Older bosses perceived that young doctors were careless and irresponsible, and did not do their jobs well. Therefore, they mistreated and bullied younger doctors over minor issues. P01, a senior house officer in Geriatrics, said: "They [bullies] are more likely to be male, they're more likely to be, um, older…they're more likely to have themselves a certain set of biases and assumptions".

In some participants' workplaces, the bullying escalated because older bosses supported their colleagues who were bullies. P15, a consultant in an interventional medicine speciality, said that when they tried to complain about their bullying experience to a senior and older doctor, he supported the fellow senior and another older supervisor who was bullying them. P15 shared:

> …he said. Look, I just don't feel comfortable investigating it in-house. Also, he has connections with what they called an old boys club…which I didn't really understand at the time. He'd be connected to lots. In his previous time, they've all bailed him out from other complaints that have gone against him and wouldn't let it go forward.

Older and experienced doctors protected associates. Participants indicated that older bosses were also more likely to delay or take no action if junior doctors raised concerns about their mistreatment, which resulted in further escalation of the bullying behaviours. In summary, age was identified as a contributing factor to bullying behaviours.

5.1.2. Individual Personalities and Attributes of the Victim

People with specific individual and social characteristics were described as more vulnerable to exposure to bullying behaviours in the NZ healthcare organisations. Participants suggested that personal attributes of victims such as ambitious and goal-oriented personality types, gender and ethnic background were factors increasing exposure to bullying.

Junior doctors were victimised because they wanted to succeed in their jobs. They were ambitious and motivated. Bullies were described as perceiving them as an easy target because they knew that junior doctors would be willing to do anything to succeed. They would not retaliate against bullying, so perpetrators victimised them more than others. P06, a surgeon by speciality, said:

> They did not care if I wanted to offer more and succeed. It was only about them. When I asked for an opportunity, he [the bully] verbalised my flaws in front of nursing staff. I was ridiculed and made to feel worthless. I was told that my job was to hold the surgical tools for bosses in the OT [operating theatre].

P06 believed they were victimised because the seniors knew they wanted career progression and were ambitious. Ambitious personalities in juniors were perceived as intimidating because seniors considered them self-serving individuals who wanted to succeed but lacked the skills essential for success.

Doctors with independent and self-assured personalities were illustrated as encountering less bullying than others. P16 explained:

> I think those cultural norms make one group more likely to be more vulnerable because of their social characteristics, their learned experiences, their expectation of society; and on the other hand, if people who are more autonomist who don't seek validation, and they might see them as being submissive or lacking in confidence. Whereas the other people might just be polite. I think those dynamics do play a part in perpetuating the situation.

Values, backgrounds, and experiences shaped the personalities of junior doctors—if they had meaningful experience and were confident, they experienced less bullying.

Another trait that was related to junior doctors' exposure to bullying was their inability to communicate their concerns openly and confidently. P15, a consultant, explained that

sometimes bullied junior doctors did not communicate their concerns about poor behaviour. They said:

> The other problem is communicating with whom, and some of these things in bullying I suppose you want to keep confidential because it's personal to you; you don't want the whole world to know at the time, but the people you tell are, unfortunately the people who are all interconnected who tell your secrets to other people. It's very difficult to tell anybody anything.

An inability to communicate openly made junior doctors less protected against bullying. They reserved communication to ensure confidentiality and shared concerns based on who they wanted to share information with.

Bullying was also experienced differently by male and female doctors interviewed. Several participants indicated that bullying was experienced more by female doctors than male doctors. P16 said: "There will be some factors that make a person vulnerable; *whether it's their own personality* [emphasis added]; whether, for example, is it [their gender]. A male or is it female…cultural expectation of their role as women". According to P16 some junior doctors encountered bullying behaviours just because they were female. In New Zealand healthcare organisations, individuals had certain cultural expectations that female doctors were required to put more effort into their work and be more efficient than their male colleagues because they had other roles to play which impacted their performance in medical jobs. Expectations and pressure to be better encouraged bullying from others although both male and female doctors were working to attain the same goals in terms of their careers and patient care.

Participants stated that immigrant doctors encountered more bullying than local doctors because general discriminatory behaviours and attitudes against immigrant doctors existed in the junior doctors' workplaces. P12 said: "I think then that organisation also just normalises the sort of racism in the workplace. But definitely racism is a big one, like a lot of Asian and

Indian doctors will get treated a lot worse". P14, a consultant in a medical specialty, experienced firsthand bullying as an immigrant doctor. They said: "Coming from a different culture there is always this little bit of a mismatch that happens, and so people try to put you down. It is one of the things that I experienced myself…". P14 explained that one of the reasons immigrant doctors were bullied more than other doctors was the difference in the cultural backgrounds of immigrants and local doctors. They are excluded from the majority and are targeted because they are perceived differently.

In summary, the core category of individual personalities and attributes explains the individual personalities, attributes and social characteristics of bullies and victims. Individual personalities and attributes of bullies indicated that bullies were older, seniors, and experienced individuals. Further, junior doctors were victimised because they were considered inexperienced and different based on their personalities, age, gender, and backgrounds.

5.2. Core Category 2: Team Dynamics

The core category of team dynamics that emerged from the data refers to team-related aspects such as interpersonal relationships and interactions of doctors that guide their behaviours within teams and departments. Team dynamics were explained by the participants as playing an essential role in escalating bullying of junior doctors. The medical workforce provides services and patient care in multidisciplinary teams involving doctors from many specialities. Participants identified that team dynamics reflected interactions of the team members (i.e., how they interact and address conflict) as well as the departmental dynamics, which refers to the impacts of the speciality of the members of the team on their behaviours, interactions, and interpersonal relations with other members of the team. Analysis indicated four themes in the team dynamics category that explained the bullying process: (1) Competition, (2) Favouritism, (3) Team conflicts due to friction between team members, and (4) Team conflicts due to differences in rules and regulations.

5.2.1. Competition

Medical teams were described as displaying competition between their team members, which in turn contributed to bullying. Participants indicated the presence of varying degrees of competition in all medical teams and departments, although some teams and departments were less or more competitive than others. P11, a senior surgeon who had experienced bullying, reported that they were mistreated by another surgeon in their department. They said: “For my case, it was a simple case of competition. He [bully] just wanted no competition in the private”. P11 explained that the perpetrator created problems for them in their workplace; he bullied them and their clinical team into eliminating competition and acquiring a role in a private healthcare setting.

While competition started with senior doctors, it was found that junior doctors competed against one another, bullied their team members, and sought validation from their seniors. P09 said: “the [bullying] attitude mostly comes from the competition in our workplace, and the reason there is so much competition is because students claim a lot of academic validation from their seniors”.

Competitive dynamics in teams were fuelled by junior doctors’ professional aspirations when opportunities were lacking. Doctors in a team compete for the available opportunities by bullying their juniors and other doctors. Rather than supporting each other, they withhold their support for the other team members, which can cause an environment of bullying.

Perpetrators put other doctors down, making other team members look professionally weak, or introducing competition to overshadow the professional capabilities of colleagues and juniors. The nature of the competition in the medical teams was such that the competition created by the perpetrators would be won only by other bullies or allies of the bullies. People who liked to victimise others would win this competition by showing abusive behaviours toward others in their teams, and this escalated bullying. P10 said:

> …they [the bullies] don't elect. They hold these positions forever and they never let others compete for those positions…and they have their own candidates to make them stand for certain posts or as a head of a specialty, they have their own candidates, they don't let others compete.

Perpetrators try to influence other team members through their bullying behaviours, so they win the competition against them in a way that could potentially sabotage the victims but would give a professional advantage to the allies or people whom the bullies supported.

5.2.2 Favouritism

Participants referred to favouritism as a senior or group of seniors preferring one individual or group of juniors over another. Favouritism involved the unfair distribution of tasks related to medical and surgical training and practice, unfair access to mentoring, and selective feedback and suggestions in teams. Several reasons for favouritism were stated and these included seniors trying to establish professional superiority, interpersonal relationships among team members, junior doctors' desire for better roles, and even the gender of the medical professionals. P02, a PGY1, explained this further:

> The attending [resident doctor] was getting favour from that particular doctor: they … would let whatever they're doing slide by, like if they missed a day off when they would be given an excuse, and it would be fine but [not for] the other doctors, and the other doctors would be expected to pick up the slack for them. And in environments like this, where you're doing your own work along with someone else's work and you're still being bullied for not doing enough.

The dynamics of the medical teams were such that senior doctors would pick one or two other doctors they relied on. Seniors distributed the tasks unfairly and provided limited access to mentoring and professional development to those they sidelined. These junior doctors were then expected to fend for themselves in a challenging team.

Some doctors were able to gain the favours of seniors. P08, a general surgeon, had experienced this process in their team. They said:

> We did get into trouble if we said anything or asked for a chance …but there were others who were favoured by him [supervisor]. He preferred the others over me because I questioned his abuse and bullying during surgical training. I was unhappy and depressed all the time because of his ill treatment of me but some people got away with all sorts of nonsense because they were given special treatment and preference.

Some team members were preferred over others in the medical teams during surgical practice and training, while others were being bullied simultaneously in the same team. P19, a PGY2 trainee in medicine, stated:

> This is very common if you observe who is in their [bullies'] surroundings. Who they want to work with…they prefer female doctors … in some departments because they believe female doctors are less likely to complain about tasks, if something happens or they are bullied. Male consultants favour them, and they assign them more tasks…if they do what they are told to do, it's good. If they don't, they are bullied.

Thus, favouritism could be based on gender characteristics or personal preferences of the perpetrators, resulting in more opportunities for some doctors compared to others. Participants felt this was bullying and also created situations of competition and frustration that contributed to additional bullying.

In summary, seniors and supervisors have particular preferences for trainees and junior doctors with whom they work in a team. Seniors favour some doctors over others, encouraging a bullying environment in medical teams. Junior doctors seek professional validation and better roles through favouritism, while seniors favour some doctors over others to emphasise their capabilities, gain control and practice superiority.

5.2.3. Team Conflict due to Friction Between Team Members

Participants described team conflict as a negative situation or dispute resulting from friction between members of the teams. Conflicts among team members led to the breakdown of interpersonal relationships and communication. Analysis indicated that team and departmental conflicts led to bullying if the friction between team members continued. Several participants had unresolved disputes that escalated into the bullying of junior doctors.

The workload of doctors also created unreasonable expectations where junior doctors were expected to perform regardless of their increased workload. Team members did not want to share workloads and take additional responsibility, which sometimes resulted in friction, tensions and resentment, leading to conflicts and bullying within medical teams. P13 explained:

> …there's always conflict in teams. I mean, the nature of the work that we have there's pressures… if you've been in ED, you've been in GP, and then you go on to be a [senior] surgical registrar, you know what it's like for the other person [the junior doctor]. How difficult it is for them with their resources. At the same time…you also know if they [the junior doctors] are being lazy…there's a tendency for junior people who've done less to be very unreasonable and not like the senior people who are giving them work because when they [senior doctors] call you, they're calling to give you more work, which everyone resents. But I think if you are tired, and you're stressed, then there's a potential for bad interactions, which you can then talk about within your silo and then you all gang up against that one ED doctor.

According to P13, seniors were aware of junior doctors' stress from increased workloads and lack of resources, yet they considered their juniors idle. If a senior doctor pushed extra work on juniors or a junior doctor declined the request to work for additional hours, it caused conflict

within the teams and team members—and this interpersonal friction created a climate that contributed to bullying.

Participants believed that conflicts impacted their work environments. The growing resentment and grudges due to conflicts made doctors spread rumours about poor interpersonal relationships and interactions between certain team members, which fostered bullying. P09 said:

> I feel like if there is conflict among a team of a particular work specialty that can really affect the working environment. If the staff holds a grudge against one particular junior doctor they can easily … spread lies about that person and everyone would believe that. I've seen that happen a lot because if the staff does not like a particular person, they would just start talking about him or her and you know the rumours just start spreading and people start believing 'Oh, this person doesn't work well with this person', 'This person did that' and that causes conflicts and bullying.

If the conflicts among team members stayed unresolved, they were described as quickly escalating into bullying. Team members could resent and hold grudges against one another, which in turn could create fear and uncertainty. Rather than communicating their concerns and resolving conflicts, doctors stay silent and ignore the conflict, which encourages passive-aggressive and bullying behaviours within teams. P16 stated: "When, from the beginning, if there's a lot of friction, if there's a lot of conflict, then people are less likely to open their mouths because they feel intimidated and scared".

To summarise, team conflicts coupled with friction and interpersonal and communication challenges were identified as precursors to bullying in the medical teams. Unresolved disputes led to bullying because ignored conflicts developed a toxic workplace for junior doctors. Fear of intimidation perpetuated a passive-aggressive team dynamic where conflicts were common.

5.2.4. Team Conflict due to Differences in Rules and Regulations

Several participants discussed conflicts resulting from different rules and regulations for various specialities and departments within healthcare organisations including the multidisciplinary teams. Medical teams consist of professionals from different specialities, and these differences can create conflicts, eventually leading to bullying. Analysis indicated that differences could result from how things worked in different departments, and the differences in rules and regulations between the departments of a healthcare organisation. Staff in medical teams, therefore, had different expectations. P09 explained how intradepartmental differences in rules and regulations created conflicts within teams:

> …if you are working in a ward, they will let you go for lunch break for like an hour and if you go to another ward they don't. They'll want you to be in the ward 24/7. So, if you're not used to, you don't get used to the routine of one ward but then you get transferred to another one and you're technically not doing anything wrong but because that particular department wants things in a different way and that will cause bullying.

Bullying also happened because junior doctors followed the rules of one department in another, or needed to adjust to the changed regulations when they switched departments during their clinical rotations. What was considered normal in one department was not acceptable or normal in another. This caused misunderstanding and conflicts, escalating into bullying. P01 narrated a story about how the difference in rules and regulations between the surgery and medicine departments made a consultant behave in a certain way towards a junior doctor. They stated:

> ...And a consultant walks in and looks around and there's no chair available. So, he just walks over to the student and says, "Oh, sorry, you are not using that chair. Are you?" and the student like, sort of, gets up and you know looks a little bit embarrassed and the consultant sits down to do his thing…So, um, I think

> it's just about what you accept as normal and, in that department, normal was consultant sits first, despite how many chairs there are.

Junior doctors were also described as being trusted more in some departments than others. However, when junior doctors moved from a department where they were trusted to another department that did not allow this decision-making, misunderstandings and conflicts could occur among team members. According to P04, "It is different in surgery. It has different rules. It is not medicine or GP office…people do not make decisions in surgery; it is the supervisor's job to decide what we'll do next". The mismatch of rules and regulations led to ambiguity, making the junior doctors vulnerable to bullying by seniors.

In summary, the core category of team dynamics illustrated processes relating to interpersonal relationships, interactions, and other team-related aspects. The first theme competition stated junior doctors competing against one another to seek validation from supervisors, which escalates bullying. The second theme indicated favouritism. Some senior doctors and supervisors in the team give learning opportunities only to their favourite trainees while bullying others. The third and fourth themes explained team conflicts resulting from friction between team members and conflict due to different rules and regulations respectively.

5.3. Core Category 3: Hierarchy in NZ Healthcare Organisations

The hierarchy system in healthcare organisations is an arrangement of roles and responsibilities of medical and non-medical professionals based on their authority and qualifications. Those at the top of the hierarchy run healthcare organisations' decision-making system and processes. The hierarchal system allows for manipulation of power in ways that can trigger bullying behaviours. The core category of hierarchy captured three themes in the data: (1) Hierarchal system encouraging bullying: (2) Misuse of power: command and control approach; and (3) Fear of retribution.

5.3.1. Hierarchal System Encouraging Bullying.

Data analysis indicated that the hierarchy in medical and surgical teams and organisations led to bullying of junior doctors. While most organisations require some structure to run organisational processes effectively, NZ healthcare organisations have several integrated levels, which rank members by their speciality, discipline, or authority. NZ healthcare organisations are characterised by a concrete hierarchy system positioning CEOs (i.e., chief executive officers), clinical directors, senior medical and non-medical management, supervisors and senior doctors above junior doctors and trainees. The hierarchy can enable non-medical and medical administration to be tough on people further down the hierarchy through their job descriptions and roles. If people in higher positions are abusive, they can create a bullying environment by manipulating what is required of them in their roles. P01, a senior house officer in a public hospital, said: “Individuals at high levels who want to make it a nasty environment, they, they’ve got that ability to do so”. P02 stated:

> I think the most important factor is the who’s at the very top of the picture. For example, if your senior is someone who is prone to bully other people, then everyone in their team will be a bully of some sort, but if your attending [supervisor] is someone who wants to break the cycle then it keeps everyone else at bay as well, no matter how much of a bully they may be.

If individuals in the hierarchy were abusive, the abuse was directed towards people lower in the hierarchy, who would redirect it to their subordinates and juniors. Analysis revealed that the hierarchy in doctors’ workplaces operated through a top-down approach, with administration being strict on medical management beneath them, resulting in bullying.

Similarly, medical management also functioned through a hierarchal or top-down approach toward the junior doctors. P16 said:

> If, for example, the non-medical management have really a very top-down approach, that creates a bigger picture in which the medical management will be operating, but the bigger fabric is actually in the background, it is the administration, and if it is very top-down and they are actually coming down hard on medical management, then the medical management…they [medical management] get the same thing because they cannot go and fight them. The only thing they can do is actually pass on that kind of vertical violence, or horizontal violence actually, then downwards to their juniors.

P16 explained that the hierarchal system is enabled by job descriptions that can be used to direct abuse towards juniors--they called it 'vertical violence'. Junior doctors were victimised because of their junior roles and positions below theirs, which triggered bullying. Medical management was unable to go against the higher administration, and this resulted in medical management passing on the abuse to junior doctors.

In conclusion, analysis showed that the hierarchal system in NZ hospitals fosters bullying behaviours. Individuals in senior positions have specific roles or job descriptions that carry the potential to direct abuse toward juniors. If people in the hierarchy are abusive, the abuse gets transferred to people further down the hierarchy; for example, junior doctors, who cannot question this abuse because of their inferior status.

5.3.2. Misuse of Power: Command-and-Control Approach

NZ healthcare organisations strengthen hierarchal system through a process or a chain of command that imparts authority and power to senior people. Participants indicated that in NZ healthcare organisations, the power dynamic in the medical hierarchy did not merely involve a supervisory element by those positioned high in the hierarchy. But also, seniors misused this power to control their juniors by subjugating them to a command-and-control approach. They made juniors obey their orders and created issues that could sabotage their juniors' professional practice—another form of bullying. P12 gave an example of the misuse of power with a

command-and-control aspect in their department. They said: “Whereas I think in surgery it’s sort of, you know, the SMO [senior medical officer] is the god, and you know their will is whatever it is, and you do it. If you diverge from that, you will get yelled at”. According to P12, power was exercised through a rigid command-and-control dynamic in surgery where the role of the senior medical officer was akin to a deity. If juniors ignored their directions even if they were not possible, they were bullied.

P15 related a story about a perpetrator who would misuse power to scrutinise junior doctors by breaching the conditions of his supervisory duties. Doctors outside of the operating team were not allowed to read the notes written by trainee doctors during surgical operations. However, according to participant P15, a senior doctor who was not on the operating team would use his position and power to get access to the notes written by junior doctors in the operating theatre so that he could find faults in those notes and control the junior doctors he disliked for complaining against him. P15 mentioned:

> If anyone makes a complaint or anything, he documents first of all everything; he also goes through your notes, which is very confidential when you’re operating. If he’s not doing the operation, it’s not for him to see, but he will go through everyone’s notes.

It was found that seniors went beyond their roles to misuse power and bully juniors because they expected juniors to follow the so-called rules created by seniors—the directions outside of juniors’ job descriptions. If the junior doctors did not follow these directions, they were bullied. P09 stated:

> Okay so you’re working in a particular department where the consultant usually starts his or her round around 9:00 AM, and you arrive at work at 8:00 AM. You have an hour to complete your work and put your morning notes, but then you change your department, and in that particular department, it starts at 7:45 AM, and your work does not start until 8:00 AM. But he will still expect you to be there before him and do your

> round. And even though it's not in your job description to be there before 8 but you have to do it. Consultant wants you to be there. And if you're not there he will put you down, he will bully you. He'll say if I can be here, why can't you?.

Unjust demands by seniors are a way to exercise power and exert control over juniors. The misuse of this power by seniors to impose control over juniors was described as leading to an escalation of bullying behaviours. In summary, people in the hierarchy wield control over their subordinates and juniors beyond mere supervision. Dominance is exerted over juniors through a command-and-control approach, and juniors are expected to obey seniors' orders. Dissenters are bullied if there is noncompliance with seniors' orders. Juniors are monitored unjustly, scrutinised, and further bullied if they try to go against perpetrators' demands.

5.3.3. Fear of Retribution

Participants described fear of retribution as the fear of being faced with consequences of raising their voices against bullying behaviours. Data indicated that junior doctors had feared retribution according to two aspects. First, the fear of retribution regarding further bullying due to the perceived power of bullies, and second, the fear of retribution with regard to career advancement. P06 explained the fear of retribution due to the perceived power of bullies, they and their colleagues faced, in a surgical speciality. They said: "We know they [bullies] have power, and in surgery, that kind of power controls how junior doctors are seen. So, most of the time, surgical trainees are afraid of consequences; they go without saying anything". According to P06, they and other trainee doctors knew that bullies were powerful and challenging their power would result in further bullying. P19 had similar views. They said:

> There is constant scrutiny during the training…there is struggle and rejection of those who are weak and less powerful. If we, um, I, I do something about it [bullying], I try to tell the management what hell I'm currently in, there are serious consequences, in that scenario, I'd rather try to escape the consequences, further abuse by the powerful…

There was a general fear among doctors due to the perceived power of the bullies; junior doctors believed that if they challenged their seniors and retaliated against bullying, they would be victimised more. Junior doctors also had a fear of retribution involving their career advancement. They feared that complaining about bullying would jeopardise their speciality training or professional advancement. For example, P16 indicated that fear of not getting further speciality training stopped trainees from speaking up against supervisors. They said: "I think above all their fear of not ever receiving further inter-education (education opportunities during multidisciplinary training), the consequences can be quite big especially if they're training in a speciality. Yes, there's a lot of power that resides with the supervisors". Trainees did not complain about bullying because they needed support for training. P11 called the fear of retribution concerning career advancement a 'vulnerability':

> In surgery you go on and on and now you have to do so many things, and you've got to get a good reference here, a good interview, good and done by the time PGY5-6 if they're lucky they'll get in. During that time, they just don't want to do anything which will adversely affect their chance of getting into training.

Similarly, P01 described: "Those examinations are usually led by seniors…so there is no external moderation available, and there is no right of appeal. A lot of registrars and a lot of house officers are very scared to say and do anything that might influence those examiners' perceptions of them". There was a pervasive fear of potential consequences for standing up against bullying. The power wielded by seniors impacted the junior doctors' careers, especially if they tried to retaliate against bullying. Junior doctors' vulnerability in such situations was described as stopping them from speaking out against bullying, which led to an escalation in bullying behaviours toward them.

In summary, the core hierarchy category identifies bullying processes associated with the hierarchy system in NZ's healthcare organisations. The findings can be grouped into three

themes. First, the hierarchy itself promotes bullying in healthcare organisations. Second, misuse of power through the command-and-control system, practised by hierarchies, is another explanation for bullying behaviours towards junior doctors. Seniors and individuals at high levels in the hierarchy misuse their powers to oppress juniors. This escalates bullying. The third theme is fear of retribution. Seniors instil fear among junior doctors with their perceived power and control over juniors' careers, which escalates bullying. The following section discusses the fourth core category of workplace culture.

5.4. Core Category 4: Workplace Culture in Healthcare Organisations

This core category contains findings on culture in NZ healthcare organisations contributing to bullying because of several factors relating to underlying assumptions, norms, and beliefs that drive individuals' behaviours and attitudes. This core category outlines three major subthemes focused on workplace culture as an explanation of bullying. These subthemes are: (1) Bullying as a tradition or norm: (2) Culture of ignoring and denial; and (3) Culture of doubt, shame, and blame.

5.4.1. Bullying as a Tradition or Norm

Participants identified that bullying has always been there in healthcare organisations; it is usual and normal in their workplaces. Most junior doctors and doctors under training were indicated as exposed to bullying during their early careers. Participants across a range of specialities shared this perspective about bullying being a norm in their workplaces. P15, a consultant who got bullied while they worked in a large public hospital, discussed bullying as a norm or culture in their department. They indicated: "This is the culture now in our department. What's the point of me making a complaint against him [bully]? Because we know that nothing will change". In these cases, bullying was a norm because doctors perceived it as standard behaviour. Workplace culture makes bullied junior doctors believe that complaining about bullying is futile because it is a tradition. Bullying, being the norm in doctors'

workplaces, hinders how they behave when it comes to raising concerns against bullying. They believed that communicating concerns was challenging in their workplaces because of this normalisation of bullying.

Related to these norms and traditions, participants also referred to the cycle of bullying as a continuous process by which seniors would pass their bullying attitudes to juniors, considering it a 'rite of passage' or a method to prepare the next generation of doctors for the challenges of the medical profession. As a result, the abuse and bullying behaviours would continue and even escalate as part of the workplace culture. P11 explained this situation: "I've seen my senior going through this[bullying], I have seen other persons [trainees] going through, *and this goes on* [emphasis added]". They further explained: "That's another problem; because they [seniors] were bullied that they will have a right to bully as well".

P01 described that they had experienced working with a group of doctors where the senior surgeon was a bully, and hence, everyone in the team turned into a bully. Doctors were stuck in a cycle of bullying.

> There was only this one surgeon who was the bully, but there was everybody else around him on the team. Other consultants, other registrars, other house officers, other students were being bullied as well. So, everyone was being bullied and some of them were also choosing to pass that on as well. So, as well as being bullied, they were bullying. And that was the case more with more senior members of the team. The other consultants and the more senior registrars.

The cycle of bullying was described as an extreme form when the most senior doctors were the perpetrators. This is because the supervisors' perceptions reinforced the bullying behaviours and the belief that undergoing bullying is critical to junior doctors' success.

In summary, bullying is a pervading norm in NZ healthcare organisations, impacting junior doctors in several specialities. The normalisation of bullying behaviours as a cultural

tradition in the workplace may potentially create a toxic environment where victims do not raise their concerns about bullying and—bosses transmit their learnt bullying behaviours to juniors, generating a cycle of bullying. Instances of seniors and supervisors were illustrated as leading to extreme bullying behaviours in junior doctors' workplaces. The ferocity of the cycle of bullying escalated when seniors victimised juniors, driven by the belief that juniors must encounter bullying to succeed. Thus, the alarming presence of a destructive cycle of bullying occurred.

5.4.2. Culture of Ignoring and Denial

Several participants indicated that their workplaces harboured a culture where bullying was ignored and denied by junior doctors, supervisors, leaders, and managers, and treated as part of the workplace culture.

Junior doctors ignore bullying behaviours toward them, and this causes bullying to escalate. One of the reasons explained for why junior doctors ignored bullying was because they were made to believe that there was no such thing as bullying. P04 stated: "'What we don't consider is how this [bullying] is dangerous. The victims ignore violence until some serious shit happens. Most people consider it normal. Victims declare bullying to external authorities only if they were bullied to a dangerous level…". Similarly, P18 said: "Consultants in some departments create a bullying environment, people don't pick up on bullying behaviours and one bad apple spoils the whole bunch. Tyrants are intentionally ignored. I've never seen a house officer directly confronting a consultant…". Some junior doctors believed that it was not a problem to undergo bullying; this situation allowed for an escalation of bullying. Ignoring and denying bullying was a form of coping mechanism. Most bullied doctors overlooked bullying unless it became significantly detrimental to them. The danger of overlooking bullying behaviours was that it further perpetuated the problem because calling out perpetrators who might be seniors was a challenging thing for juniors.

Supervisors, leaders, and managers ignored and denied bullying because they considered it normal behaviour. If junior doctors retaliated, they were ignored. P12 stated: "I think a lot of the time they [seniors, leaders and managers] think oh, it's just a stupid medical student, ignore, don't worry about it. Or like when you get to a junior doctor, it's like, 'Oh, they're just a junior doctor, don't worry about it, they're cheap as chips". Seniors dismissed bullying, calling it an insignificant matter. They attributed bullying to the junior doctors' inexperience and labelled it an attention-seeking attitude. Similarly, supervisors and managers viewed bullying as an interpersonal issue or a mere exaggeration of workplace issues between colleagues.

To summarise, bullying is ignored for several reasons. Seniors ignore bullying because they think bullying is not an issue. Seniors think junior doctors demand attention by making things up and exaggerating minor workplace issues, in order to get their way through complaining. Managers ignore bullying because they perceive it as a coworker misunderstanding or an interpersonal issue. This attitude may escalate bullying because it results in bullying behaviours going under the radar and continuing to happen.

5.4.3. Culture of Blame, Shame and Doubt

For some participants, a culture of blame, shame and doubt is present in healthcare organisations. Participants identified it as behaviours that involved shaming junior doctors, blaming them for things they did not do or for someone else's mistakes—and instilling doubts about their abilities and decisions to be doctors. P15 said putting others to shame was common in the surgery department. Seniors would constantly find fault with juniors. P15 added: "This is in front of nurses, technicians, everybody; like putting you down where you lose respect with your peers". P09 stated that the senior bullied them. Seniors instilled doubt in them about their decision to be a doctor whenever they could not answer challenging curriculum-related questions during clinical work. P09 said: "And the question would be really hard. It would be

something that's not even taught at your level, but they [seniors] will still make it feel like you just made the biggest mistake of your life joining medicine…". P09 explained: "It's a very toxic culture…you are consistently being drilled, being asked different questions, um, you're actually, a scapegoat for a lot of people". Rather than supporting juniors during their clinical practice, seniors would blame juniors for their lack of awareness about the curriculum and bully them.

Blame and shame also resulted in a lack of confidence among junior doctors, exposing them to further bullying. P12 said: "I think that was probably my second attachment that I had as a medical trainee and it [bullying from seniors] just makes you think "Shit, I don't think I can do this if every speciality is going to be like that". P12 explained that they encountered bullying behaviours during clinical attachments, which made them question their ability to perform well in their own and other specialities. Blame, shame, and doubt were identified as creating a toxic environment where bullying behaviours escalate. This culture results in doctors doubting themselves, leading to a lack of confidence. Junior doctors question their ability to work as doctors due to blame, shame and doubt. This toxic culture was described as exposing them to further bullying.

In summary, the core category of workplace culture identifies bullying processes associated with the workplace culture of NZ's junior doctors. Analysis revealed three sub-themes in this core category. First, bullying is a norm. Second, a culture of ignoring and denial fosters bullying. Third, a culture of blame, shame and doubt is the hallmark of a bullying culture in NZ healthcare organisations.

5.5. Core Category 5: Bullying Due to Systemic Issues

Five themes emerged within the core category of systemic issues in the NZ healthcare organisations. These themes are: (1) Increased workloads and understaffing, (2) The training structure for junior doctors, (3) Issues regarding policies for bullying prevention and

management, (4) Ineffective bullying reporting system for doctors in training, and (5) Lack of consequences for bullies.

5.5.1. Increased Workloads and Understaffing

Participants reported that bullying has escalated due to their increased workloads, which have resulted from understaffing and the current shortages of doctors in NZ healthcare organisations. P01 believed that understaffing was a major factor contributing to bullying in their workplace. They said: "I think that the fact that we are understaffed is a major component of that [bullying]. Um, the job is more stressful". Understaffing was indicated as leading to longer workhours and stress, which acted as driver of bullying. Consistent with P01, P09 explained that for them and other doctors in their department, a typical week involved working very long shifts, which caused doctors to be stressed and resulted in bullying. They said:

> So, I'm working for like 36 hours and after that, even a minor inconvenience can piss me off more than usual. So, that actually contributes a lot to bullying. People are very impatient after working so much, and they tend to lash out a lot and mostly they lash out on their juniors.

In addition, understaffing and increased workload also impacted the senior doctors, resulting in bullying behaviours. P16 indicated that fewer resources in terms of staffing and greater work demands pressured senior doctors in his workplace. Seniors let go of their pressure in the form of bullying behaviours toward junior doctors. P16 stated: "Then there are the demands of the work. If the resources are less, then I think again, in turn, we put more pressure on senior people, and they're more likely actually to develop a culture [of bullying] which is more punitive". A direct link was identified between understaffing, increased workload, and the worsening of bullying. A lack of resources, including human resources, fosters a workplace where bullying escalates because both junior and senior doctors' frustration and retaliation manifest as bullying behaviours.

5.5.2. Training Structure for Junior Doctors

Participants' accounts highlighted that the medical training process was complex. Bullying was evident as a pressure technique to increase junior doctors' resilience so they could perform well in challenging situations and when patients' lives were at stake. Bullying was also used as a teaching and learning tool for junior doctors. Junior doctors experienced bullying behaviours during training as a stimulus to pass their exams successfully, advance their careers, and receive good references.

Medical training has a complicated nature and doctors go through several stages of assessments. During these stages, doctors encounter bullying. P12, a surgeon in advanced training, had encountered bullying several times during their training. They explained the nature of the medical and surgical training and its relationship to bullying. They said: "People who want to do surgery and you go through your junior doctor and then your first year as a registrar and then on the training programme. I think the training programme for surgical training is probably where it [bullying] starts a lot." Similarly, P09 suggested that the medical training was tricky and complicated for them and their colleagues. Supervisors distributed tasks for training purposes depending on supervisors' personal understanding of the junior doctors' capabilities, exposing them to pressure and bullying behaviours. P09 highlighted:

> Most [seniors] will treat you unequal. They won't give you equal learning opportunities… but most of them think that we are the people who can just do the steth work [use stethoscope], so they'll sometimes assign us useless tasks and make us run around all time and not even give us any breaks.

The complicated nature of the training programme puts doctors under pressure to perform well and move to the next level. Junior doctors allow bullying behaviours to persist because they are focused on moving to the next stage of medical or surgical training. They also believe that bullying helps them prepare for the stressors in patient care and treatment.

Bullying is used as a teaching practice or learning strategy to make junior doctors develop into better medical professionals. Participants revealed that their seniors and supervisors will bully them in the name of professional development. P11 said that junior doctors tolerate bullying by seniors to become surgeons. They explained: "For junior doctors, there is a perception that "If I want to become a surgeon, this [bullying] is [what] you have to go through". Thus, junior doctors dealt with destructive behaviours because they believed bullying was part of their learning and curriculum. They believed that if they let their supervisors bully them when they taught, it would help them reach their full potential. They thought that they would develop skills to become better surgeons if they learned to go through it.

In summary, the complicated nature of training that facilitates licensing, career advancement, and referrals for speciality training and other work-related opportunities renders doctors susceptible to bullying behaviours during training. Supervisors want them to succeed through these stages. They put junior doctors under pressure to perform and bully them during training.

5.5.3. Issues Regarding Policies for Bullying Prevention and Management

Participants explained systemic issues involving policies and procedures regarding bullying prevention and management, stating potential consequences, particularly for bullied junior doctors. The participants identified antibullying policies as ambiguous, inadequate, and lacking clear guidelines. Inefficacy and ambiguity were illustrated as leading to poor implementation. In P15's experience, severe issues resulted from ineffective policies that had no clear directions to address bullying. They said: "The reason everyone is having this issue [of bullying] is because of this one problem; there is nothing to address that problem." The root problem leading to an escalation of bullying was an absence of clear guidelines and specific measures in an anti-bullying policy".

Similarly, P12 explained that in their experience, managers and leaders used a 'tick the box' approach to address bullying but did not act when people were being bullied. There probably is but it's probably in such a box-ticking policy that, oh, we've got it on paper but we're not actually going to implement anything or tell anyone about it. So, they can't do anything. But if someone came and questioned us, we could turn around and be like, "Oh we've got this policy" and it's just a box tick.

Policies were present more for appearance than genuine support. While antibullying policies and procedures were in place, these policies aimed to indicate that management was active in resolving issues rather than supporting the victims. Participants explained that policies focused on general health and safety compliance, and passing audits. This further illustrates the superficial nature of anti-bullying policies. In addition, the challenges of introducing consequences for perpetrators and management's worries about reputation management created a scenario in which if a complaint was taken to external attorneys, it moved the focus away from the bullied junior. P11 explained this situation: "When you go to the lawyer it becomes against the hospital, the person just becomes insignificant, and hospital then tries to protect their own interests. They don't want to have a bad name".

In essence, participants' accounts revealed complex systemic issues relating to antibullying policies, highlighting an absence of clear guidelines and adequate policies that address the root cause of the problem and support bullied junior doctors effectively. The inadequacy of policies, and lack of action on policies due to hierarchal dynamics and reputational challenges collectively create the multilayered nature of implementation issues.

5.5.4. Ineffective Reporting Process for Doctors in Training

Several participants explained that the inefficacy of the bullying reporting system for juniors in their workplaces prevented bullied doctors from making complaints, and thus, bullying persisted in their workplace. An ineffective reporting system results were indicated as

particularly involving their own supervisors handling bullying complaints rather than a neutral person. P16 said:

> People often make a complaint, and who they will go to first is their own supervisors, then they will go to, let's say a clinical director of that place, but if the clinical director thinks that this will spoil his or her relationship with the rest of the bullies; he's not likely to spoil his or her own relationship.

According to P16, reporting bullying to supervisors and seniors does not work because supervisors or leaders, such as clinical directors, prefer not to address bullying complaints because it can jeopardise their relationship with seniors or leaders who are their colleagues and who bully junior doctors. P09 had similar thoughts about the reporting system being inefficient. They stated: "…I haven't even seen a complaint go through. They don't really work on this at all". P09 believed that people who dealt with the bullying complaints in their workplace did not pass the complaint to seniors who could handle the issue. Management was indicated as too busy and uninterested in dealing with the bullying.

Another reason for the ineffective reporting system was the presence of bullies and their allies in the committees that oversaw bullying complaints and worked on bullying reports. P01 stated:

> …when I had my bullying happened, and um, in that surgical department there was actually supposed be an antibullying team in place in that department who you were supposed to bring things to, that department, that team consisted of the bully and a few of his associates and the team was led by a person who was the bully so I was supposed to bring my complaints to them and he would supposedly step out of it and let his supposedly neutral coworkers and friends handle it. I just knew that wasn't going to work for me. That didn't seem sensible at all.

P01 knew their bullying report would not be addressed when they noticed that the bullying complaint they filed was handled by the bully and the bully's associates, including seniors with clear conflicts of interests in dealing with the complaints. Busy managers also slowed down the management of bullying reports. The analysis underscored the need for an impartial, timely and effective reporting process in NZ healthcare organisations.

5.5.5. The Absence of Consequences for Bullies After Bullying Complaints.

Participants' accounts revealed that there was no indication of consequences for bullies in their workplaces enabling the bullying behaviours. P08 stated that human resources and clinical management in their workplace had no interest in talking about the consequences that might occur when one of their colleagues was bullied. They stated that they "never saw anybody mentioning some sort of consequences for aggression and bullying in his organisation". There was a minimal emphasis on holding the bullies accountable for their poor attitudes toward junior doctors.

Accounts from P11 validated these views. They said: "The person who is bullying, he goes in the corner. He is never punished; he's never talked to." They further added that bullies are not worried because they know there are no consequences for them: "I don't see that [consequences] happening here. That is why people are not worried. They're bullies; they're not worried that something will happen because they don't see it happening, any action being taken …" (P11). An absence of observable consequences for perpetrators made them immune to the worry that they could be held accountable for their destructive behaviours.

Participants also explained the reason for the lack of consequences. P01 stated: "I think it all ultimately comes from the fact that there are no consequences and that there are no doctors". P01 offered insights into the structural challenges of healthcare management. The reprimanded doctors were often seniors, and taking action against them posed a dilemma for managers; their removal or disengagement from the workplace to manage the bullying

complaint further exacerbated the shortage of specialist doctors in medical or surgical specialities.

To summarise, systemic issues in NZ healthcare organisations were identified as escalating bullying of junior doctors. Five major themes were noted. First, increased workloads and understaffing lead to stress and frustration that can manifest as bullying. Second, the complicated training structure of junior doctors involves bullying behaviours practised as a learning and teaching method. Third, issues regarding antibullying policies, such as inadequate policies and poor implementation, can cause bullying behaviour in healthcare organisations. Fourth, an ineffective reporting system increases the incidence of bullying, and fifth, the absence of observable consequences for bullies due to structural and managerial challenges fosters bullying behaviours.

5.6. Core Category 6: Acceptance (Culture) of Bullying

Participants indicated that acceptance of bullying is another phenomenon that explains the bullying processes of NZ junior doctors. While the core category of culture refers to behaviours, attitudes, and beliefs of individuals in healthcare organisations, the core category of “acceptance’ culture is multifaceted, and it presents different themes about acceptance of bullying. More specifically, acceptance culture is a larger framework that signifies not only the (accepting) attitudes and behaviours of individuals towards bullying but it also shows why doctors accept bullying. Thus, this core category differs from the core category of workplace culture and all other categories. It is a supra-core category with themes organised by acceptance of bullying across the previous levels of core categories including individual or social characteristics, hierarchy, workplace culture, and systemic issues. This supra-core category has four themes which align with these levels: (1) acceptance due to individual and social characteristics; (2) acceptance (culture) due to hierarchy; (3) acceptance as part of culture; and (4) acceptance due to systemic issues.

5.6.1. Acceptance due to Individual and Social Characteristics

The individual and social characteristics of individuals in NZ healthcare organisations may make them prone to accepting bullying. Some individuals may have passive or submissive personality traits, rendering them prone to conforming rather than confronting bullying behaviours. As a result, these individuals may tolerate bullying despite being aware of its negative impacts. For example, P05 explained that the bullies targeted junior doctors with low self-esteem because they accepted bullying: they were perceived as weak by the bullies. They said:

> …such people become abusive with the underconfident types. The individuals who accept bullying because they don't believe in themselves, they question themselves about bullying taking place. Like, 'it's obviously a toxic behaviour but I am still not going to trust myself. I see it as an abusive behaviour but um, then, I give up and accept it because I don't see myself doing anything, but then, I'll be bullied again because they [perpetrators] know I am an egg and I have accepted it.

The lack of self-belief and confidence made junior doctors accept bullying by those who had more assertive or confident personalities. Individuals with low self-esteem accepted bullying to fit in and maintain social harmony in the workplace.

Bullying was also accepted more by doctors who had an agreeable personality than by those who were less agreeable. P18 said: "Doctors who let it happen accept things by natural default. We agree to certain things because this is what we do…we signed up for tolerating it [bullying] and agreed to tolerate most of the [abusive] things.". Accepting bullying was a default mechanism that enabled junior doctors to accept abusive behaviours, including bullying, fostering an acceptance culture. Doctors with agreeable personalities accepted bullying to avoid conflict and confrontation with bullies.

Participants noted that immigrant junior doctors with resilient personalities accepted bullying more than those who displayed fragility. P16 compared the acceptance of bullying to "resilience and stamina' in junior doctors' personalities. P16 stated:

> …a lot of doctors who have come here; they have that resilience and temperament anyway, it's built in oddly through training, and part of it's you leave your country, and that process, that hardship, gives you a bit of stamina and resilience.

According to P16, some doctors accepted bullying because of their resilience and stamina. P16 believed that resilience and stamina in the personalities of immigrant junior doctors developed through challenges during immigration to NZ and the demands of medical training in NZ. In addition to junior doctors, senior doctors' personalities also contributed to the acceptance of bullying. Senior doctors who lacked interpersonal and leadership skills accepted bullying of junior doctors to mask their inadequacies. P01 pointed out:

> Individuals who don't have any interpersonal skills or don't have any leadership ability or, you know, any words, who like to make themselves feel more powerful by bullying others, those decisions [about bullying] are just accepted without a question as well.

Senior doctors accepted bullying to feel that they had control over all kinds of situations and believed that bullied junior doctors had the ability to manage bullying themselves and make their own decisions. In summary, individual and social characteristics contribute to the acceptance of bullying in NZ healthcare organisations. Junior doctors' lack of self-belief and agreeable personalities, along with their resilience and stamina, make them prone to accepting bullying. On the other hand, seniors with a lack of leadership skills accepted bullying to hide their professional inadequacies.

5.6.2. Acceptance (culture) due to hierarchy

Acceptance due to hierarchy was referred to as an acceptance of bullying by the NZ junior doctors because of the inherent power dynamics of NZ hierarchal healthcare organisations, in

which people at higher levels in the hierarchy can misuse their power to abuse their juniors. Several participants mentioned that junior doctors tolerated and accepted bullying because of the perceived bullies' senior positions in the organisational hierarchy. P12 explained:

> But the problem is … the person who is bullying you is usually your supervisor. Your clinical supervisor or your consultant that you work with every single day and so, you know, starting that off on a bad foot is not a great way so I think a lot of people *just put up* [emphasis added] with the shit just to make work easier the next day.

Despite junior doctors knowing of bullying behaviours toward them, they accepted bullying because the bullies were often their supervisors. Therefore, junior doctors had no choice but to tolerate bullying to avoid trouble from their supervisors.

Some junior doctors' acceptance of bullying was rooted in their acceptance of the abuse from supervisors: junior doctors accepted bullying and chose not to reject abuse because they did not want to damage their relationships with supervisors. Misuse of power by abusive people in the hierarchy is accepted by junior doctors regardless of its negative consequences for junior doctors. P14 said:

> then you go do things and then you realise there is a better way to do, so you try to do a little differently or something like that, then the boss will come back and say, "I asked you to do this way and you did it this way. This is not the right way." Trying to put you down in front of everybody…you feel bad but then…you will be stoic, be resilient, get on with it, *so we got on with* it [emphasis added].

Junior doctors accepted and 'got on' with everything, including bullying, because they were terrified that if they raised their voices against bullying, there would be repercussions. Junior doctors' decisions to accept bullying portray a pragmatic approach driven by their past experiences with the people in the hierarchy—they keep working despite all the bullying that they encounter.

Senior people in the hierarchy also accept bullying; they misuse their powers to breach the rights of those who cannot stop their bullying in any way. According to P16, seniors accept bullying because they don't consider it an issue. P16 explained:

> It's about power dynamics; it's about power structure … a general manager or CEO, he can be condescending and dictate to the people in the food chain below. Well, I mean, then it gives a very clear message that *you can pass it on, and this is okay* [emphasis added].

P16 compared misuse of power to a kind of food chain where the rights of the weak were exploited by the powerful in the organisation. Junior doctors accepted bullying from people in the hierarchy. They justified the abuse, considering they needed to tolerate it because they were juniors. To summarise, junior doctors tolerate bullying with a perception of becoming better medical professionals with no workplace issues. Seniors accept bullying, thinking it is okay to transfer bullying to juniors simply because they can misuse power by being in senior roles. As a result, bullying is accepted by both junior and senior doctors with the potential to propagate aggressively within the entire organisation.

5.6.3. Acceptance of Bullying as Part of Workplace Culture

Participants offered a variety of reasons for acceptance of bullying due to culture. Some participants indicated why bullying was accepted as their workplace culture. They explained that acceptance related to their personal beliefs around tolerating bullying; they believed that bullying was allowed and was a tradition. A desire to maintain their specific workplace traditions resulted in the acceptance of bullying. P05 explained that bullying was accepted in their department as part of the workplace culture. Yelling and screaming was a tradition, they said:

> Consultant yelled at the registrar, registrar yelled at resident…resident yelled at house officer, house officer then yelled at the medical student, it was part and parcel of

> allowing and accepting bullying…we were served an impression that our supervisors accepted bullying, yelling and bullying was allowed…I tried to make it a big deal, but they said, 'nah she'll be alright'.

According to P05, abuse was accepted because people considered it a tradition and developed tolerance to it. P02 also looked at bullying as something that the junior doctors were used to seeing. Junior doctors accepted it as part of their workplace culture despite calling it a disturbing phenomenon for them. P02 said:

> It made me realise how internalised…bullying is for all of us because we see it so often that we've reached *a point of acceptance* [emphasis added] where sometimes you can laugh at it but when it's actually happening to you it's not that funny and it actually can be quite nerve wracking as well.

Similarly, P16 explained that the reason for the acceptance of bullying is culture. They stated:

> … lot of western culture is that you just serve the line, and it is just your own self confidence that determines. Whereas people in Asian cultures they seek their validation often through others, through seniors, and this is how they are set up; they will show a lot of respect to teachers, to seniors. It is almost ingrained that you have to show a level of submissiveness.

Acceptance of bullying emerged from the junior doctors' cultural backgrounds. If the junior doctors had a Western cultural background, they accepted bullying as part of their work, where they tolerated bullying to stay at work. However, for junior doctors from Eastern cultures, a focus on their cultural values of respect and submissiveness for individuals in positions of authority made them accept bullying, which resulted in them being further bullied.

In summary, acceptance emerged as a cultural phenomenon from bullying being a usual aspect of doctors' workplace cultures. Acceptance is also shaped by the cultural backgrounds of junior doctors, with junior doctors from Eastern and Western cultures both enduring and

accepting bullying. Thus, bullying is internalised and is accepted despite being recognised as a disturbing experience for junior doctors.

5.6.4. Acceptance of Bullying due to Systemic Issues

Another aspect of acceptance of bullying by junior doctors emerged as 'acceptance due to training structure'. Participants stated that bullying is sometimes accepted because it is embedded in the training of junior doctors. Junior doctors keep putting up with bullying behaviours because they are made to believe that it is part of their training. P12 explained: "Bullying is just an accepted part of a surgical trainee's role". Bullying was accepted as part of training because junior doctors were ambitious and wanted to succeed. Thus, they tolerated it until they felt more confident about their professional skills. P09 also noted that junior doctors accepted bullying because there was a general preaching during training that 'putting up' with bullying could help them become better doctors. P09 said:

> They [seniors] would keep saying that uh we have to endure it everyone goes through it. We went through it as well and so you guys have to put up with it as well. It will turn you into a refined version of yourself. You will be a better doctor.

Junior doctors in surgical training accepted bullying to successfully complete training and become surgeons like their supervisors. If junior doctors did not accept bullying, they were discouraged by their seniors. P11 mentioned:

> Go back to GP. Become a GP of somewhere, but [you] can't be a surgeon. If you want to be a surgeon, you have to tolerate it. That's the message you get here, and these people see how the training are being treated and they still want to be a surgeon, so it is the accepted behaviour. "Okay, I'll become a surgeon." It is a temporary phase. Probably they think it is temporary phase. It will go away, just study, learn, and become a surgeon then it will go away.

Juniors are asked to go back to being general practitioners if they do not tolerate bullying. They are expected to accept bullying in the surgical side of the medical profession to train successfully. Doctors under surgical training presume that accepting bullying is a temporary phase. They accept bullying behaviours, unaware of the fact that they are trapped in a vicious cycle of bullying, and therefore, the bullying continues.

To summarise, junior doctors accept bullying as part of their training structure. Acceptance is ingrained as a perception that enduring bullying is a critical component for success as a medical professional. The idea of tolerating bullying perpetuates a cycle of bullying that continues to be fostered by junior doctors' acceptance of bullying. The core category of Acceptance culture included themes: (1) Acceptance due to individual and social characteristics, (2) Acceptance of bullying due to hierarchy illustrating junior doctors' acceptance of bullying due to seniors' positions, (3) Acceptance as part of workplace culture describing junior doctors' acceptance of bullying both to maintain the workplace tradition of bullying and based on their cultural backgrounds and, (4) Acceptance of bullying due to systemic issues, explaining acceptance of bullying because training structure demands junior doctors endure bullying in the hope of achieving success.

5.7. Summary of Chapter 5

Chapter 5 includes the findings addressing RQ1 regarding the explanation of the bullying process for NZ junior doctors. Six core categories were identified and discussed. First, individual and social characteristics of perpetrators and victims: individual and social characteristics of the bullies and victims can impact how bullying emerges and continues in NZ healthcare organisations. Second, team dynamics: favouritism, competition, and team conflict lead to bullying of junior doctors. Third, hierarchy in the NZ healthcare organisations operates through a command-and-control system that results in a power imbalance between individuals, leading to misuse of power and extreme bullying behaviours toward people who

are positioned lower in the organisational hierarchy. Fourth, workplace culture: Bullying is a norm in the cultural tradition of doctors' workplaces. A culture of blame and shame, along with ignorance and denial of bullying, escalates bullying. Fifth, systemic issues: issues around antibullying policies and procedures, poor implementation and a complicated training system for junior doctors lead to bullying. Sixth, acceptance (culture): bullying is accepted in NZ healthcare organisations by both junior and senior doctors based on individual, social, hierarchal, cultural, and systemic aspects such as training. Acceptance of bullying fosters extreme bullying behaviours toward NZ junior doctors.

Chapter 6: Findings: Prevention and Management

Chapter 6 explores the crucial aspect of bullying prevention and management for junior doctors in NZ healthcare organisations. While Chapter 5 discussed RQ1 about theoretical explanations of bullying, the accounts offered in this chapter outline the suggestions made by the research participants on improving the prevention and management of bullying of NZ's junior doctors, thereby addressing the research question:

> ***RQ2: How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?***

Participants identified prevention and management as multifaceted, requiring a nuanced awareness of the underlying barriers to effective prevention and management, and tailored solutions at various levels. Five distinct themes emerged. The first theme, flattening of hierarchies in NZ healthcare organisations, responds to hierarchal systems described in the NZ healthcare organisation, with participants indicating a need for a shift to a flatter hierarchy, with minimal power differentials between healthcare employees, to address bullying. The second theme, frequent change of leadership, acknowledges the role of rotating people in leadership positions to minimise the potential for bullying of NZ junior doctors. The third theme, organisational support, outlines support mechanisms including education and awareness programmes and proactive roles for managers and seniors in creating a bullying-free culture, and the role of junior doctors in breaking the acceptance culture to reduce bullying. The fourth theme discusses systemic changes, encompassing suggestions for revisiting antibullying policies and protocols, and effective implementation of policies to create a bullying-free workplace. The fifth theme focuses on effective reporting systems, emphasising the significance of accessible and transparent reporting processes for bullying incidents.

Table 6.1 Core Category, Themes and Exemplar Quotes for RQ2

Core Category	Theme	Exemplar Quote
1.Flattening of Hierarchy	No themes	…DHBs [District Health Boards] can start with power regulation within the hierarchy or demolish the authority structures to start with… (P17)
2.Frequent Change of Leadership	No themes	…it [bullying] stopped when the person [the bully] accepted another position, and then the clinical staff called me because they had nobody to lean on; they [managers]emailed me the incidence report form. (P03)
3. Organisational Support	Awareness and education about bullying	…manager organised a health and safety seminar which informed people of what is abuse, and what should not be tolerated. Most juniors are clueless. If a hospital educates people about the impacts of bullying, trainees can be more vigilant and aware of any bullying behaviours…it can eliminate bullying. (P18)
	Roles of healthcare employees in prevention and management	How can management really change it? I think one way is actually leading by example, that they themselves are, in a way, and they hold the powerful people to account, to start with. (P16)
4. Systemic Changes: Policies and Procedures	Crafting effective antibullying policies	They [policies] are in the manuals, but they [policies] are not there to make a change. Practical strategies should be developed. (P19)
	Effective implementation of policies and procedures	They can manage the system by effectively managing the rules and regulations (P04)
5. Effective Reporting System	No themes	…it was done because the report went to another doctor, and the complaint was dealt with by someone else. Reporting processes were aligned, and everybody coordinated during that time to find a solution to the issue. (P08)

6.1. Flattening of the Organisational Hierarchy

Flattening of hierarchy refers to the dissolution of power structures within the hierarchies in NZ healthcare organisations. Several participants proposed that bullying prevention and management could be improved by a transformational shift, cultivating a workplace where power is shared equally between junior and senior doctors. Equal distribution of power will prevent bullying due to misuse of authority. P03 suggested:

> Managing bullying means consultants and senior doctors should not be given administrative roles where they have more power than others…there should be no such thing as hierarchy in hospitals, it is teams sharing a goal [of patient care] and anything against it, let's say, hierarchy, will empower bullies.

For proper prevention and management of bullying, granting excessive power to administrative roles such as consultants and senior doctors must be avoided to remove the power difference. P01 also talked about addressing hierarchal structures to stop bullying from escalating further. They said, "There needs to be some soul searching, there needs to be an understanding that … the way in which things are done, this hierarchy or values…is not a good way of doing work". P01 added that their current department has a bullying-free culture because there is no hierarchy. They explained: "…my current department's culture is really quite good overall because there's this, this hierarchy has been flattened". Similarly, P09 advised that changing the hierarchal system is a critical step towards preventing and managing bullying of junior doctors. They said: "…hierarchal systems in the hospital should be changed… I understand that you need to have seniors to learn, but…there shouldn't be a dead system in the New Zealand hospitals, so you are forced to do whatever your seniors just told you to do".

According to participants a system based on power struggle is a nonfunctional as it makes it difficult for seniors to be held accountable for their bullying behaviours towards

juniors. For this reason, hierarchal systems should be discouraged. A system based on a flattened hierarchy can create a bullying-free workplace. Preventing and managing bullying requires a collaborative structure in junior doctors' workplaces.

6.2. Frequent Change of Leadership

Participants identified that recurring change of leadership could facilitate the prevention and management of bullying because this was indicated as an opportunity to disrupt the association between the leadership and the perpetrators of bullying, encouraging a proactive strategy for bullying prevention and management. P03 stated that bullying behaviours directed towards them stopped when the bullying senior took over another job following a structural change in their department. P03 said: "…it [bullying] stopped when the person [the bully] accepted another position and then the clinical staff called me because then they had nobody to lean on, they [managers] emailed me the incident report form to report his bullying behaviours". P03 explained that managers rely on bullies for smooth departmental operations; change in supervisors can encourage bullying management. Clinical management becomes more efficient in addressing the bullying issues that affect junior doctors when the perceived bullies' role changes or they move to another position. Similarly, P17 said:

> The persons in charge must have different roles and job descriptions after being in power for a while. If the leadership changes frequently, bullies will not be able to team up with leadership to avoid consequences, and managers will be more proactive in preventing and managing bullying.

P15 also indicated that leadership change could foster the prevention and management of bullying because new leaders may introduce positive changes to the workplace culture. They commented:

> Whereas, if you're constantly rotating people, in leadership, you're getting new ideas, but you're also getting new people who haven't been accustomed to that culture and

can change [culture]…and they bring new ideas, a new way of managing things, and that helps their department for sure.

To sum up, leadership changes can assist with bullying prevention and management because altering the person in charge can break the connections between the bullies and their allies. In addition, new leaders can introduce positive changes which may foster a bullying-free workplace.

6.3. Organisational Support

A clear theme that emerged from data analysis was the major role that organisational support can play in bullying prevention and management for junior doctors in NZ. Two distinct subthemes were identified: (1) Awareness and education about bullying, and (2) The roles of healthcare employees in prevention and management.

6.3.1. Awareness and Education About Bullying

According to participants, organisations can play an important role in preventing and managing bullying by taking concrete measures around educating junior doctors about bullying and its negative consequences. P03 shared a personal experience, noting that their recognition of bullying behaviours resulted from their participation in a health and safety workshop. They mentioned: "I was unaware of the bullying attitudes of the supervisors and the impact it had on me until I was asked to attend a health and safety workshop one day outside of my department…being aware of bullying attitudes and workplace violence can prevent junior doctors from getting trapped in bullying".

P09 offered similar ideas: "They [organisations] can actually organise workshops or different presentations and conferences regarding workplace harassment or workplace bullying and tell people about the consequences they can face if they bully someone". P09 believed that if people were aware of bullying behaviours and their consequences, they would be more likely to recognise if they were being bullied and would be more careful about bullying others. P05

attended a training session on bullying prevention and management and emphasised the significance of educating junior doctors about the antibullying rules and regulations and reporting procedures. P05 stated: “We had no clue about where to go if someone was rude to us. Generally, we will go to our supervisor to complain but he would shut us up… [the] training session gave us the information we needed to navigate departments where bullying was considered a normal aspect of training”. P05 added that prevention and management extend beyond simple education and awareness—they are intricately related to teaching doctors about creating a bullying-free environment. P05 thought that if doctors knew the harmful impacts of bullying, it is likely that they would not bully anyone.

Effective bullying prevention and management requires organisational measures such as raising awareness and educating junior doctors about recognising bullying behaviours and their negative impacts. Training sessions, workshops, presentations, and conferences can enhance junior doctors’ awareness of the issue of bullying so they are able to recognise and report it, which will contribute to the elimination of bullying behaviours in their organisations.

6.3.2 Roles of Healthcare Employees in Prevention and Management

Participants revealed that administrators, leaders, managers, seniors, supervisors, and junior doctors must play active roles in preventing and addressing bullying.

6.3.2.1 Role of administration, higher management, and leadership. It was identified that anti-bullying change must start from the management level because they hold the power to prevent and address bullying. P11 explained: “The change has to come from [the] top. If you really need change the will has to come from[the] top and then will has to be translated into action. Then real change will come “. P17 offered similar advice:

> The onus is on the leadership, the directors, senior medical officers and managers; if they have a sincere concern for the bullied person, they will open their offices for the sufferers and advocate against bullying through actions.

According to participants, managers' ability to express genuine concern requires tangible action. P01 described the need for managers to enable consequences for bullying behaviours:

> …responsibility lies with the leadership to be happy to tackle bullying cases and be happy to enforce consequences, to create consequences first of all because currently they're minimal, and then enforce them when bullying is reported. They're going to need to be happy to make examples out of [a] few people.

A consensus among participants was that leaders, senior managers, and administrators should act in ways that favour the victim and make examples out of perpetrators. Concrete action will dissuade abusive individuals from directing their aggressive behaviours toward junior doctors and it will prevent further bullying from happening.

6.3.2.2. Role of senior doctors and clinical supervisors. Participants advised that seniors and supervisors can foster the creation of a workplace where there is zero tolerance for bullying. P05, a postgraduate year three trainee, noted that supervisors' support encouraged junior doctors' communication and this, in turn, leads to the prevention and management of bullying. They explained:

> In my department, the house officers are dependent on supervisors for all kinds of support. We look at our seniors for reassurance and assistance when there are things we can't handle. Most of the times we need to be heard and be seen…especially if we are around those who are aggressive to us when we are not willing to do their bidding…

Junior doctors relied heavily on experienced guidance and support, assistance, and reassurance in challenging situations. Seniors' support also meant recognition of junior doctors' issues with supervisors when they faced aggression. Similarly, in P02's opinion, supervisors' support was a pivotal element of a healthy work environment. It was easier to prevent bullying if supervisors were engaged in bullying prevention and management and supporting junior doctors in

standing up against bullying. P02 stated: “If the attending [the resident doctor] is someone who wants to have a healthier work environment, then everyone will try their best”.

Bullying behaviours were indicated as diminished if supervisors were opposed to bullying behaviours and wanted a healthy work environment for trainees. Thus, clinical supervisors and senior doctors can provide support by offering guidance when junior doctors are facing bullying. They can encourage junior doctors to stand up against bullying.

6.3.2.3. Role of junior doctors. Several participants emphasised that junior doctors could contribute to organisational support by fighting against bullying to break the acceptance culture. P11, a senior surgeon, said that junior doctors needed to ‘unlearn’ the acceptance of bullying they learnt during medical school:

> Same thing we have seen in ragging [in] medical college. When we are first year we are being ragged and we are so harassed, but when you become second year we will rag the first year. It is a tradition. That’s all we say, “It’s alright. It’s tradition. We also were done. We were ragged, nothing happened.” Unless someone stands up and said, ‘No. Enough is enough’. What will happen?.

P11 further advised: “Stand up for yourself. I think these [junior] doctors will stand up and they will not tolerate bullying”. P19 shared similar accounts: “…and if trainees get the courage at a point, to retaliate and fight for the case [bullying], they certainly can win”. P07 said that action needs to be taken at some stage, and junior doctors can prevent bullying by saying no. They further mentioned: “Someone has to stand up and say no … someone has to do something about it so that culture of being bullied or bullying others breaks”. P07 explained that NZ junior doctors saying no, standing up and taking the right action against bullying can break the acceptance culture. To summarise, junior doctors can play a crucial role in organisational support by practicing zero tolerance to bullying. Junior doctors, by standing up against

bullying, can develop a culture of intolerance toward bullying behaviours that will end the cycle of bullying.

6.4. Systemic Changes: Policies and Procedures

Participants' accounts showed that a focus on policies and procedures was critical for the prevention and management of bullying of junior doctors in NZ healthcare organisations. Systemic changes such as creating adequate antibullying policies, and effective implementation of policies and procedures, could assist in the prevention and management of bullying.

6.4.1. Crafting Effective Antibullying Policies

Several participants discussed recrafting policies to address bullying. Up-to-date and adequate policies can stop bullying by giving a clear picture of what needs to be done and how to prevent and manage bullying behaviours. P08 believed that clear policies may help junior doctors and managers differentiate between normal behaviours and bad behaviours:

> …policies should be revised to clearly define what is considered bad behaviour and why bullying won't be tolerated…bullying [damages the] mental health of house officers and residents; addressing bullying through setting clear rules and regulations is choice hospitals have to make.

P20 agreed that management should overhaul current policies to better handle bullying: "Management should change the policies they have on their desks for preventing and addressing bullying. Policies should support victims and punish oppressors". P06 had similar thoughts: "Policies are to be revisited each year because bullying reflects vague organisational policies in action. Policies and procedures are rusted, they don't serve their purpose. They must be updated". These participants indicated that a proactive approach was needed to combat the issue of bullying. By reviewing antibullying policies frequently, management can ensure that

the guidelines they have are maintaining their effectiveness and relevance in the workplace for NZ's junior doctors.

6.4.2. Effective Implementation of Policies and Procedures

Effective implementation of policies refers to applying policies in a manner that successfully eliminates bullying of NZ junior doctors. Participants indicated that bullying could be prevented and managed if policies are implemented in way that reflects management's capabilities about resolving bullying issues. P09 said: "…if there are rules or laws against bullying, they should be properly implemented. Like every time you see someone bullying someone else or you're being bullied, you file a complaint against a particular person". According to P09, the implementation of policies meant that management was capable of taking action on complaints according to the rules and regulations and this made the victim feel confident that bullying would be resolved—or that management would forward the victims' complaints to higher authorities.

P01 said that antibullying policies could be implemented successfully if the implementation involved people from the human resource department who are familiar with policy implementation rather than having their own supervisors deal with bullying complaints. P01 said:

> There needs to be proper HR departments with proper … processes and procedures for going through handling bullying cases. I think that, uh, bullying policies need to be taken out of in-house management and put in the hands of people who are one step removed from the department so that they can be handled in a more objective way.

Similarly, P04 believed that the implementation process must involve people from different teams and experts aware of the policy implementation and outcomes of preventing and managing bullying, rules and regulations: "Policies can only be implemented if someone other than clinical management stands up and says, 'You are fired, no more bullying for us".

These participants proposed that antibullying policies can be implemented effectively if management is able to understand the policies and take action according to the relevant laws. In addition, well-established units with clear systems are needed for successfully implementing antibullying policies. Most importantly, bullying can be eliminated if trusted people from outside of the affected workplace can be hired for objective implementation of the policies for prevention and management.

6.5. Effective Reporting System

Participants described that an effective reporting system should be in place to facilitate proper reporting of bullying or filing of bullying complaints, so management is aware of the bullying issues in the workplace. Participants offered ideas about establishing a reporting system that is functional and convenient, enabling junior doctors to report bullying. Simplifying the reporting processes and establishing a genuine commitment to addressing reported bullying incidents can deter further bullying of junior doctors. P17 believed that an effective and practical reporting system can prevent and manage bullying: "It [bullying management] all drills down to one thing, [the] reporting process and what it takes to report it. If [the] reporting process is made easy and management truly wants to deal with the incident reports, it can end our bullying".

A reporting system run by internal managers and supervisors is a difficult system to follow. Doctors may hesitate to report bullying to their own management, believing management will not facilitate a response. P04 shared that the current reporting system favoured the bullies in their workplace because it was operated by managers who had no idea of recording the bullying reports and facilitating reports from victims. P04 believed that victims can be supported only if reporting is monitored by those who have skills and knowledge about dealing with bullying complaints. P04 explained: "Salvation lies with those who know how to run the engine and how to monitor it. Every step of the reporting process needs to be thoroughly checked and monitored to gauge how well it is running". P04 further added that "professional

bodies outside of the doctors' workplaces" must be involved to analyse the reporting system and monitor the reporting procedures:

> Reporting bullying starts with a long and tiresome process. Hearing complaints is at [the] discretion of [the] manager or clinical director. If I am victimised by someone I am already stressed and if [the] reporting system allows letting the right person know about the bullying incident, it will be less of a challenge.

Participants highlighted that there is a need for a thorough oversight of each step of the reporting system. Assessing the effectiveness of the reporting process through auditors and professional bodies external to the bullied junior doctors' workplaces can prevent and manage bullying because reporting bullying through an externally run and monitored system will be more accessible and trustworthy for junior doctors.

6.6. Summary of Chapter 6

The findings in this chapter addressed RQ2: *How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?* Core category 7 listed the following themes: First, the flattening of organisational hierarchy: power sharing and alleviating hierarchal structures in the NZ healthcare organisations can prevent bullying by assisting medical professionals in working effectively towards common patient care goals. Second, frequent leadership changes can bring positive changes and prevent bullies from exerting their power over a long period. Third, organisational support through raising awareness and education, and active roles of managers and leaders, mean that supervisors can prevent bullying. Junior doctors can contribute effectively to organisational support for bullying prevention and management by standing up against bullying. Fourth, systemic changes are required. Policies need to be recrafted and implemented effectively. Fifth, ensuring there is an effective reporting system can facilitate the prevention and management of bullying.

Chapter 7: Discussion

The purpose of this study was to explore explanations of the bullying process of NZ junior doctors and the perspectives of junior doctors on bullying prevention and management, which have implications for NZ's health system. This research was guided by two research questions (RQs):

> ***RQ1: What are the theoretical explanations for bullying of NZ junior doctors?***
>
> ***RQ2: How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?***

Chapter 7 presents a discussion of the qualitative findings of this study in association with the extant literature. The first section discusses the findings of the first research question and the second section focuses on the second question.

7.1 RQ1: Theoretical Explanations for Bullying of NZ Junior Doctors

Six core categories were found to explain workplace bullying: (1) Individual and social characteristics, (2) Team dynamics, (3) Hierarchy in NZ healthcare organisations, (4) Workplace culture in NZ healthcare organisations, (5) Bullying due to systemic issues, and (6) Acceptance culture. Each of these categories is briefly summarised and then contextualised within the extant literature.

7.1.1. Individual and Social Characteristics

Individual and social characteristics of the individuals were found to be one explanation of the bullying process among NZ junior doctors. Two themes were identified under this category: (1) Individual personalities and social attributes of the bullies, and (2) Individual personalities and attributes of the victims. Senior, male, and older doctors were more inclined to exhibit bullying behaviours towards their colleagues and juniors compared to younger, female, and junior doctors. This is consistent with prior research in other countries showing that senior healthcare staff, clinical leaders, supervisors, and senior managers tended to be the perpetrators

of bullying (Imran et al., 2010; Wilson, 2016). Similarly, personality characteristics were factors for bullying; this study found that workplace bullying was rooted in authoritative personalities. The literature also notes that individuals with dominant, aggressive, and authoritative personalities may try to exert control and have tendencies to bully others (Seigne et al., 2007). These positional and social differences are likely fuelled by disparities in power, with some individuals trying to assert dominance over others.

Victims' personalities, gender and cultural backgrounds also played a role in perpetuating bullying in NZ. Ambitious and success-oriented junior doctors became a primary target of bullying because their goal-oriented natures exposed them to bullying behaviours. Participants reported that perpetrators considered their victims vulnerable due to their tendency to tolerate bullying to achieve their career goals. Further, the gender and cultural backgrounds of victims also rendered them vulnerable to stereotyping attitudes, bias and discrimination, with female and/or immigrant doctors with foreign backgrounds facing more bullying than male and NZ-born medical professionals (Hoosen & Callaghan, 2004; Jóhannsdóttir & Ólafsson, 2004; Rutherford & Rissel, 2004). These findings are also supported by previous research (Green et al., 2017; Mendonca & D'Cruz, 2021) suggesting that an individual's status in a healthcare organisation and whether they experience bullying is significantly associated with factors such as their age, personality type, skill level and foreign education and immigrant background. This is further supported by the Social Identity Theory, which illustrates that bullying may result from the in-group/outgroup dynamics in the workplace, where individuals categorise themselves and relate to the members of the perceived ingroup based on similar attributes and shared goals (Tajfel et al.,1971). In contrast, those who are perceived differently, for example, based on gender, ethnicity or cultural background, can be socially excluded and victimised (Tajfel et al., 1971).

NZ junior doctors' inability to be assertive and initiate open communication due to their lack of confidence and self-esteem, and fear of retribution, also made them a target of bullying because they were less likely to challenge it. Therefore, perpetrators viewed them as weak and vulnerable. This is consistent with literature reporting that junior doctors who encountered bullying were those who were less likely to fight it (Hoosen & Callaghan, 2004). Some scholars also emphasised lack of self-esteem as the hallmark of an oppressed group that tolerates exclusion, marginalisation and workplace abuse in an attempt to appease the dominant individuals (Boyle & Wallis, 2016; Roberts et al., 2009).

7.1.2. Team Dynamics

The second core category was team dynamics. Four themes were identified under this core category: (1) Competition, (2) Favouritism, (3) Conflict due to friction between team members and (4) Conflict due to differences in rules and regulations. The medical workforce functions via teams of doctors, nurses, and other allied health staff. This study found that the dynamics of the interactions between the medical professionals in the teams, as well as inter- and intra-departmental dynamics between various medical and surgical specialities, can create a work environment where conflict can arise, which may eventually lead to bullying. These findings are similar to the findings of several other studies, which determined the role of conflict in creating a bullying environment (Baillien et al., 2017; Einarsen, 1999; Skogstad et al., 2007). Competition between the members of medical teams can create friction between colleagues. Competitive dynamics result from a resource imbalance in the medical profession, where junior doctors compete with one another to acquire better career opportunities (Kyriakides & Virdee, 2003). Studies incorporating the Job Demands-Resources Theory to investigate bullying indicate that a lack of resources in the workplace creates tensions among group members. When there is an absence of adequate resources to address the job demands, and individuals compete against one another to access essential resources (e.g., workplace support) to perform their jobs;

for example, organisational support to get the tasks completed, a competition dynamics in the teams can result in conflicts which may turn into bullying (Van den Broeck et al., 2011). Scholars also suggest that a competitive environment in healthcare organisations not only sabotages cooperation between the members of the medical teams but also imparts a sense of inadequacy and self-doubt in junior doctors, ultimately making them vulnerable to all kinds of abuse and bullying behaviours (Crowe et al., 2017)

Favouritism was another theme of the team dynamics. Participants described favouritism as one of the explanations for bullying, as it led to unfair distribution of tasks and career development opportunities. Gender bias, interpersonal dynamics and workplace relationships exacerbate favouritism. Scholars also argue that favouritism may cause resentment and a feeling of exclusion in teams, leading to friction and bullying of team members (Demirel & Seçkin, 2014). These findings are consistent with the propositions of Social Identity Theory (Tajfel et al., 1971). Studies describing the role of social identity in bullying emphasise that individuals relate to and favour those individuals who they consider the members of their group and exclude others perceiving them as outgroup members (Escartín et al., 2013; Ojala & Nesdale, 2004). Thus, the favouritism-competition dynamic may emerge from the interplay of social identities in teams (Escartín et al., 2013; Tajfel, 2010).

Conflicts due to friction between team members disrupted communication and adversely impacted the interpersonal relationships of team members, resulting in a breakdown of teamwork. Workload imbalance within teams and reluctance to handle tasks also led to a build-up of tension and resentment. This impacted their ability to communicate effectively, leading to unresolved conflict which emerged as bullying. Several authors also suggest that negative communication patterns within healthcare teams can lead to conflict that results in bullying of healthcare workers (Nicotera et al., 2014).

Conflicts due to differences in rules and regulations was the final theme of the core category of team dynamics. Differences in rules and regulations between departments and specialities in healthcare organisations cause conflicts because the expected processes, practices and regulations of one department may differ from those of another. Several studies have explained that differences in rules and regulations within various departments – for example, the rules and regulations around authority and power structures – can lead to conflicts (Nicotera & Clinkscales, 2010; Nicotera & Mahon, 2013). Junior doctors rotate through several departments of healthcare organisations during their training. Unfamiliarity and differences in rules and regulations between these various departments and specialities may expose them to bullying behaviours. This is because lack of clarity leads to misunderstandings resulting from contrasting sets of rules and regulations and departmental expectations of individuals in terms of their performance within teams (Nicotera et al., 2014).

7.1.3. Hierarchy

The third core category of hierarchy in the NZ healthcare sector had three themes: (1) hierarchal systems encouraging bullying, (2) misuse of power: command and control approach, and (3) fear of retribution. Participants viewed the hierarch systems as creating power differentials that can become opportunities for bullying. The literature affirms that power differentials are present in healthcare organisations (Dhar, 2012; LaGuardia & Oelke, 2021). Further research notes that the layers of the hierarchy of medical professionals are based on their professional experience and professional skills, with many positioned above junior doctors (Noyes, 2022; O'Shea et al., 2019). This structure creates the possibility for junior doctors to be bullied because if the people high in the hierarchy are abusive, they use the system to victimise their subordinates (Karabulut, 2016; Reilly, 2006).

Another theme that explained bullying was the misuse of power in command-and-control systems. Seniors have greater authority, and some seniors misuse this authority to

intimidate and control juniors with unjust demands (i.e., not just issues of normal supervision) as also indicated in the literature (Normandale & Davies, 2002). If junior doctors try to deviate from what is expected of them by the hierarchy, they are bullied.

Fear of retribution was identified as another explanation for the bullying of junior doctors and an enabler of ongoing bullying. Junior doctors accepted bullying behaviours from the hierarchy, and thus, bullying continued to happen. The fear among junior doctors of facing consequences of standing up to bullying behaviour was described as making junior doctors accept abuse and bad behaviour from their seniors. They fear that if they speak up against seniors who hold powerful positions in the organisational hierarchy, these seniors might sabotage their opportunities for further growth and development in the medical profession. Other studies have also proposed that junior doctors fear the consequences of fighting bullying putting up with bullying behaviours because they want to excel in their careers and need references from their seniors (Crowe et al., 2017; Lempp et al., 2020). Junior doctors do not report bullying because they want to stay and progress in speciality training programmes, and such responses further encourage bullies to victimise vulnerable individuals.

7.1.4. Workplace Culture

The fourth core category explaining bullying was the workplace culture of the healthcare organisations. It included three themes: (1) Bullying as a norm, (2) A culture of ignoring and denial, and (3) A culture of blame, shame, and doubt. A culture of bullying is present in various departments and specialities where junior doctors accept it as a regular aspect of their professional journey (i.e., a norm). Studies also point out that workplace cultures can perpetuate bullying. Seniors make juniors believe that bullying is a traditional practice, and therefore, if seniors witnessed or experienced it, juniors should deal with bullying too (Edmonson & Zelonka, 2019; Rajalakshmi & Gomathi, 2016). This normalisation of abuse creates a cycle of bullying that keeps junior doctors silent—they are trapped in a bullying environment, resulting

in the encouragement of bullying and toxic behaviours. These findings are consistent with Mistry and Latoo (2009), who proposed that bullying can be passed on from bullied junior doctors to other doctors.

In addition, the conditioning of juniors by their seniors to accept bullying as normal behaviour often resulted in ignoring and denial of bullying issues. A culture of workplace bullying was instigated when supervisors and seniors ignored bullying or denied that bullying was happening. If junior doctors tried to fight against bullying, they were immediately shut down by their seniors, who disguised bullying as a tradition or a regular practice. These accounts complement the findings of some scholars who proposed that in some workplaces where bullying is considered normal, it can contribute significantly to bullying behaviours because victims deny the abuse, calling it a tradition or a common practice in their workplace (Mistry & Latoo, 2009; Wild et al., 2015).

A culture of blame. shame and doubt is present in NZ healthcare organisations. Senior doctors blame and shame junior doctors for their mistakes even if the subordinates are not at fault. This often results in a lack of confidence and diminished self-respect among junior doctors. Several scholars have indicated that a culture of blame and shame can escalate bullying (Shin, 2005). In this study, many junior doctors felt scapegoated (i.e., they were blamed unfairly for others' problems) and this led to feelings of doubt about their abilities and questioning their decision to choose the medical profession.

7.1.5. Systemic Issues

The fifth core category was bullying due to systemic issues. Participants suggested multifaceted systemic issues that contributed to bullying behaviours in NZ junior doctors' workplaces. These were described according to the following themes: (1) Increased workloads and understaffing, (2) Training structure of junior doctors, (3) Issues around policies for bullying

prevention and management, (4) Ineffective bullying reporting systems for doctors in training, and (5) Lack of consequences for bullies.

The extreme workload of junior doctors and understaffing in the NZ healthcare sector contributed to elevated stress levels that acted as a catalyst for bullying. For junior doctors, long work hours can lead to an environment that creates heightened impatience and frustration. Although junior doctors were most affected by understaffing and increased workloads, both junior and senior doctors were affected by extraordinary workloads and a shortage of staff. Bullying emerged as a coping mechanism to deal with pressure to perform during long working hours. Prior literature revealed that junior doctors were under pressure due to long working hours and resource imbalances, such as a shortage of staff (Imran et al., 2010; Riley et al., 2021). The findings of stress and increased workload are supported by Job Demand-Resources model that states that lack of adequate resources, such an absence or lack of organisational support such as compromised autonomy, absence of opportunities for growth and unclear job definitions still require employees to complete tasks under strict deadlines which may cause stress, misconduct and conflicts in the workplace potentially causing bullying (Bakker & Demerouti, 2007; Demerouti & Bakker, 2011).

Similarly, literature discusses frustration and anger resulting from high job demands and low resources, which may pose situations of heightened emotional responses, making bullying behaviours develop and escalate (Weiss & Cropanzano, 1996). These findings are further strengthened by the Affective Events Theory, which explains that bullying can be seen as the result of emotional responses and stress caused by challenging situations around assigned tasks, role ambiguity or negative events in the workplace (Christensen et al., 2023).

Another systemic issue identified was the training structure of junior doctors. Participants revealed that bullying was used as a learning strategy by supervisors and seniors during medical training. Junior doctors tolerated the bullying behaviours from supervisors to

complete the training and move to the next level in their careers. The literature supports these findings, also describing that trainee doctors encountered more bullying than senior doctors because they were part of a training system where bullying behaviours were used as a tool to teach and make junior doctors learn (Colenbrander et al., 2020; Quine, 2003). Seniors believed that the more bullying junior doctors go through, the better doctors or surgeons they will become (Scott et al., 2015); it will 'toughen them up' so they can grow professionally (i.e., the illusion of professional development) (Bentley et al., 2014; Hoosen & Callaghan, 2004).

Issues involving policies and procedures for bullying prevention and management were also part of systemic problems. Participants commented that current policies are inadequate for effective bullying prevention and management as they provide no direction for bullying prevention and management. The literature also points to the fact that the inadequacies of policies and procedures come from a lack of clear directions and guidelines and a failure to provide adequate support to the victims of bullying (Einarsen et al., 2002). In particular, the system seems to focus on reputation management for the powerful rather than eliminating the root cause of the bullying, which further exacerbates the challenges of addressing bullying. These findings are supported by the literature, which shows that policies must be improved for effective prevention and management of bullying: they must be socially accepted and must provide clear instructions and targeted solutions for bullying prevention and management (De Cieri et al., 2019; Hutchinson & Jackson, 2015).

The findings relating to an ineffective bullying reporting system for doctors in training also suggested systemic flaws. Participants identified a reporting system in NZ healthcare organisations that was influenced by conflicts of interest because the senior doctors and supervisors who may have been bullying their subordinates also had the task of filing and managing the bullying complaints of junior doctors. Studies indicate that an absence of impartiality in bullying reporting can lead to the reporting system being seen as not credible

(Hoel & Einarsen, 2020; Ironside & Seifert, 2002). The current reporting process for junior doctors undermines their efforts to report bullying or file grievances.

Finally, the lack of consequences for bullies provides another explanation for why bullying exists and escalates, revealing a system that encourages bullying because of the absence of accountability for those who exhibit bullying behaviours. Participants expressed their concerns over the systemic setbacks in NZ healthcare organisations. Scholars also suggest that managerial and structural challenges encourage a workplace environment of bullying where perpetrators face no consequences for their toxic behaviours (Hoel et al., 2020; Lutgen-Sandvik et al., 2010; Madolo & Hloba, 2023).

7.1.6. Acceptance Culture

The previous core categories collectively describe elements that relate to creating acceptance of bullying at multiple levels in the NZ health systems. Acceptance culture provided a supra-category, which explained the bullying of NZ junior doctors as a multifaceted phenomenon. The supra-category of acceptance culture involves themes around an acceptance of bullying that are rooted in the previous core categories: (1) Acceptance of bullying due to individual and social characteristics, (2) Acceptance of bullying due to hierarchy, (3) Acceptance of bullying as part of workplace culture, and (4) Acceptance of bullying due to systemic issues.

At the individual and social level, acceptance results from positional and social power along with the submissive, agreeable, and passive personalities of victims. The bullies accept bullying because it supports their positional power; the victims accept bullying in part because of their personalities and self-esteem. Individual and social characteristics and certain personality traits of bullies and victims, therefore, generate tolerance to bullying behaviours in junior doctors' workplaces (Einarsen et al., 2002; Parkins et al., 2006).

The hierarchal structure of healthcare organisations fosters an environment where bullying is accepted because the perpetrators may be in positions of authority. NZ junior

doctors accept abuse from people positioned higher in the hierarchy to avoid the consequences of challenging their supervisors in their training and careers. Scholars have also supported the notion that hierarchy drives acceptance of bullying among trainee doctors (Hoosen & Callaghan, 2004; Leisy & Ahmad, 2016). Acceptance of bullying from those higher in the hierarchy fosters the cycle of bullying, further fuelled by the power dynamics of the hierarchy system where junior doctors have no choice other than accepting bullying to remain in the profession (Cheema et al., 2005; Hoosen & Callaghan, 2004; Leisy & Ahmad, 2016).

Acceptance of bullying also stems from a workplace culture where abuse and toxic behaviours emerge as a tradition or norm (Bremert, 2021; Foster et al., 2004; Riley et al., 2021). Destructive behaviours such as frequent yelling, screaming and putting others down in front of their colleagues and other staff are described as normal with trainee doctors internalising the bullying and abuse as part of their workplace culture (Rajalakshmi & Gomathi, 2016). Regardless of junior doctors' frequent experience of this toxic behaviour, they accept it under the label of 'workplace tradition'. The cultural backgrounds of the junior doctors were also identified as an avenue for explaining how individuals from Western cultures accept bullying, considering bullying is a norm, and those from Eastern cultures accept bullying because they perceive that conforming to toxic behaviours from authority figures is a form of respect for seniors and supervisors in their workplaces.

The findings illustrated that junior doctors also accepted bullying due to systemic issues related to training. There is an acceptance that a bullying experience is part of 'professional development' (Mistry & Latoo., 2009). Junior doctors believe that enduring bullying is crucial to their success during training, and it is essential to cope with abuse to become a successful doctor (Dhar, 2012; LaGuardia & Oelke, 2021; Vickers, 2014). Further, junior doctors need references to attain career goals, and this makes them continue to accept bullying and abuse (Hoosen & Callaghan, 2004). The ingrained acceptance of bullying by junior doctors in training

encourages bullies and abusive individuals to victimise the targets, considering them weak and unable to protect themselves.

In summary, this research has provided several novel explanations for the bullying of NZ junior doctors that build on the extant literature. Workplace bullying of NZ junior doctors is a complex interplay of many factors: social and individual characteristics of the bullies and victims, favouritism–competition team dynamics, and abuse by people at higher levels in the hierarchy. In addition, a workplace culture of bullying and abuse and systemic issues related to policies and procedures also fosters bullying of junior doctors.

The acceptance of bullying by the junior doctors comprehensively points to social processes at the individual, organisational and systemic levels that perpetuate the issue of bullying. This research emphasises that acceptance of bullying among NZ junior doctors is deeply rooted in a culture of acceptance of bullying where seniority and power dynamics allow bullying to thrive unaddressed. Unchallenged and rigid training structures of junior doctors further discourage them from speaking out. The normalisation of bullying, in such a situation, turns into a self-reinforcing mechanism as the victims may internalise bullying as a compulsory part of their training. This study challenges the conventional narratives of bullying in literature by framing bullying as a structural issue embedded at multiple levels (i.e., micro, meso and macro) of the junior doctors' work environment rather than describing bullying as an isolated depiction of individuals' misconduct. These findings will be further emphasised as an original contribution in the next chapter—Chapter 8.

7.2. Research Question Two: Effective Prevention and Management

The accounts shared by the research participants on improving the prevention and management followed their ideas of theoretical explanations of bullying, outlining possible processes and opportunities for effective bullying prevention and management. Participants identified multidimensional mechanisms for successful prevention and management and targeted

solutions at multiple levels. Five distinct themes offered suggestions for the prevention and management of bullying. These themes were: (1) Flattening of hierarchies in NZ healthcare organisations, (2) Frequent change of leadership, (3) Organisational support, outlining support mechanisms and roles of employees in prevention and management, (4) Systemic changes, and (5) An effective reporting system.

7.2.1. Flattening of Hierarchy

Participants indicated that transforming the organisational hierarchy, involving a frequent change of leaders and an environment where power-sharing is encouraged and distributed among the employees, could be beneficial for eliminating bullying. Participants emphasised that bullying triggered by the misuse of power granted to medical staff and medical management in NZ healthcare organisations can be mitigated by more equal distribution of power. Several previous studies support these findings (Escartin et al., 2011; Green et al., 2017; Wright, 2020).

7.2.2. Frequent Change of Leadership

Participants' accounts suggested that frequent change of leadership is a proactive approach to bullying prevention and management because it breaks the alliance between the bullies and their associates, who may try to protect the perpetrators and, thus, support bullies to evade accountability. Changes in leadership were described to encourage cooperation and responsibility for all individuals, including leaders, fostering a bullying-free workplace. A structural change in the organisational hierarchy, including changes in the roles of supervisors and senior leaders, can alter the power dynamics in healthcare organisations so that bullies are unable to manipulate management to avoid consequences.

7.2.3. Organisational Support

Bullying is less likely to thrive in an environment where organisations are focused on preventing and mitigating bullying through practical organisational support (Boyle & Wallis,

2016; Chan, 2009; Hoosen & Callaghan, 2004). Both healthcare organisations and their employees can play crucial roles in preventing and managing bullying. The key findings related to organisational support in this study confirmed other literature indicating that awareness, education, and proactive roles for healthcare employees in prevention and management, can discourage bullying behaviours (Chan, 2009). Healthcare managers, leaders, senior doctors, supervisors and junior doctors all need to participate in preventing and managing bullying. Awareness can be raised by arranging workshops, conferences, and presentations on bullying and abuse so that employees know how to recognise, report, and manage bullying. Further, organisations can support junior doctors by helping them understand the negative impacts of bullying and the importance of speaking out against bullying so junior doctors can feel supported and empowered to report bullying and abuse.

7.2.4. Systemic Changes

Leadership's role in preventing and managing bullying emerged as an essential aspect of bullying prevention and management. Medical administration, clinical leadership and senior management must embrace transformation and an antibullying stance to prevent and manage bullying (Hoosen & Callaghan, 2004; Laschinger & Fida, 2014). Participants suggested that change should start at higher levels of management and move to lower management. It must be top-down, starting at the broader societal and organisational level and moving to the individual level. Similarly, senior doctors and supervisors have an essential role in addressing bullying by providing guidance and support to junior doctors facing bullying (Einarsen et al., 2002). Seniors' and supervisors' demonstration of zero tolerance to bullying can create a culture of respect and trust that discourages victimisation and abuse of NZ junior doctors.

Systemic changes regarding policies and procedures were also identified as critical for the prevention and management of bullying. Data suggested that clear, on-point and targeted policies for the prevention and management of bullying play an essential role in addressing

bullying in junior doctors' workplaces. Policies that define bullying clearly and comprehensively, and identify the consequences of bullying behaviours, can effectively help to eliminate bullying (Johnson, 2015; McElroy, 2019; Pisklakov et al., 2013). Policies need to be revised regularly to ensure that they are relevant and effective against bullying (McElroy, 2019). Setting clear expectations and guidelines around what is considered normal behaviour and what is bullying can assist junior doctors and managers in recognising abusive behaviours and bullying, which is the first step to effective bullying prevention and management by encouraging accountability for destructive behaviours in healthcare organisations.

Effective implementation of the policies and procedures was another insight that emerged from the findings of this study. Participants suggested that effective implementation of the policies and procedures meant management's determination and commitment to resolve bullying when it arises. Managers' drive to take action and hold the perpetrators accountable for their abusive behaviours can address bullying behaviours (Munro & Phillips, 2023; Sheehan et al., 2020). Effective training around understanding and implementing policies and procedures is also a vital aspect of prevention and management. Managers can be proactive in moving away from in-house handling of bullying complaints to involving independent experts in policy implementation who are familiar with the protocols for addressing bullying complaints. Such a collaborative system for preventing and managing bullying can foster a healthy work environment for junior doctors.

7.2.5. An Effective Reporting System

Establishing an effective reporting system was another important theme described within the prevention and management core category. Junior doctors explained that reporting processes must be straightforward, hassle-free, and functional, as also indicated by extant literature (Munro & Phillips, 2023). The literature also emphasises the importance of establishing an effective reporting system to address bullying (Hutchinson & Jackson, 2015). Simplification

of the steps involved in reporting bullying can take pressure off the victims and encourage them to come forward with their complaints. A reporting system that is run by an impartial individual and is easy to navigate can ensure that victims report bullying without fear of facing repercussions for standing up to bullies (Munro & Phillips, 2023).

In summary, the flattening of hierarchal systems by power sharing in healthcare organisations, organisations' support, and actions that portray genuine concern for addressing bullying while handling bullying complaints can help mitigate the bullying of junior doctors. In addition, proactive behaviour from managers, leaders, supervisors and junior doctors may prevent further victimisation and abuse of vulnerable individuals. Systemic changes with precise, up-to-date and effective policies may also contribute to effective prevention and management of bullying. The involvement of external bodies with critical skills in antibullying laws, policies, and procedures may ensure impartiality and a positive outcome for the victims of bullying, thereby increasing junior doctors' trust in managers to address reported bullying behaviours. Regular monitoring at each step of the reporting system to identify systemic shortcomings may also ensure critical adjustments and improvements in the reporting system so that the reporting mechanisms are responsive and effective in resolving bullying complaints. These findings in the NZ context are supported by the international literature and extend the evidence for the specific enablers of bullying and mitigating opportunities for bullying in the healthcare sector. The suggestions from participants are grounded in a desire to change the acceptance culture around bullying, as introduced in the first research question. The next chapter presents the grounded theory developed in this thesis.

Chapter 8: Acceptance Culture Theory

The purpose of this thesis was to develop theoretical explanations for the bullying of junior doctors to assist in preventing and managing bullying. This chapter theorises the evidence presented in chapters 5 and 6 and noted in the discussion chapter 7, and provides overarching theoretical explanations for the bullying of junior doctors.

CGT is a flexible framework for grounded theory analysis that provided me with an opportunity to immerse myself in the experiences and views of participants and gain a comprehensive view of the bullying phenomenon and potential prevention and management. CGT analysis helped me get a deeper understanding of bullying. It allowed me to connect the data and explore relationships, make comparisons, and explore any variations. I used CGT analysis flexibly, and rather than incorporating my data in a single core category, I used the CGT approach to identify multiple core categories, providing focal points in the data that allowed me to overlay the foundational elements for constructing a theory. Strauss and Corbin (1998) introduced this approach to acknowledge the role the researcher plays as the creator of theoretical abstraction. Insisting on a single core category can prevent the researcher from recognising patterns in data, making interconnections and, therefore, theorising effectively (Strauss & Corbin, 1998). Charmaz (2006) also encouraged qualitative researchers to think 'out of the box'. Inspired by this approach, I took the opportunity to be flexible in my CGT approach. Thus, multiple core categories were developed rather than subsuming various themes in a single core category. I developed numerous core categories also because of the complexity of the social processes underlying the bullying of NZ junior doctors. Developing multiple core categories was also beneficial because unravelling the processes and connecting the dots could facilitate a better understanding of the relevant social processes.

Then, following the detailed understanding of the multiple core categories and how they are interrelated, the most effective approach for theoretical abstraction and to propose a

theoretical framework was articulating a supra-core category. Six core categories in total, including one supra-core category, emerged from data analysis. All six core categories included processes underlying explanations of bullying. A seventh core category, illustrating bullying prevention and management, was also identified. In this chapter, I engage in active exploration of the meanings, patterns, connections, interactions and variations in core categories to develop a theoretical framework that will contribute to the broader scholarship and discourses on the explanation of the bullying process and prevention and management of bullying. I predominantly focus on the social process of acceptance that was found to be an all-encompassing or supra-core category or framework, with elements of all other core categories that explained bullying processes for NZ junior doctors. I also propose a model that will help understand the bullying process and assist in bullying prevention and management.

8.1. Conceptual Elements of the Study

Before engaging in the complexities of theorising, I aim to provide an environmentally contextualised, nuanced overview of the concepts that provide the foundation of theoretical abstraction around the explanations of the bullying process of NZ junior doctors. By presenting these foundational concepts, I want to ensure that the theory that emerges from the CGT is an adaptable theoretical sketch, inviting researchers to interrogate and engage with the emerging theoretical framework critically.

The first foundation of my theory is acceptance culture. Participants' accounts provided meaningful insights about a broader framework that illustrated the acceptance of bullying by junior doctors. Researchers have talked about passive acceptance of abuse and bullying by individuals, overlooking broader social and societal impacts on this behaviour (Darjan et al., 2020; Pronk et al., 2020; Waasdorp & Bradshaw, 2011). Similarly, other groups of researchers explained bullying behaviours considering the organisational and social aspects, ignoring the

interplay between the individual agency and acceptance of bullying to describe the bullying process (Hutchinson et al., 2006a; Liefooghe & Mac Davey, 2001).

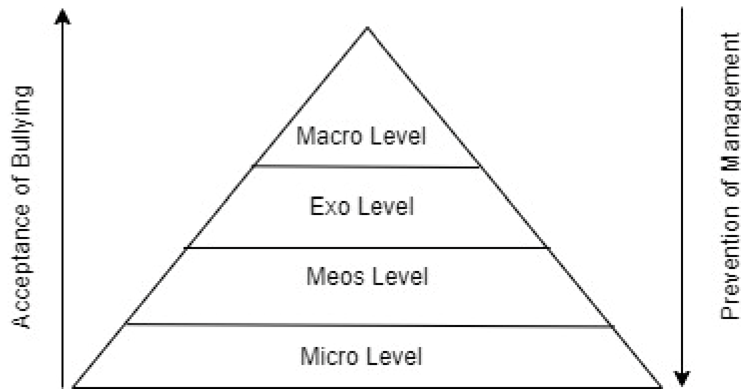
My analysis offered insight into a phenomenon that closely resembled the concept of organisational culture that contributes to bullying yet is different to this organisational culture that contributes to bullying in several ways. Organisational culture is constituted by the hidden values, beliefs and attitudes of individuals in workplaces; management researchers looked into this construct to understand better how to provide solutions to issues in organisations (Schein, 2010). I argue that although workplace culture offers one way to consider the bullying process, it is the phenomenon of acceptance that takes place at multiple levels that contributes more strongly to bullying. Acceptance culture is related to participants' behaviours, attitudes, and beliefs regarding the acceptance of bullying in their workplaces. It is a larger framework that has its roots in several elements driving social processes related to acceptance of bullying (e.g., individual and social characteristics of individuals, hierarchy, workplace culture and systemic issues). Acceptance culture captures the complex phenomena that underline why junior doctors accept bullying—the processes that may cause bullying or escalate bullying behaviours. Thus, acceptance culture is an essential theoretical foundation for explaining bullying.

The second foundational element of my theory is the interplay between acceptance culture and multiple levels of doctors' work environments. Drawing on the ecological system theory approach (Bronfenbrenner, 1992, 2005), I argue that an acceptance culture of bullying develops through many social processes taking place simultaneously at multiple levels of the junior doctors' ecological system' (i.e., micro, meso, exo, and macro levels). The micro level of the system is based on the connections and interactions of individuals with their immediate environment and has the most impact on human responses to their environment (Elliott & Davis, 2020). Acceptance at the mesosystem level moves beyond an individual-level focus to the elements of the environment that are closest to the individual level, for example, the junior

doctors' workplace culture and hierarchy. The exo level illustrates the interactions between individuals and their external environment—it relates to the network that facilitates the remote social set-up of individuals in a group or community (Espelage, 2014); for example, the exo-system is the effect of regulatory matters on a group of doctors or the medical workforce. At the macro level, social processes related to systemic issues, national culture or societal aspects have an influence (Jack, 2012). Later in this chapter, I further describe the social processes of the development of acceptance culture at the micro, meso, exo and macro levels when I present my theoretical assumptions and propositions.

My research data indicated that acceptance of bullying can be seen at the micro-level of the junior doctors' ecological system, with individuals accepting bullying in their immediate environment. The process of acceptance emerged as an attitude through individually mediated factors (individual and social aspects) as well as a larger framework covering the social and organisational elements. Acceptance of bullying is a comprehensive phenomenon, which means that although acceptance may be present at the micro or individual level, it links through meso, exo, and macro levels of the junior doctors' ecological system. Analysis revealed that bullying emerged and was accepted at multiple levels. Similarly, effective prevention and management of bullying was also identified as a complex and comprehensive phenomenon, which means comprehensive steps must be based on processes from macro, exo, meso and micro. Figure 8.1 shows the multiple levels of the ecological system where acceptance of bullying takes place.

Figure 8.1 *Four Levels of the Ecological System*



The third concept is the individual stress response (i.e. fight, flight, freeze responses). Fight refers to attempting to alleviate bullying by confronting the bully or reporting it so it can be addressed (Reyneke, 2019). The flight response involves escaping the challenging situation around bullying and not addressing it to avoid conflict in the workplace (Field, 2011). Freeze is an individual's inability to respond to the bullying situation because they are stuck in a repetitive cycle of bullying (Field, 2011). Several studies explored the psychological stress reactions to bullying (Einarsen & Mikkelsen, 2002; Hogh et al., 2011; Nabe-Nielsen et al., 2017; Taniguchi et al., 2016) with some exploring the psychological stress response to bullying in relation to socio-ecological frameworks (Swearer & Hymel, 2015) However, there is an absence of research exploring the concept of acceptance as an individual stress response like other stress responses (e.g., fight, flight, freeze responses) in victims' ecological systems.

Bullying happens as a result of a complicated phenomenon that has a unique nature. There is evidence that processes related to individuals' personalities, choices, and responses foster a bullying environment (Reknes et al., 2021). Some scholars have also talked about coping mechanisms that moderate bullying (Bernstein & Trimm, 2016; Van den Brande et al.,

2021). These processes seemed to impact individuals' agency and their flight, fight or freeze approach. The questions remain: Why do junior doctors accept bullying? How does the acceptance take place? Why do some take action against bullying? The complicated nature of the bullying process is evidenced by the fact that some aspects of the bullying process happen at the individual level (i.e., the micro level) while others occur at a level that is beyond individual agency and control; for example, at broader organisational or societal level (Heames & Harvey, 2006; Hoel & Cooper, 2001). For this reason, I argue that conceptualising the phenomenon of acceptance to various stages of the fight-flight-freeze stress response at multiple levels of the ecological system can effectively explain why junior doctors accept bullying behaviours.

Having introduced the key concepts and foundational elements, I now systematically explain the development of acceptance culture through 'Acceptance Culture Theory'(ACT). In the next section, I introduce the assumptions of the theory, which provide a grounding for theoretical propositions.

8.2. Theoretical Assumptions

Assumptions are the foundational aspects on which a theory relies. A concrete assumption has the potential to be verified. Facts are assumed from the available facts. These assumptions act as pillars for building my theory. Through these assumptions, I explain the answers to the questions I considered (e.g., why do doctors accept bullying?) while developing the theory and application of ACT.

8.2.1. Acceptance Culture at the Micro Level

A1: Individuals' reactions to bullying. Acceptance of bullying at the microlevel emerges in the form of the stress response; junior doctors may adopt acceptance as a strategy to appease abusers in the face of adversity. At the micro level, acceptance advances through several steps of fight, fight, or freeze stress reactions.

Individual and social characteristics (e.g. self-esteem, gender) and coping mechanisms, such as an individual's stress response, can describe individuals' responses to bullying behaviours and how they react (Hansen et al., 2006; Lutgen-Sandvik, 2008; Samnani, 2013). Humans, being social animals, initiate this response at the individual level to seek social support and engagement with other individuals to cope with the stress (Baldwin, 2013). If they are self-assured, they may try to resolve the issues themselves but end up being bullied more, regardless of their efforts to fight the bullying. On the other hand, those with a lack of self-esteem will accept bullying more than those who are self-assured and, therefore, will be further bullied (Khalib & Ngan, 2006; Skues et al., 2005). Acceptance of bullying becomes an inevitable process for victims in the absence of support from other individuals, fostering an acceptance culture at the micro level.

A2: Acceptance emerges as a conciliation strategy. In situations when victims are unable to fight or flee from the bullying situation, they will freeze. Victims will resort to a 'conciliation strategy', assenting to the perpetrators' aggressive behaviours and trying to make peace with the situation. This will trigger acceptance culture at the micro level in healthcare organisations.

To satisfy the perpetrators, victims agree and respond in the way that the perpetrator likes to see: individuals do anything and everything to prevent the abuse, depending on their individual and social characteristics and personal attributes. For example, when the victim of abuse is in an environment where they cannot fight or flight, regardless of the individual and social characteristics of the victim, the highly evolutionary adaptive response to threat is trying to pacify the aggressor by acceding to their demands or making peace with the situation by accepting it (Mullen, 2020). Victims may even try to minimise bullying by apologising for bullying, calling it a mere 'misunderstanding' even if they are not at fault (Cowan, 2012;

Strandmark & Hallberg, 2007; Walfisch et al., 2013). This is fuelled by an acceptance of the situation.

Acceptance culture at the micro level stage is a 'freeze' response, with individuals feeling a sense of helplessness and being unable to take any action against bullying. In this situation, victims accept bullying and stay in the same organisation, with the exception of some who choose to quit and move to other organisations in severe cases of bullying (Hämmig, 2023; Smith et al., 2016). However, several studies indicate that a typical pattern in the medical profession is that victims of bullying choose to stay and work in the same organisation where they encountered bullying (Lutgen-Sandvik et al., 2010).

A3: Normalisation of Bullying. Individuals justify bullying behaviours by attempting to regulate the strain of the situation and appease authority figures positioned higher in the organisational hierarchy, thereby generating an acceptance culture through a normalisation process.

In case of a threat from a colleague or a supervisor, the first response of the victim is to normalise the situation by ignoring and agreeing to appease the supervisor (Braithwaite et al., 2008; Pheko et al., 2017). Initially, at this stage, the use of avoidance is practised as 'doing nothing' to escape the situation (i.e., flight) (Jóhannsdóttir & Ólafsson, 2004). Then, in the next stage, victims try to regulate bullying through a coping response (i.e., a freeze response) of normalising as a way to ignore the conflict. However, for perpetrators, normalisation is a way to escape the consequences (Hirzalla et al., 2019). This normalisation eventually leads to the acceptability of bullying (Power et al., 2013; Salin, 2021).

8.2.2 Acceptance Culture at the Meso Level

A4: Hierarchy System Impact: If supervisors in the hierarchy are abusive, junior doctors avoid direct confrontation with the perpetrators during bullying and times of distress. At this stage,

junior doctors' acceptance may be visible as conflict avoidance (flight) as well as passive-aggressive attitudes (fight).

At the meso level, individuals show acceptance in a manner similar to the 'fight or flight' stress response through passive-aggressive behaviours (fight) and avoidance (flight) simultaneously. When victims are in the fight mode, they try to retaliate against abusive people (Bjørkelo, 2013). Further, victims attempt to save themselves by modifying the previous micro-level 'doing nothing' (freeze) response to passive-aggressive behaviours (fight). Victims choose avoidance over direct confrontation with abusive people higher in the hierarchy as a flight mechanism (Ireland, 2013; Zhang et al., 2020). They recognise that any direct response to the threat of bullying (e.g., direct aggression in response to aggression/ or bullying in response to bullying) is not a favourable choice, with bullies being in a position of power. As a result, victims accept their junior status in the hierarchy and try to 'prey on predators' by exhibiting passive-aggressive behaviours (Lee & Brotheridge, 2006; Paull et al., 2012). At the meso level, avoiding direct confrontation slowly turns into the acceptance of bullying, triggering an acceptance culture.

A5: Perpetrators' Reactions and Lack of Support: Victims turn to their supervisors, managers, and leaders for support to feel safe and protected. Supervisors may withhold their support, trying to make the victims conform to their authority. They may force victims to accept the situation, triggering an acceptance culture. Victims may start to believe that fighting against abuse is futile because the abusers are in a position of power, and there are no consequences for them.

Junior doctors' fight mechanisms may reactivate at this stage, only to become a flight response visible through ignoring and denial of the issue. Victims want to retaliate against or at least address bullying and turn to seniors for support, but they face mistreatment and further abuse (Liefooghe & Mac Davey, 2001). Victims retaliate, inspired by a need for justice and to

seek a solution to the issue. However, evidence from my study suggested that the more victims tried to fight and retaliate, the more bullying they encountered from the abusive people in the hierarchy. Efforts to counter and defend against bullying emerge, but victims face more obstacles and even further bullying (Bjørkelo, 2013; Meglich-Sespico et al., 2007). As a result, they stop fighting and resort to denial of the bullying. Victims convince themselves to keep quiet and tolerate bullying to avoid the negative consequences for their careers (Easteal & Ballard, 2017). This situation fosters an acceptance culture.

A6: Exploitation by powerful seniors, leading to self-preservation through acceptance: Victims are perceived as a problem by the seniors; fear of further bullying discourages the bullied individual from taking action—facilitating an acceptance culture as a way of self-preservation.

Self-preservation is a critical instinct in humans, adopted as a protection mechanism against harm (Khantzian & Mack, 1983). Although it may seem that fighting against bullying is the ultimate step towards finding a solution to the issue, it is not always the final step for victims. Junior doctors engage in 'self-preservation' as a way to protect themselves from further abuse. By the time bullied junior doctors are ready to fight the bullying, its management by the authorities is already at a stage where victims are perceived as an issue. There are efforts in place to silence them. Any step that is taken to prevent further bullying is already ineffective. My data indicated that a lack of understanding of the victim's situation results in questions about bullied doctors' professional competency and capabilities to grow into better medical professionals**.** They are considered weak if they retaliate because medical and surgical training demands doctors to toughen up and face bullying as part of their training (Colenbrander et al., 2020).

A7: Workplace Culture. Organisational culture facilitates acceptance of bullying. Junior doctors face discouraging behaviours from seniors and leaders who fail to acknowledge the issue, considering bullying a tradition. In such a case, when victims escalate a complaint, they

are perceived as weak and unworthy of the profession. They are shut down, and the action against the bullying is delayed.

Junior doctors who choose to escalate the complaint may be emotionally, physically and mentally exhausted at this stage. Fear of retribution takes over, which makes them accept that bullying is a norm and nothing is going to change (Peng et al., 2016; Vie et al., 2012). There is no choice but to accept bullying, labelling it as an evitable part of workplace culture, which leads to an acceptance culture (Rahm et al., 2019). Victims activate the acceptance culture by perceiving that bullying happens as part of their medical or surgical training. Bullied junior doctors are made to believe that they are not good enough. They start questioning their abilities as doctors and whether they are meant to be in the medical profession as a result of gaslighting. Gaslighting is a term that explains the manipulation of victims by bullies (Garrick & Buck, 2022). It is a way of making an individual feel doubtful about their professionalism, thoughts and competencies (Ahern, 2018). Bullied individuals are specifically targeted when healthcare organisations enforce reprisal and assume that victims are overreacting to a normal interaction (Ahern, 2018). When victims receive this kind of treatment, they believe that they are personally responsible for all the bullying behaviours they are facing and that they are experiencing bullying in their workplace because they are in the medical profession.

8.2.3. Acceptance Culture at the Exo level

A8: Regulatory bodies. When regulatory oversight is absent and external bodies fail to facilitate antibullying policies, there may be a lack of consequences for bullying, which fosters an acceptance culture.

Even if some doctors decide to take legal action or take external legal advice, the resources available to junior doctors to escalate complaints and fight at this level are negligible compared to the organisational hold on resources and approaches. Research indicates that employee unions may support management because they lack the professional skills to fight

on behalf of bullied employees (Hoel & Beale, 2006; Mawdsley & Thirlwall, 2021). If victims escalate bullying complaints, employee unions may not create positive outcomes for the victims during negotiations with healthcare organisations due to employee unions' inability to challenge the system or lack of authority to implement antibullying policies. There also is no authority to change the inadequate antibullying policies to support the victims. This situation may result in victims choosing not to pursue the bullying complaint and instead, they accept bullying in their workplaces. If any victims decide to fight, they may bypass the use of their employee union to represent their case because of a lack of action. They would rather seek external legal advice. Those who choose to fight through lawyers are aware that winning the legal battle is not easy, and if they decide to fight, there will be consequences for their careers because the bullies may be their supervisors and seniors who provide them with referrals and career advancement opportunities. At this stage, junior doctors who want to stay in the organisation may accept the bullying and consider a middle ground to settle the dispute with the organisation to advance their careers. Alternatively, they may choose to leave their jobs to avoid being bullied any further.

8.2.4. Acceptance Culture at the Macro level

A9 Medical Training. Bullying becomes normalised during medical training and fosters an acceptance culture of bullying.

Victims believe that speaking up is useless because it requires giving up their training, their career advancement and their career development prospects. Acceptance [culture] becomes an inevitable choice for junior doctors during training. While acceptance looks like giving up for victims, perpetrators believe that junior doctors' acceptance of bullying during training is the foundation for becoming a successful doctor or surgeon. Seniors think that bullying happened to them and, therefore, it must happen to their juniors and subordinates. Seniors expect junior doctors to 'toughen up' (Barrett & Scott, 2018; Scott et al., 2015).

Consequently, bullying behaviours toward junior doctors continue. Bullying becomes a recurring pattern and a continuous cycle during training (Peterkin & Bleakley, 2017). During training, when junior doctors in a workplace with extreme bullying choose not to fight back, they don't opt for quitting because they do not want to lose career development opportunities. Instead they get stuck in the cycle of bullying, which is difficult to escape, and bullying continues to happen (Jeffrey, 2014). The cycle of bullying keeps junior doctors in a state of powerlessness and fear (Bremert, 2021). Victims may be in freeze mode at this stage. They are aware of the bullying they encounter during training, yet they do not choose to act against it. They accept bullying and stay in the same organisations, strengthening the acceptance culture by enduring bullying as part of their training and professional development even though their mental, physical and emotional well-being may be at stake (Colenbrander et al., 2020; Leisy & Ahmad, 2016).

Junior doctors are afraid of the consequences if they choose to speak up (Brennan & Davidson, 2019). This again fosters the acceptance culture. Most junior doctors, in a state of freeze, are unaware of the ongoing complexity of the bullying process. The bullies may function through a 'test and trial' strategy. This means that perpetrators, who are, in most cases, the seniors or the individuals in positions of authority, push the subordinates because they have perceptions and beliefs that are shaped by their own experiences of bullying. They get to interact with a coworker or a colleague or trainee who has an aggressive personality. Worse, they are all in a vicious cycle of conflict and bullying, where the more powerful one will push the other person more and more (Brennan & Davidson, 2019). Although they might have started on an equal level, the conflict can quickly turn into a power struggle and control, leading to bullying, as an imbalance of power is the main attribute of the bullying process (Kumari et al., 2020; Samsudin et al., 2020).

A10: Systemic shortcomings. Ineffective antibullying policies and procedures and their poor implementation facilitate an acceptance culture.

Bullying policies are ineffective because one of the significant challenges of prevention and management of bullying is that prevention and management policies are primarily focused on the individual level, rather than placing an emphasis on all aspects at individual, organisational and social levels (Hodgins et al., 2020). Because of this, victims are left unsupported when they need the most social and organisational support. Victims are ignored and avoided when prevention and management policies do not offer reforms at the organisational and social levels. For example, my research data indicated a need for comprehensive outcomes for bullying management, with participants identifying a need for a top-down (macro- to micro-level) approach. Participants stated that change should start with the seniors and higher-level management. Perpetrators, who could be seniors, supervisors, or leaders in their specialities, do not believe that they are responsible for the bullying of junior doctors. From the seniors' perspective, the acceptance of bullying is interpreted as 'it happened to us, and so it should happen to them [junior doctors] too'. Participants talked about bullied doctors retaliating through aggression toward their colleagues due to the bullying, thus taking their frustration out on others. By the time they realise that it is bullying behaviour, they may have been in a state of acceptance for a very long time. I compare this 'acceptance' to a state of 'freeze once again'. To get out of the freeze response, junior doctors need to break the acceptance culture by standing up for themselves. However, a broader understanding of my research data showed that junior doctors' using their agency and choosing to stand up in situations of bullying rather than accepting bullying is a challenge for perpetrators being in senior positions.

A11: Current strategies are ineffective in preventing and managing bullying because of their enhanced individual focus.

The bullying process is a complex phenomenon happening at multiple levels (Berlingieri, 2015). Acceptance of bullying may initially be seen at the individual/ micro level, but the bullying process is also visible at the meso, exo and macro levels. Therefore, it requires efficient prevention and management strategies with all-inclusive individual, social and organisational elements at several levels of the ecological system to address bullying effectively. Strategies address individual behaviours, but they miss the multi-level nature of bullying. The bullying process can be complex, involving multiple levels. This means that although acceptance of bullying can be an individual phenomenon at the micro level, but the bullying process can be visible at the meso, exo and macro levels through seniors bullying their juniors or colleagues bullying other colleagues. Current strategies with an individual focus are not effective because the acceptance culture creates an environment where it is impossible for junior doctors to recognise bullying from seniors and fight against bullying. It becomes challenging for victims to seek help or initiate a healing process to come to a place of safety that would help them break the culture of acceptance and avoid further damage. Tolerance of abuse is inherent in the culture of NZ doctors' workplaces. When acceptance of abuse becomes a choice in freeze mode with an attitude of 'everybody goes through it, so everyone should', individual behaviours give rise to acceptance culture: victims and perpetrators are both entirely trapped without realising the serious impacts of workplace bullying. Victims' acceptance of the bullying paralyses them. They remain trapped in a cycle of bullying where, in most cases, they are unable to take action or decide to quit. For this reason, management must take action to break the freeze response or cycle of bullying at all levels.

In summary, the theoretical assumptions (A1-A11) of ACT explain the process of bullying among NZ junior doctors, with a focus on the acceptance of bullying that creates an acceptance culture, which is not only a culture but also a broader framework that encompasses individual, organisational and societal elements (e.g., individual and social characteristics,

hierarchy, systemic issues, and workplace culture) at the micro, meso, exo and macro levels. At the micro level, individuals accept bullying behaviour as a stress response that is governed by processes such as conciliation mechanisms and individuals' self-esteem. Acceptance can emerge as a way of conciliation or normalisation of bullying. At the meso level, power dynamics due to hierarchy and a lack of support from managers and supervisors can result in junior doctors' response of conflict avoidance and, eventually, acceptance of the bullying. The systemic flaws and regulatory shortcomings in addressing bullying also encourage an acceptance culture. When bullying is normalised, the cycle of abuse strengthens, and it is difficult for NZ junior doctors to escape it. Current strategies are ineffective in preventing and managing bullying because of the multifaceted nature of the bullying process, which takes place at several levels of the ecological system. The inadequacy of current policies emphasises a need for comprehensive strategies that address bullying at individual, organisational and social levels across several layers of the ecological system. An ineffective regulatory system can be addressed via a comprehensive approach at all levels of the ecological system to successfully counter the acceptance culture and prevent additional harm to NZ junior doctors.

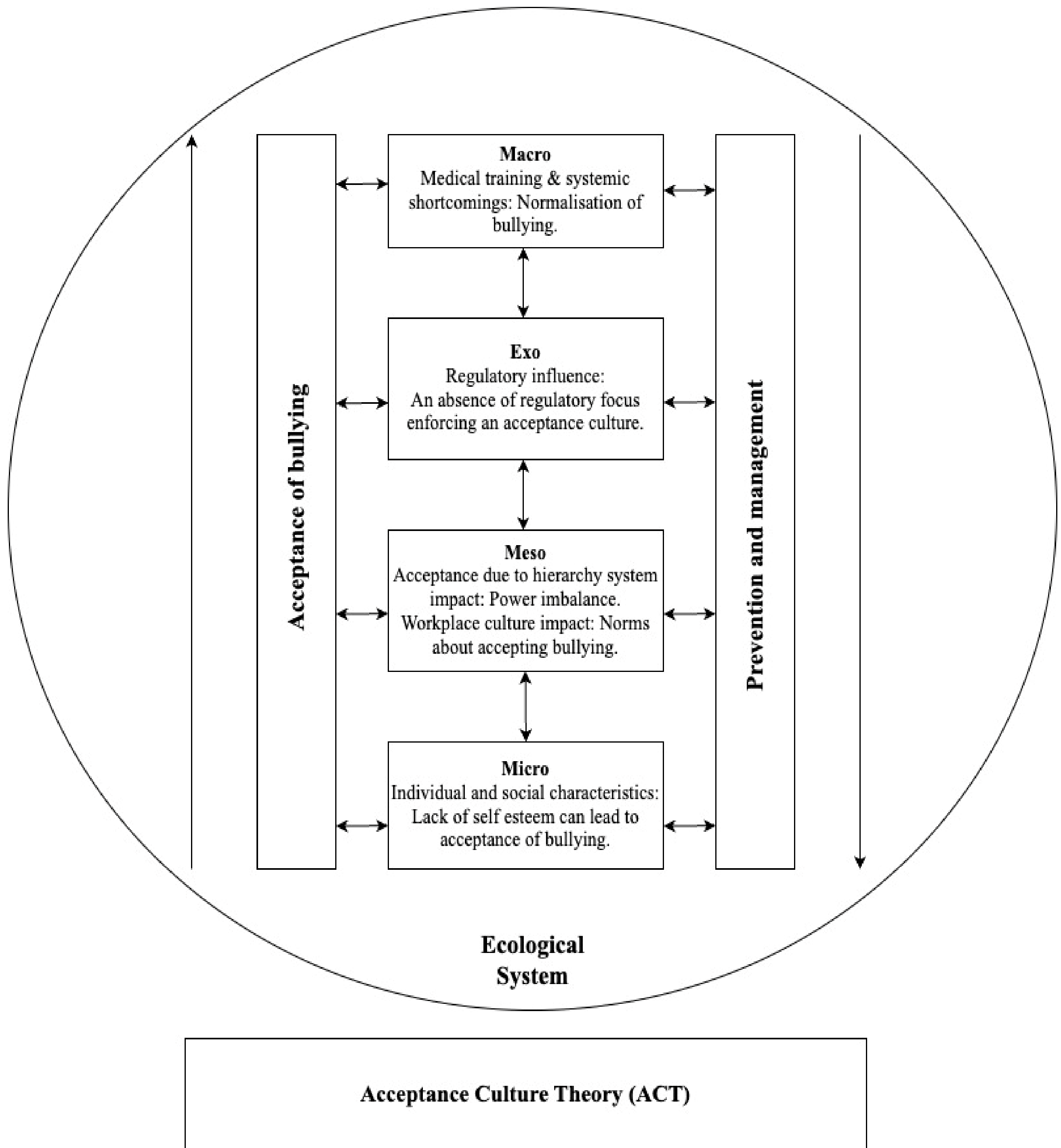
8.3. Propositions of ACT

The data in this thesis contributed to several explanations of bullying, including individual and social characteristics, hierarchy, workplace culture, systemic issues, and an acceptance of bullying. The core category of acceptance signifies that acceptance (culture) is an extensive framework encompassing individual, organisational, and social elements such as individual and social characteristics, hierarchy, culture, and systemic issues. The ACT model (Figure 8.2) is based on the theory's assumptions and propositions. The ACT model explains the process of acceptance of bullying at multiple levels. Acceptance of bullying happens at all levels of the ecological system, creating an acceptance culture. Acceptance of bullying is seen at multiple

levels including micro, meso. exo, and macro level. Similarly, prevention and management of bullying is also a multilevel and comprehensive phenomenon.

I also present and discuss propositions that relate to ACT. Propositions (P) 1-3 explain why NZ junior doctors accept bullying at individual levels. P4-7 discuss acceptance at the meso level. P5 also discusses the exo level, P7-P8 outline the macro level, and P9 details bullying prevention and management.

Figure 8.2 *Acceptance Culture Theory Model*



8.3.1. Propositions at the Micro Level

P 1: (a) Role of personal and social attributes in responding to bullying: Junior doctors' personal attributes and characteristics influence how they respond to bullying behaviours and create an acceptance culture.

The ACT proposes that social and personal attributes of the individuals in healthcare organisations guide their attitudes and inclination toward accepting bullying. Several studies suggest that victims respond to bullying behaviours depending on their individual and social attributes (Golmaryami et al., 2016; Saiz et al., 2019). Scholars introduced the idea that personal attributes relate to responses to bullying (Pöyhönen et al., 2010; Pozzoli & Gini, 2010; Zapf & Einarsen, 2002). Individuals with a lack of self-esteem accept bullying more than those who are confident and self-assured. It is challenging for those with low self-esteem to detect bullying and fight against it (Suggala et al., 2020; Vartia, 2001). Also, female doctors and migrant doctors are bullied more than those who are male and non-migrant (Gerada, 2020; Purkayastha, 2005). They cope with bullying behaviours and accept bullying to protect their careers (Brugha et al., 2021; Gerada, 2020; Purkayastha, 2005).

(b) Coping mechanism: *The lower an individual's sense of self-esteem, the more likely they will cope with and accept bullying.*

Victims use responses like fight to react and cope with bullying. Some individuals may not even fight against bullying. Rather, they cope by avoiding the situation because of their lack of self-esteem and negative self-image. They prefer to accept bullying rather than fighting and standing up against it (Ebrahim & Elrefaey, 2018; Li et al., 2020). Studies indicate that individuals with higher self-esteem, self-acceptance or self-worth are confident about their abilities to maintain relationships and create a positive self-image (Li et al., 2020). They may not tolerate abusive behaviours that sabotage their self-image or self-worth (Yoo et al., 2017).

In contrast, those employees who have negative perceptions about themselves may not be able to defend themselves in challenging situations or maintain positive relationships in their workplaces; they become a target of bullying behaviours (Khalib & Ngan, 2006). They do not show a fight or flight response against bullying. They cope with the bullying through avoidance, consequently facing more bullying (Upton, 2010). An ability to cope with challenging conditions may impact junior doctors' level of acceptance of bullying. Individuals' coping responses, such as fighting, are linked to acceptance of bullying (Bernstein & Trimm, 2016). Lower self-esteem results in acceptance of bullying because of an inability to fight against it.

P2: The more one work group member accepts bullying through a stress response such as flight or freeze, the higher the likelihood that another work group member will also accept bullying.

The proposition is based on the evidence that I collected through my research where bullied doctors responded to the bullying in a similar manner; i.e., acceptance (culture). I propose that if one individual in a group accepts bullying, it is likely that another in the same group will similarly accept bullying. The nature of the response to bullying can be the same for most victims in a similar environment, but the intensity of the response may differ among individuals (Cooper et al., 2004; Hansen et al., 2006). I argue that there are several reasons for this. First, organisations affected by bullying generally have a work environment that promotes abusive behaviours; thus, it is likely that bullying emerges and impacts every employee in the same toxic workplace to some degree (Agervold, 2009; Salin, 2015). There is also evidence of similar group behaviours in response to bullying. This means that if one person in the group accepts bullying, others in the same group will also accept it (Escartín et al., 2013). This can be due to social identity and culture-related aspects of group members (Glambek et al., 2020). Evidence suggests that group members may do it to fit in or become socially more acceptable (Ballien et al., 2009). Similar responses to bullying might also be due to similar group identities

and cultural norms (Salin, 2021; Samnani, 2013). Victims may also have similar experiences of bullying in the group as a result of similar types of bullying behaviour (Pope & Burnes, 2009).

8.3.2. Propositions at the Meso Level

P 3: (a) Power Imbalance due to Hierarchal Systems: The more individuals see that power is distributed unequally, the more likely they will be to accept bullying from a supervisor.

The hierarchal nature of the healthcare organisation produces power imbalances, which play a critical role in the acceptance of bullying. Power distance warrants psychological consent between the supervisors and the supervisees, where junior doctors are bound to accept the misuse of power by the supervisors in the form of bullying because of their higher status in the organisational hierarchy and greater power distance (Salin et al., 2019). Scholars have discussed the social acceptance of power in the context of bullying (Hutchinson et al., 2010; Yahn, 2012). Evidence also indicates that the social acceptance of power among colleagues puts them at risk of bullying because of lack of resistance and, therefore, acceptance of bullying (Salmivalli et al., 1996; Vaillancourt et al., 2009).

P 4: Workplace culture impact: The more organisational cultural values are inclined toward accepting bullying, the more junior doctors accept that bullying is normal.

This proposition is based on the evidence from my study indicating that workplace culture can escalate bullying if bullying is considered a tradition. Multiple studies have demonstrated that bullying escalates when it is regarded as an accepted part of workplace culture (Leisy & Ahmad, 2016; Pheko et al., 2017). Bullying being considered a norm may encourage acceptance of bullying because junior doctors might try to maintain this norm to preserve workplace harmony (Power et al., 2013; Salin, 2021). Individuals may believe that not accepting bullying would disrupt the solidarity of the workplace (Power et al., 2013). Thus, NZ junior doctors accept bullying under the influence of prevailing workplace culture in

healthcare organisations. The cultural values, norms and attitudes of individuals in organisations markedly shape the way bullying is perceived and sanctioned, therefore predicting the presence of an acceptance culture (Loh et al., 2010; Sidle, 2010). An organisational culture that encourages bullying may lead to the normalisation of bullying and the development of an acceptance culture (Pheko et al., 2017),

8.3.3. Proposition at the Exo Level

P5: The more regulatory focus is absent and external bodies fail to regulate antibullying policies, the fewer consequences there are for bullying behaviours, fostering an acceptance culture.

If the external legal consultation is not adequate, bullying behaviours may escalate. For example, without a proactive role of laws, legislations and external legal bodies including unions, accountability systems and health and safety authorities to regulate antibullying policies, bullying may prevail in workplaces (Rayner & Lewis, 2020). Victims who do not accept bullying and choose to fight seek external legal advice when management and administration fail to implement antibullying policies and address the bullying reports from victims (LaVan & Martin, 2008; Richards, 2003). Internal authorities may not take action against perpetrators because of their positions in the organisations. Therefore, victims seek external support, but the regulatory inefficiencies may not lead to positive outcomes for victims: this results in a workplace culture where bullying prevails as a cycle (Bryant, 2003; Mawdsley & Thirlwall, 2019). Victims may fear reporting because they feel unsupported and ignored (Hallberg & Strandmark, 2006). NZ Health and Safety Act (2015) emphasises policies must aim to create a healthy workplace for employees. However, in the absence of an organisational focus on antibullying laws, rules and regulations, victims have no choice but to accept the bullying and stay in the organisation. To cope with challenging situation, victims

accept the bullying behaviours. Victims stay in a freeze state and are unable to escape the cycle of bullying.

8.3.4. Propositions at the Macro Level

P6: Systemic Issue: (a) The more training ignores bullying issues and/or encourages acceptance of bullying, the more junior doctors engage in accepting bullying or show flight or freeze coping responses.

Several studies have indicated that medical and surgical training creates an environment for doctors where bullying behaviours are ignored; thus, bullying becomes a part of junior doctors' training (Colenbrander et al., 2020; Loerbroks et al., 2015; Parikh et al., 2017; Tahrekhani & Dinmohammadi, 2024). Training structures and junior doctors' educational experiences affect junior doctors' perception of bullying (Fnais et al., 2014). This also means that junior doctors consider bullying behaviours as usual aspects of their training because they are given an impression by their seniors that bullying is a form of learning and it will help them become better doctors (Colenbrander et al., 2020; Quine, 2003; Scott et al., 2015). In this way, medical and surgical training structures create an environment for trainee doctors that encourages the development of immunity and/or coping mechanisms; for example, escaping the situation, ignoring bullying (i.e., flight), or an inability to report bullying or take action (i.e., freeze), leading to acceptance of bullying.

(b) The more training discourages bullying, the more junior doctors don't accept bullying and engage in fight behaviours.

Altering training systems in a way that discourages bullying by educating the medical workforce about its adverse impacts can help junior and trainee doctors recognise bullying and fight against it (Leisy & Ahmad, 2016). Medical training can discourage bullying by creating an environment that cultivates compassion, empathy and support for the trainees if they make an error during the learning process (Robertson & Long, 2019). If the training structure is

centred around ensuring a bullying-free learning environment, junior doctors will not accept bullying. Rather, they will feel encouraged to fight any bullying behaviours that could hinder their learning. An education-oriented approach based on performance-related teaching strategies will create a training system that will not cause distress for trainee doctors (Paice et al., 2004).

(c) Antibullying policies and procedures: The more policies are perceived as inadequate, the more junior doctors accept bullying and engage in flight or freeze coping behaviours.

Antibullying policies and procedures are visible standards of ethical behaviour in terms of what is accepted and what is not accepted in organisations (Hodgins et al., 2020). A code of ethics to preserve a bullying-free workplace requires a perception of focus on self-regulation and self-management strategies as well as an emphasis on the broader organisational and social aspects (Giorgi et al., 2016). If the policies are perceived as ineffective, junior doctors accept the bullying behaviours by ignoring and escaping the situation (flight) or by taking no action against the bullying (freeze). Antibullying policies must consider the risk of tolerating or accepting bullying (Giorgi et al., 2016). Antibullying policies are expected to require an understanding of the issue of bullying, and practical implementation with consequences for perpetrators so bullying can be efficiently eliminated for junior doctors. Several studies indicate that workplaces with inadequate policies with a lack of focus on the consequences for perpetrators encourage the normalisation of bullying behaviours in the workplaces, eventually creating an acceptance of the bullying behaviours (Aldawsari & Mabkhot, 2023; Schindeler, 2016).

P7: Organisational support (a) The more organisational leaders actively promote an antibullying stance, the less junior doctors accept bullying and thus engage in fight responses.

This proposition illustrates a significant relationship between leadership's advocacy of the antibullying stance for junior doctors (Johnston et al., 2010; Woodrow & Guest, 2017).

When leaders in healthcare organisations are proactive in preventing bullying, it indicates leaders' intolerance of abuse and discouragement of bullying behaviours, which, in turn, encourages junior doctors to reject mistreatment and bullying rather than accept it (Stouten et al., 2010). Leadership's stance against bullying in the workplace also helps to break the cycle of bullying (Patton, 2020). Transformational leaders who work with employees to bring positive changes can contribute to decreasing bullying behaviours (Nielsen, 2013). Leadership's rejection of abusive behaviours encourages junior doctors to become more aware of bullying situations, recognise bullying and take appropriate measures against it. They retaliate and fight against bullying. Junior doctors are encouraged to stand up against bullying, considering the leadership's interest in addressing the issue and eliminating bullying in junior doctors' workplaces.

(b)The less effective organisational support strategies and anti-bullying initiatives are perceived to be, the more likely junior doctors are to show a freeze response and accept the cycle of bullying.

Ineffective and inadequate organisational support can lead to confusion, instability and uncertainty for victims of bullying (Duffy, 2009). Organisational support can involve the roles of leaders, seniors, and junior doctors, as well as antibullying initiatives. Strategies without adequate guidelines for leaders and seniors to act against bullying, clear channels of communication to report bullying, and efficient assistance for bullied junior doctors may fail to address bullying. When effective organisational strategies to address bullying are missing, a sense of powerlessness and inability to take action can immobilise victims. They are unable to respond to the ongoing bullying. There is evidence that bullied doctors avoid fighting against bullying and rather accept it to escape the consequences of whistleblowing when organisational support is missing. My research data pointed out that victims felt that reporting bullying incidents was futile because organisations may perceive them as troublemakers rather than

vulnerable individuals. In such circumstances, for victims, the cost of retaliating against bullying behaviours outweighs the benefit of standing up against bullying. Thus, the victims accept bullying. As a result of staying silent, victims get trapped in a cycle of bullying in a state of freeze, perpetuating an acceptance culture.

P 8: Societal values around authority: The more societal values encourage submissiveness and conforming to authority, the more likely the organisations and the employees are to accept bullying.

Societal norms around mutual respect and conforming to authority allow organisations and their employees to demand unjust submissiveness to authorities and compliance with peers and seniors (Pheko et al., 2017). This may contribute to the acceptance of bullying. Societal norms play a crucial role in cultivating organisational dynamics relating to how individuals perceive bullying behaviours (Johnson, 2011). This is because, in a society where submissiveness and conformity are rewarded (for example, in the form of career-related aspects), employees may cope with the abuse directed at them and accept bullying to avoid being rejected and reap the benefits of conformity (Martin & Hewstone, 2007; Siegel, 1964).

Organisations and those in positions of power may reward submissiveness and compliance to preserve authority and control. In contrast, a desire to present a good self-image, or 'face' concerns, may be drivers of conformity because 'face' or self-image may be lost when individuals fail to engage in the behaviours expected by virtue of their social status (Ho, 1976; Kim et al., 2021). Scholars suggest that at more expansive societal and public group levels, individuals adjust their attitudes to conform to individuals around them and avoid social exclusion (Levitan & Verhulst, 2016; Nielsen et al., 2020). Data from my study showed that NZ junior doctors tolerated mistreatment and adjusted their behaviours to conform to authority figures. They accepted bullying and even sometimes tried to justify it by minimising the bullying behaviours to acquire career progression and advancement opportunities; in other

words, to reap the rewards of submissiveness. NZ societal norms encourage cohesiveness (Gluckman et al., 2021). This may imply that individuals practising cohesiveness conform to authority as part of group norms because of fear of negative evaluations and social rejection (Jenson & Saint-Martin, 2003; Prapavessis & Carron, 1997). They may not perceive bullying behaviours as bullying. They may rather perceive bullying from authority figures as a societal norm, thus perpetuating an acceptance of bullying. Conversely, individuals following societal norms that emphasise individual empowerment, autonomy, and accountability on abusive behaviours are more likely to retaliate and take action against bullying behaviours (Griffin & Clark, 2014).

P9: Prevention and management strategies with a top-down multilevel approach will have positive outcomes for individuals.

Prevention and management are hindered by a lack of action mediated by inadequate organisational, social, and institutional support at the macro level. Effective prevention and management are possible only through cut-through approaches that are targeted at multiple levels with comprehensive approaches (Llewellyn et al., 2018). Data from this study showed that NZ juniors felt that prevention and management must be extensive with the macro level initiatives to introduce positive outcomes at all other levels. The complexity of the ACT model also explains why a comprehensive approach is critical for prevention and management. The current individual-focused strategies (e.g., classroom handouts, printed resources and pieces of infrequent training) are not effective because such prevention and management initiatives focus only on the individual level. Prevention and management must address societal, organisational, and individual levels. There should be policy changes and accountability at all levels, starting at the broader societal and institutional level. From my data, the process of acceptance emerged as an attitude dependent on individually mediated factors (individual and social aspects) as well as a broader framework covering the social and organisational elements. Although acceptance

may be mediated by individually driven attitudes, resulting in cultivation of an acceptance culture, addressing acceptance at all levels from macro, meso to micro can provide effective prevention and management solutions for junior doctors.

8.4. Implications of ACT

The purpose of the ACT theory is to foster an awareness that encourages employees to recognise bullying behaviours and 'act' against negative behaviours in their workplaces. I use the acronym for Acceptance Culture Theory (ACT) as an invitation to 'act' and further explore the underlying social processes that cause bullying behaviours to suggest effective prevention and management. ACT explains the role of individuals in accepting bullying because of multi-level influences. It recognises the importance of individual empowerment and human agency not only in standing up against bullying behaviours and creating positive changes in the workplace in terms of healthcare workers' safety and well-being, but it also describes the importance of broader macro-level initiatives and how systems-level components constrain and restrict human agency.

8.4.1. ACT to Understand Victim Stress Response

ACT can be used to explain the victim stress response of healthcare workers, including junior doctors. Victims show different kinds of responses to bullying and an acceptance culture of bullying; for example, physical symptoms, emotional distress, cognitive impairments, behavioural changes, and psychological issues (Hansen et al., 2006; Hoel et al., 2002; Hogh et al., 2012). Thus, studying victim stress responses in association with acceptance culture may play a role in exploring mitigation or an escalation of bullying resulting from a particular victim stress response. In addition, ACT may provide a platform to examine the choice of adaptive policies, procedures, and strategies to mitigate bullying by studying a particular type of victim stress response at all levels of their social-ecological system to highlight the processes involved in bullying. ACT can help navigate the victim's stress response by emphasising the fact that

individuals have the agency to act against bullying behaviours. Victims of bullying can stand up against bullying to break the cycle of bullying.

8.4.2. ACT to Understand Hierarchy-Driven Acceptance of Bullying

ACT is an invitation to researchers to explore the intricate dynamics of hierarchy in healthcare organisations and the role of power play in the medical workforce that fosters an acceptance culture. As evidenced by my research data, ACT unravels several processes at the micro, meso, exo, and macro levels that potentially link to organisational hierarchy. While transforming hierarchies is a multifaceted and complex phenomenon, ACT may shed light on specific individual, social and organisational elements that could be the reason for bullying behaviours from people in the hierarchy of healthcare organisations. Researchers could study the steps that may be involved in the emergence of an acceptance culture of bullying because of the interplay between the power and social status of the victims and perpetrators in the organisational hierarchy.

While individuals positioned high in the hierarchy, and seniors, may attain a sense of superiority over their subordinates by practising command-and-control and misusing power (Rodwell et al., 2013). ACT can provide an avenue to explore further how these social processes are relevant to the people in the hierarchy, and subordinates can mitigate an acceptance culture of bullying. By challenging the acceptance culture of bullying, workplaces can encourage a shift in the social identities around the hierarchal positions. Seniors and people in authority may reassess their positions and roles, while victims may view themselves as valued members of healthcare organisations rather than mere employees.

8.4.3. ACT to Understand a Culture of Psychological Safety

ACT can be potentially valuable in understanding how a safety climate can be fostered by breaking an acceptance culture of bullying that ensures psychological safety for healthcare employees. In organisations where workplace culture normalises employee abuse, and bullying

is considered a norm, the psychological safety of the employees is compromised (Dollard et al., 2017; Nguyen et al., 2017). Employees may feel unsupported, and because of bullying, they are hesitant to function efficiently. Acceptance of bullying can be addressed to create a safe climate in organisations that do not exhibit bullying behaviours (Rosander & Salin, 2023).

8.4.4. ACT to Explain Various Forms of Bullying

ACT is significantly relevant to various forms of bullying, regardless of whether bullying is perceived as a homogeneous concept or one that has many forms, as indicated in the literature (Nielsen & Einarsen, 2018). This is because ACT describes how bullying is normalised and accepted across multiple levels of the socioecological system of the victims. It points to both the enabling and sustaining parts of the bullying process by highlighting how systemic norms and an acceptance culture across micro, meso, exo, and macro levels perpetuate both overt and covert bullying behaviours (Ballien et al., 2009). By conceptualising bullying as a process that is significantly shaped by systemic norms (Salin, 2003), ACT provides an overview of how bullying progresses, whether overt or covert, it is perpetuated by an acceptance culture. While overt bullying is visible as direct aggression, covert bullying is subtle and an indirect mistreatment that is harder to identify (Said, 2018). Thus, ACT may be relevant to all forms of bullying as it explains both the enabling factors (power imbalances and silence over abuse) and sustaining aspects of bullying or motivating factors (desire for control or desire to maintain social dominance within the workplace). ACT can build on Salin's (2003) framework to understand the bullying process because acceptance culture may act as an enabling factor, foster hierarchal power dynamics and normalise bullying.

8.4.5. ACT to Explore Trainees' Identity Formation During Medical Training

In healthcare organisations, the structure of junior doctors' training involves an opportunity to examine junior doctors' professional identity formation. Several studies have explored the concept of professional identities with workplace bullying (D'Cruz & Noronha, 2012; D'Cruz,

2010; Hosseini et al., 2021). Junior doctors' professional identity may develop during medical training, and their self-esteem and self-worth may be compromised if they are being bullied. Thus, junior doctors may internalise abuse due to their lack of self-esteem and inadequate support from seniors and managers. Subordinates and doctors in training may also internalise their junior status in the hierarchy and may accept bullying as a usual aspect of their professional identity. By considering ACT as a tool to break the acceptance culture, a meaningful impact can be made on junior doctors' professional identities.

8.4.6. ACT and Multilevel Interventions for Changing Acceptance Culture

Additionally, ACT may provide an opportunity to explore the effective implementation of antibullying policies. ACT can be used to study the acceptance culture of bullying and its role in the implementation setbacks relating to antibullying policies and procedures at multiple levels of the junior doctors' ecological system. This may provide a range of recommendations for preventing and managing bullying.

8.5. Summary of Chapter 8

In this chapter, I theorised the evidence that was presented in the findings (chapters 5 and 6) and discussion (chapter 7). The evidence presented in the findings and discussion chapters provided accounts to address the first research question exploring theoretical explanations of bullying of junior doctors. Drawing on this evidence, CGT guided me to construct a theory and propose the theoretical framework of ACT. I proposed the ACT Model through sets of assumptions and propositions, which outline the social process of acceptance of bullying at multiple levels of the ecological system. ACT theory is a significant contribution to literature that explains the bullying phenomenon as it affects junior doctors in NZ, and why victims accept bullying. I also discussed several theoretical implications of ACT in chapter 8. The following chapter 9 concludes this thesis and offers practical implications of the ACT theory.

Chapter 9: Conclusion

The challenges of bullying and abusive behaviours significantly impact healthcare organisations (Al Omar et al., 2019; Teoh et al., 2021). Thus, it is of paramount importance to consider the welfare and well-being of employees, including junior doctors, to ensure positive outcomes for both healthcare workers and patients (Shanafelt et al., 2003). Quality patient care is directly related to the well-being of medical practitioners (Nørøxe et al., 2018). A healthy work environment where bullying and abuse are discouraged can help to produce a thriving medical workforce that strengthens quality patient care and patient safety (Eisenberg et al., 2001). In this study, I explored the pervasive challenge of workplace bullying experienced by junior doctors in NZ. My research aimed to explain the bullying process of NZ junior doctors, and thus lead to meaningful prevention and management. This chapter offers brief answers to my two research questions. It also presents practical implications, recommendations, the limitations of this study, and recommendations for future research.

In my study, two research questions were addressed: (1) What are the theoretical explanations for bullying of NZ junior doctors? And: (2) How do these theoretical explanations support the effective prevention and management of bullying of NZ junior doctors?

Through a thorough investigation and exploration of the bullying phenomenon among NZ junior doctors, and by conducting a rigorous qualitative analysis of the data, it became evident that there is a prevailing culture of acceptance of bullying in NZ healthcare organisations, which plays a significant role in how bullying behaviours are viewed, experienced, and managed.

9.1. Theoretical Explanation of Bullying of NZ Junior Doctors

My research led to several explanations of bullying of NZ junior doctors. Individual and social characteristics of individuals, accompanied by complex team dynamics, a well-established hierarchy, a workplace culture that encourages bullying as a tradition, and systemic issues in

healthcare organisations pose a significant threat to the well-being of junior doctors because they may trigger the development of a breeding ground for bullying behaviours. These complex factors explain a multi-level understanding of bullying of junior doctors that the Acceptance Culture Theory (ACT) can explain. ACT suggests that healthcare employees respond to and accept bullying at multiple levels of their ecological systems (i.e., micro, meso, exo and macro). Their responses to bullying are observed as fight, flight and freeze stress response mechanisms at different levels of the ecological system, which can explain why individuals accept bullying in a way that potentially leads to a worsening of bullying in healthcare organisations.

At the micro level, junior doctors' personal attributes and characteristics shape the way bullying behaviours are viewed and how they respond to bullying to develop an acceptance culture of bullying. Group members may also accept bullying in a similar way or show similar responses to bullying at the micro level. They may or may not fight against bullying, depending on their level of self-esteem. At the meso level, unequal distribution of power can lead junior doctors to accept bullying from their supervisors. An organisational culture's values of accepting bullying may also make junior doctors accept bullying at the meso level.

At the exo level, an absence of regulatory emphasis and a lack of consequences may result in an acceptance of bullying, and flight or freeze responses to bullying. At the macro level, systemic issues such as ignorance of bullying during training can create an acceptance culture of bullying, and doctors may show a flight or freeze response. If the training structure discourages bullying, junior doctors choose to 'fight' against bullying.

9.2. Prevention and Management of Bullying for NZ Junior Doctors

My research also aimed to pave a path to effectively addressing workplace bullying. Without having an explanation or a clear view of the processes involved in the bullying phenomenon, effective prevention and management remain an underexplored process. Understanding the role of acceptance culture provides an avenue to address workplace bullying.

The participants of my research offered several suggestions for addressing bullying. They provided a direct answer to the second research question, and their accounts are linked to the theory of acceptance culture. Participants reported that the flattening of hierarchy in NZ healthcare organisations, power sharing among healthcare workers by alleviating hierarchal structures, and frequent leadership changes to bring positive changes to the workplace and prevent bullies from practising their power for long periods of time could contribute to prevention and management. The literature suggests that the power and control dynamics instilled by people in the organisational hierarchy can be addressed by emphasising collaboration within teams and team members speaking up, without fear of retribution, against their coworkers or seniors whose behaviours or actions are visibly unjustified or wrong (Green et al., 2017). Also, if people in the hierarchy are unaware of their bad behaviours, it may have a negative impact on the workplace because they can continue to show bad behaviours toward others without self-reflection. Therefore, collaboration within teams and communication, and between team members, without threatening the positions of those in the hierarchy, are some ways in which power can be shared in healthcare organisations (Green et al., 2017; Noyes, 2022; Tsao & Browne, 2015). Communication and collaboration may help individuals voice their concerns and thus break an acceptance culture by encouraging not surrendering to or accepting abuse and bullying by abusive people positioned higher in the hierarchy.

Organisational support in the form of raising awareness and educating junior doctors about recognising and effectively reporting bullying likely results in individuals' refusal to accept bullying. Awareness can be raised by informing healthcare workers about written antibullying policies and procedures and employees' rights to a healthy and safe environment in their workplaces (Salin, 2008). Education and awareness measures may include providing information about what triggers bullying, how bullying is different from other behaviours, and the effects of underreporting bullying so healthcare workers are encouraged to report it

(Sauders et al., 2007). If individuals are aware of their rights and have knowledge of what is available to them in terms of support, they may choose to fight against bullying and report abusive behaviours rather than tolerate the bullying, thereby breaking the acceptance culture and the cycle of bullying. Junior doctors' contribution to organisational support for bullying prevention and management is their agency to stand up against bullying.

Additionally, the role of leadership and systemic changes, including effective policies and procedures against bullying, proper implementation of policies, and efficient reporting systems, are also critical for preventing and managing bullying because clear guidelines about prevention and management can bring consequences for bullying behaviours. Policies may be present, but if organisations encourage bullying by rewarding people who exhibit bullying behaviours rather than supporting victims, efforts to effectively implement antibullying policies to protect victims may fail (Hodgins et al., 2020). In contrast, if policies clearly address the bullying issues, organisations have a system to enforce consequences for bullying behaviours, and system-level support is available to victims, individuals may choose to fight against bullying rather than accept it because they believe that justice will be served, and bullies will be held accountable for their abusive behaviours.

9.3. Practical Implications

Implications for policies and practices at multiple levels are a significant contribution of this study. Specific suggestions for prevention and management of workplace bullying are provided. The acceptance of bullying plays out at all levels (micro, meso, exo, and macro), and strategies need to be introduced at all levels of the ecological system to break or dissolve an acceptance culture. For effective prevention and management of bullying, a comprehensive approach from the macro level and across all other levels may be beneficial.

9.3.1. Implications at the Macro level

Policy reforms at the broader institutional level, which encourage systemic changes, can be a significant contribution to eliminating structural shortcomings in healthcare organisations (Crimp, 2017; Ng, 2012). Policy reforms at institutional level may help break an acceptance culture of bullying because when victims are confident that the laws drive policy changes and guidelines about workers' safety, they trust the system rather than accepting bullying behaviour and showing a flight or freeze response. For example, Australian workers' unions are given rights under the law to include antibullying provisions in the collective agreements of staff, and their best practice framework that includes antibullying interventions in the organisational bargaining agreements ensures employees' rights in the cases of bullying. As a result, employees are protected by the law (Ng, 2010). In the case of ineffective and inadequate policies, campaigns can be initiated in the form of advocacy for an efficient change in legislation that could address regulatory oversight during the crafting of anti-bullying policies (Arshad, 2022; Rayner et al., 2001).

At the societal level, collaborative efforts involving different stakeholders, such as healthcare organisations, government bodies, public agencies, and academic institutions, can result in an impactful transformation of the current situation of bullying prevention and management. Community organisations and public institutions can form a multidisciplinary task force to combat issues of bullying at the broader societal and institutional level (He, 2022). The literature suggests that workplace bullying may be encouraged in societies and cultures that support aggression, bullying and abuse based on differences in social status and individual power (for example, gender-based societal expectations and norms around the roles of males and females) (Arshad, 2022; Gardner et al., 2020; Salin & Hoel, 2013). To mitigate bullying at the macro level, steps can be implemented to challenge societal and cultural beliefs around the acceptance of bullying, which may help to alleviate an acceptance culture with regard to

bullying. Scholars have suggested using print, digital and social media to introduce messages that may reach a wider audience, change societal norms and cultural beliefs, and advise against aggression and bullying (Arias, 2019; Perkins et al., 2011; Yamin et al., 2019). Antibullying messages reaching wider audiences may influence individuals to break an acceptance culture relating to bullying.

9.3.2. Implications at Exo level

At the exo level, the regulatory focus of healthcare organisations, in terms of aligning organisational decisions with victim support processes, can facilitate the prevention and management of bullying. Involving regulatory bodies and external stakeholders to help make effective decisions in favour of victims or bring meaningful changes in organisational or corporate policies that would enforce anti-bullying measures more promptly can be very beneficial. For example, lawyers and consultants who may have expertise in resolving organisational challenges that may prevent organisations from implementing antibullying strategies may significantly contribute to victim support mechanisms, compared to internal handling of bullying issues using inadequate organisational policies and procedures that hinder appropriate action against perpetrators (Fox & Stallworth, 2009b; Lockhart & Bhanugopan, 2020).

At the exo level, organisations may make decisions around redesigning the internal organisational environment elements that may act as role stressors (role ambiguity, role conflict) directly causing bullying (Balducci et al., 2012; Hauge et al., 2011). Redefining jobs and roles, minimising role ambiguity and resolving conflicts may reduce abuse and bullying in such organisations. When victims of bullying know that organisational decisions are in their favour and are facilitated by internal and external support mechanisms and stakeholders to mitigate bullying-enabling conditions (e.g., job stressors) in organisations, they are less likely

to accept bullying. Organisational decisions that are taken in favour of the victim's safety and wellbeing can help employees break an acceptance culture related to bullying.

9.3.3. Implications at Meso Level

At the meso level, a step-by-step process of reporting bullying and declaring the consequences for bullies, can prove beneficial in managing bullying complaints because victims will feel supported. These steps may include making sure that victims know what to do, where to go when they need support, how the bullying reports will be documented and processed and what assistance is available to victims (Becton et al., 2017). If the process to report bullying is already clear to employees, and consequences for exhibiting the bullying behaviours in the workplace are observed by the victims (i.e., punishment for perpetrators), victims will be encouraged to report bullying rather than accepting it (Woodrow & Guest, 2017). Victims may accept bullying when proper channels for reporting bullying are not available. In some cases, bullying concerns are handled by the victims' own seniors and supervisors, who may be the bullies themselves (Roscigno et al., 2009). This might prevent victims from reporting bullying. Thus, a system based on reporting bullying through diary keeping, and critical incident report forms with questions about the frequency of the bullying behaviour, duration and incidents experienced, may provide an avenue for reporting bullying effectively (Cowie et al., 2002).

At the meso level, clear organisational policies and procedures must be developed and communicated to the staff to ensure that employees are aware of the support available to them and to ensure that bullying reports are taken seriously (Duffy, 2009). Also, a workplace culture of respect and inclusivity for junior doctors can bring consequences for perpetrators because they can be held responsible for their toxic behaviours (Dzurec et al., 2017; Greer & Peters, 2022).

Practitioners can introduce educational workshops that include training around recognising bullying, effective communication, conflict management, and emotional

intelligence (Gardner & Cooper-Thomas, 2021). Awareness programmes based on carefully evaluated training and educational content, introduced as an ongoing process, can prove more effective than scattered programmes such as one-off bullying management presentations and seminars (Escartín, 2016; Roberson et al., 2001).

9.3.4. Implications at the Micro Level

At the micro level, interventions can be introduced to enhance individuals' self-awareness. Individuals' rights, boundaries, coping strategies, and assertiveness can be included in bullying prevention programmes so that individuals are able to recognise bullying and have the agency to take action against bullying behaviours (De la Fuente et al., 2014; Vickers, 2011). Support at this level to address bullying may also be seen in the form of individual-focused practices such as learning strategies to develop self-efficacy and mentor support or support from colleagues, managers, and leaders through measures that are focused on empowering individuals (Metzger et al., 2015; Strandmark & Rahm, 2014; Wollan, 2013). These measures can build resilience so individuals will fight against bullying and break an acceptance culture. For example, assistance from counsellors and mental health professionals can also help the victims of bullying to address bullying behaviours at the micro level. Conflict management skills training can also be introduced to individuals who tend to accept bullying due to a lack of self-regulation and get trapped in the cycle of conflict and bullying.

In summary, my study emphasises that by implementing steps starting at the macro level and on through meso, exo, and micro levels, stakeholders can coordinate to present a united front against eliminating bullying by breaking the culture of acceptance of bullying, which can lead to creating a healthy and safe work environment for healthcare employees. In the following section, I summarise my research and offer recommendations for healthcare workers, practitioners and policymakers.

9.4. Recommendations

The complex social processes that relate to the issue of workplace bullying, specifically in the context of the NZ medical profession, go beyond the understanding of individual, social and organisational aspects of the healthcare system. While individuals encounter and manage bullying differently depending on their individual and social characteristics, complicated social and organisational factors, such as power dynamics and systemic issues, render healthcare workers immobile and trapped in an environment where they have no choice but to accept bullying. In that case, it becomes imperative to understand the explanations of bullying and what needs to be done to mitigate the endemic nature of bullying. I offer the following recommendations to junior doctors, policymakers, and practitioners to eliminate bullying effectively.

9.4.1. For Junior Doctors

I recommend that NZ junior doctors stand up for themselves. They need to advocate for themselves if they encounter bullying in their workplaces. Junior doctors must break free from the culture of acceptance and escape the cycle of bullying by reporting bullying to the authorities concerned. Junior doctors should also seek support from their colleagues, employee assistance programmes (EAPs), counsellors and mentors. I recommend junior doctors invest their time in self-care practices and seek professional growth and career development opportunities from the proper channels. They must build relationships within and outside of healthcare organisations to create a robust support system to oppose bullying. In addition, junior doctors should know about anti-bullying policies and procedures. They should also be familiar with their rights in instances of bullying and what kind of support they are entitled to within their workplaces. Understanding a course of action can help junior doctors take the proper steps to stop bullying behaviours directed toward them.

9.4.2. For Policy Makers

Policymakers must take concrete steps to craft clear policies and procedures to address the issue of bullying. Proper implementation of policies can be ensured by emphasising zero tolerance for bullying regardless of the position of the perpetrators in the organisational hierarchy. Establishing an efficient reporting system and clearly indicating the consequences for bullies can alleviate bullying.

Training programmes about anti-bullying policies and procedures and their implantation must be offered so healthcare workers are aware of the right course of action in cases of bullying. Training programmes about recognising and reporting bullying must be included in the medical education curriculum to ensure that junior doctors are familiar with preventing and managing bullying right from the start of their medical education and training.

9.4.3. For Senior Management and Supervisors

Senior management and supervisors must try to create a supportive and safe environment for healthcare workers, including junior doctors. They must play a proactive role in creating a healthy workplace where collaboration, mutual respect, mentorship, and an emphasis on open communication can reduce bullying. Managers should also consider ways to enhance the mental well-being of healthcare workers, especially junior doctors. A workplace culture of safety where values around safety are respected can prove to be a critical element of bullying management for practitioners. By implementing these recommendations, junior doctors, policymakers, and practitioners can collaboratively take essential steps to reduce bullying.

9.5. Limitations

My study involved constructivist grounded theory (CGT) methodology, which has its strengths but also has some limitations, which should be noted. The researcher's bias may influence the interpretation of data, impacting the objectivity of the findings in CGT. However, CGT recognises the subjectivity bias and observes a shared reality between the researcher and the

research participants. This also means that the data analysis becomes a co-created process between the researcher and participants. For this reason, in susceptible topics such as workplace bullying, recognising and keeping researcher bias to a minimum is crucial. As I mentioned earlier in Chapter 4 (i.e. in the theory development section), due to my prior experience in the healthcare sector, I had a bias that female healthcare workers face more bullying in healthcare organisations compared to their male colleagues and leaders are more concerned about chasing organisational goals than about addressing employees' issues. I addressed my bias by constantly reinforcing the process of the CGT method during data collection, interpretation and theory development, with the aim of maintaining a reflective and nonpolarized stance during analysis of participants' accounts in a nonpartial manner (O'Connor et al., 2018). CGT analysis is a shared process between participants and the researcher. Participants' views were respected and considered during my analysis. Hence, the research became a meaningful and co-created process between the researcher and the participants of the study.

CGT is a process that involves the creation of theory from the data rather than using preexisting theories. While this is a critical and beneficial aspect of CGT in exploratory and explanatory qualitative studies, it may bring the challenge of generalisability. My research was embedded in the NZ context, with participants being junior doctors working in NZ healthcare organisations. This implies that the findings of this study may not be applicable to other professional settings or healthcare sectors across NZ or in other countries.

The findings of this study are based on the subjective experiences of the research participants only. Data were not collected from other healthcare workers, such as nurses, paramedical staff or healthcare managers. Therefore, the results of this study are based only on the opinions of the research participants. Additionally, the participants in the study were mostly from three DHBs (District Health Boards, prior to a reorganisation of the health system to a single unit) in NZ. This also put some restrictions on the generalisability of the findings. A

broader sample of participants could facilitate a more comprehensive understanding of the bullying phenomenon.

Workplace bullying is a sensitive topic. The method for my study involved in-depth interviews with NZ doctors. In CGT research, concerns may arise because data are collected based on the views of research participants through interviews only. In such a situation where intensive interviews are used for data collection, participants may feel pressured to adhere to social norms and expectations during the interaction between the researcher and the participant during the interview. This may cause a degree of hesitation about sharing ideas openly. A complementary method, in addition to interviews, such as journalling or storytelling, could provide participants with a way to reflect on their thought process deeply. For the researcher, using complementary methods such as storytelling may offer the opportunity to examine data and explore the topic under investigation from multiple angles. Using the additional method was not suitable within the time and resource constraints of this research, particularly during the post-pandemic (COVID-19) period but would be of value for the future.

9.6. Strengths

Regardless of the limitations, this research exhibits several aspects that emphasise its contribution and significance. My background in the healthcare sector brings a unique perspective to this study that deepens its contextual understanding. My viewpoints fostered a nuanced investigation of the research topic, allowing for increased sensitivity to the complexities of the research on workplace bullying of medical professionals.

Despite the demanding situations post COVID-19 pandemic and the formidable challenges of the NZ health sector reforms following COVID-19 pandemic, I was able to access a wide range of participants who were willing to share their accounts of the research topic. This diversity of the participants enriched my study, making it more meaningful to explore workplace bullying among NZ junior doctors and offer explanations of this phenomenon.

A meticulous approach to data collection and analysis in this research led to the development of a comprehensive framework that elucidates the multidimensional nature of the bullying process. By examining the intricacies of the issue of workplace bullying through the proposed ACT model, I offered specific, actionable recommendations for policy and practice, therefore contributing to concrete improvements in the work environments of healthcare organisations. Finally, these strengths collectively point to the significance and importance of this doctoral research, positioning it as a beneficial resource for academia and healthcare professionals.

9.7. Directions for Future Research

Acceptance culture may help significantly in understanding the bullying phenomenon in several different healthcare settings within and across NZ and different specialities of the medical profession. Future studies could also use alternative methods such as longitudinal research, surveys, and qualitative studies in other platforms of the healthcare sector to further identify the processes associated with the acceptance of bullying and offer comparisons of the phenomenon of acceptance in various settings. Moreover, adopting a social-ecological system perspective (Bronfenbrenner, 1992) while investigating the acceptance culture may provide an opportunity for researchers to thoroughly examine phenomena similar to bullying, such as mobbing, harassment, and workplace abuse, at multiple levels.

Another research direction could be replicating the study by recruiting participants from several different specialities and backgrounds in healthcare organisations. For example, the issue of workplace bullying could be explored from several angles if the sample included other participants in addition to doctors, such as managers and paramedical staff administrators. Individuals can have contrasting opinions and views on the same topic, and encompassing different perspectives on a research topic can help bring a deeper understanding of the phenomenon in question.

9.8. Personal Reflection

"Two roads diverged in a yellow wood
And sorry I could not travel both
And be one traveler long I stood
And looked down one as far as I could
To where it bent in the undergrowth…
…I took the one less travelled by
And that has made all the difference"
(Robert Frost)

I call my PhD the inception of another journey for a seeker who decided to traverse the halls of knowledge and wisdom. I embarked on this voyage driven by a strong sense of purpose and meaning that illuminated my path through the days and nights of pursuit. My vision goes beyond the mere quest for intellect. I am guided by a longing to serve my purpose. As I challenge the reasons of self-limitation and doubt, I find the glory of determination and perseverance. As I continue to walk this path, I meet others, who are enlightened and led by a desire to serve.

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Appendix A: Scoping Review Protocol

Title: A Scoping Review of the Systematic Reviews and Meta-analyses on Workplace Bullying of Healthcare Workers

Contributor: Sarah Bashir

Reviewers: John Oetzel, Mark Harcourt, Polly Atatoa Carr

University of Waikato, Hamilton, New Zealand

Introduction

The phenomenon of workplace bullying has detrimental effects on individuals and organisations (Ariza-Montes et al., 2013). Various scholars have studied the process of workplace bullying to address this issue and explore the underlying factors that may act as antecedents of bullying (Einarsen et al., 2003). Studies have also been done further to explain workplace bullying through many different lenses and address the adverse outcomes associated with workplace bullying (Randal et al., 2007). While workplace bullying may happen in all organisations, recently, there has been an increase in healthcare workers' bullying due to various individual, organisational, and social factors. These factors may increase the risk of bullying among healthcare employees (Olender, 2017). Several studies explored the topic of workplace bullying of healthcare employees and offered explanations of the bullying phenomenon, risk factors, antecedents and consequences of bullying (Olender, 2017; Randle et al., 2007). In the context of the healthcare workforce and bullying literature specifically, there are several systematic reviews and meta-analyses studies that address workplace bullying definitions, antecedents, and consequences of bullying. Yet, an overarching view of the workplace bullying literature describing how bullying is explained and its prevention and

management are not thoroughly discussed. This gap implies that critical areas for consideration are the theoretical explanation of bullying and the prevention and management of bullying. Identifying these knowledge gaps will help to inform future research.

Considering the general objectives of scoping reviews, the review focuses on identifying knowledge gaps and mapping the systematic reviews and meta-analyses studies on the workplace bullying of healthcare workers (i.e., doctors, nurses, allied health professionals, and first responders or emergency services workers). Joanna Brigs Institute (JBI) suggests that scoping review questions can be formulated by considering the mnemonic “PCC”. PCC stands for the population, concept, and context**.** Inspired by the PCC approach for designing research questions, this scoping review will seek to answer the following research questions: First, how is workplace bullying theoretically explained in the literature? Second, how is the prevention and management of workplace bullying of healthcare workers discussed in the literature?

To date, there appears to be no scoping review of systematic reviews and meta-analysis of workplace bullying of healthcare workers. To my knowledge, this scoping review is the first to scope the systematic reviews and meta-analyses on workplace bullying of healthcare workers.

Methods

Protocol and Registration

A crucial step in developing a scoping review methodology is following reporting guidelines which act as tools for authors to report their research (Tricco et al., 2016). These tools may be reporting checklists; the use of reporting checklists helps the readers in comprehending the validity and reliability of the methods in addition to ensuring the transparency of the methods (Tricco et al., 2016)

The protocol for this scoping review is developed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (i.e., PRISMA-ScR) checklist as a guideline.

PRISMA extension for scoping reviews (or PRISMA-ScR) checklist comprises instructions that assist researchers, policymakers, editors, issuers, publishers, healthcare workers, and reporters to understand the items reported in scoping reviews (Tricco et al., 2016).

In order to indicate the planning, approach and analysis of this scoping review in advance, this scoping review protocol is being registered on Open Science Framework (OSF). Registering a protocol before conducting the scoping review emphasises that there was a strategy in place before the start of the scoping review, and the analyses are not influenced by the data that emerges during the review process. Protocol registration, therefore, facilitates methodological rigour and prevents selective reporting of the scoping review results (Pollock et al., 2021). Further, it is beneficial to register the scoping review protocol beforehand to assist in submitting it to academic journals (Pollock et al., 2021).

Eligibility Criteria

Inclusion Criteria

1. English-language publications
2. Healthcare workers (i.e., doctors, nurses, allied health professionals, and emergency medical workers/or first responders) because they are the critical components of the healthcare system.
3. Systematic reviews and meta-analyses published between January 1, 2005, to January 1, 2022 in order to cover relatively recent research contributions and knowledge gaps.

Exclusion Criteria

Non-peer reviewed literature and narrative reviews will be excluded.

Information Sources

For this scoping review, I will search ProQuest Central, PubMed, PubMed Central, Google Scholar, Scopus, PsycINFO (PscNet) and Web of Science databases for published systematic reviews and meta-analyses on workplace bullying of healthcare workers. The gathered sources will be assessed for inclusion and exclusion by the reviewers to improve the

search process. A preliminary search will take place in January 2022. Additional searches will be done using reference lists of identified articles. During the search stage, reviewers will identify the studies included and excluded, considering the inclusion and exclusion criteria. Bibliography and duplicates from all database searches will be managed through Endnote software.

Search Strategy

Keywords

The search will be carried out by using the keywords in the combination of terms from three groupings (using Boolean operations): 1) systematic reviews and meta-analysis with 2) workplace bullying or employee abuse or employee mistreatment with 3) healthcare workers, healthcare employees, doctors, nurses, allied health, first responders, emergency workers.

After completing the search, the following processes will be used. First, the duplicates will be removed. Following this, article titles will be read, and studies will be assessed based on inclusion criteria. Afterwards, the abstract will be read and will be assessed for inclusion. The bibliographic content of the articles meeting the inclusion criteria will be read to further search for articles meeting inclusion criteria. In case further information is required, the authors of the publication will be contacted. The first reviewer will thoroughly screen articles satisfying the preliminary screening process. The second reviewer will verify this process.

Data Charting Process (Data Extraction) and Data items

In scoping reviews, the data extraction process is referred to as charting the results (JBI Manual for Scoping Reviews, 2019). During this step, a descriptive summary of the results will be generated. In this stage, a data charting form or table will be developed by identifying essential items related to the research question. Data charting will involve PRISMA-SCR and JBI guidelines for scoping review. The extracted data will be presented in categories in the form of a table. According to the JBI Reviewer's Manual (i.e. Methodology for Scoping

Reviews, chapter 11, key information to chart for each paper includes: Author(s), Year of publication, Origin/country of origin (where the study was published or conducted), Aims/purpose, Study population and sample size (if applicable), Methodology/methods, Intervention type/duration, comparator, outcome measures (if applicable) and key findings that relate to the scoping review question/s (Peters et al., 2020). For this scoping review and following the JBI general principles, the specific data extraction table/ will be an excel spreadsheet including the following information: a) citation; b) country of origin; c) healthcare discipline, aim(s) and purposes, number of articles, type of review, methodology/methods and key findings (i.e., definitions, the terminology used for workplace bullying, antecedents consequences of workplace bullying, theoretical explanation of workplace bullying, prevention, management of bullying, and the type of critical appraisal for the review.

Critical Appraisal of the Sources of Evidence

A critical appraisal of methodological quality is not a requirement for a scoping review. However, this step will include assessing whether or not the systematic review included a critical appraisal of the studies.

Synthesis of Results

In the case of all kinds of knowledge syntheses, developing a standard for clarification of scoping review methods is essential (Tricco et al., 2016). The synthesis will include tabular representation with narrative.

Results

Results will be shown as a table with a description that aligns with the scope and objectives of the review and answers research questions. Thematic analysis will be performed. Thematic analysis will involve familiarisation, coding, generating, reviewing, defining, and naming themes and writing up the findings. The findings will be discussed concerning the

research questions and scoping review objectives (i.e., any gaps in the literature will be identified and finally discussed to highlight the implications for practitioners and researchers).

Selection of Sources of Evidence

Studies will be searched and screened for eligibility using the keywords. Studies will be identified by titles using the keywords and screened for eligibility. Abstracts will be read to identify the required information. Full text of the articles will be accessed if required. The studies not meeting the eligibility criteria will be excluded. This process will be explained in the form of a PRISMA-SCR Flow chart.

Characteristics of Sources of Evidence

A list of every review included will be presented in a table. The number of articles included in each article and the location of the studies will be given. The critical information on findings—the antecedents, consequences, the healthcare workers, and explanation around workplace bullying in each article will be represented in the table.

Method of Handling and Charting data

For each piece of evidence included in the scoping review, a summary of findings as various categories will be provided in the form of an excel spreadsheet. The excel sheet will be exported to a Word file for coding the data.

Results of Individual Sources of Evidence

As above, for every source of evidence included, the relevant charted data will be presented to address the objective and review questions.

Synthesis of Results

The results will be a narrative discussion about findings that will address the two research questions, i.e. themes will be identified about the theoretical explanation of bullying when it happens and how individual studies have discussed the prevention and management of workplace bullying also be given.

Limitations

The search will be restricted to systematic reviews and meta-analyses includes articles published in English only. I have excluded narrative reviews because, unlike systematic reviews and meta-analyses conducted in a much systematic way, narrative reviews are more biased.

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Appendix B: Scoping Review Summary Table

Source	Healthcare Discipline	Total Articles	Review Type	Critical Appraisal	Countries of Included Studies	Aims/Purposes.
Averbuch et al. 2021	Medical	68	Systematic review	Y	USA, Canada, Australia, Asia, Europe, Middle East	To define and classify patterns of academic bullying of medical interns, assess the characteristics of perpetrators and victims. To describe the impact of bullying, review institutional barriers and facilitators of bullying, and identify possible solutions.
Bambi et al. 2020	Nursing	79	Systematic review	Y	Most of the original studies were carried out in Canada and a minority in the USA	To detect particularly the prevalence of workplace incivility, lateral violence and bullying among nurses. To address the potentially related factors and their impact on the psychological and professional areas of the victims.
Binmadi & Alblowi, 2019	Oral healthcare/ dental professionals	8	Systematic review and meta-analysis	Y	Saudi Arabia	To evaluate violence prevalence and related workplace policies at oral healthcare facilities. To identify the factors linked to violence and their effects on oral healthcare professionals.
Capper et al. 2020	Midwifery/ midwifery students	9	Systematic review	Y	Australia, Iran, UK, Finland, Slovenia, Turkey	To identify what is currently known through literature about workplace bullying and violence of midwifery students
Chadwick & Travaglia, 2017	Varied healthcare context	62	Systematic review and meta-analysis	Y	International and Australian	To capture a range of international and Australian literature regarding bullying behaviours in Australian health context from the management point of view and identify gaps in literature.

Source	Explanation of Bullying	Prevention and Management
Averbuch et al. 2016	The cycle of bullying prevails and continues due to power structures and hierarchical systems. A fear of reprisal, ineffective implementation of anti-bullying measures by institutions, and perceptions of hopelessness can escalate bullying. In addition, individual barriers to bullying management can increase bullying, such as concerns about privacy, lack of awareness, and fear of futility.	To prevent and manage bullying, an effective reporting system and ensuring privacy of victims is essential. Anti-bullying committees can help prevent bullying. Additionally, professionalism must be critical for career progression without bullying. Encouraging anti-bullying, gender and power abuse prevention committees is useful. Effective policies, education about stopping bullying, providing institutional support and running internal reviews to create solutions for the environment can also be beneficial Organization-level steps, for example, workshops to help workers identify bullying may also help manage bullying.
Bambi et al. 2020	Several risk factors and explanations were identified which may be associated with bullying. Bullying may result as a learned phenomenon in the workplace within a group, conflicts, inefficient leadership and decrease of social competence, and micropolitical motives to attain one's benefits. In addition, several in-groups in the same workplace may also escalate bullying.	Interventions from nursing leadership and management may be beneficial. For example, general and advanced education about bullying prevention and management throughout the workplace and concrete calls for action to mitigate bullying.
Binmadi & Alblowi. 2019	Lack of staff training, long waiting times, psychiatric illnesses, alcohol intoxication and nonreporting of bullying were associated with bullying. Fear of complaining about bullying if the bully was a senior could also increase bullying.	Increasing knowledge of bullying by using educational content on how to identify and prevent bullying may be beneficial for bullying management. In addition, courses about prevention and management and using instructional material may reduce bullying.
Capper et al. 2020	The role of power and its misuse of midwives and students make them feel less valued. Mentors had the upper hand over juniors which manifested in the reports of bullying in the healthcare setting. A culture of complying with bullying where bullying was acceptable as normal teaching practices escalated bullying.	Knowledge about sensitive cultural aspects in the workplace may help prevent bullying. For example, workplace support for the mentors in conducting teaching responsibilities and education in particular about identifying bullying behaviours might help prevent and manage bullying.

Chadvick & Travaglia 2017	Academic bullying resulted from fear of reprisal, perceived hopelessness and institutional nonenforcement of anti-bullying policies.	Anti-bullying committees and ensuring professionalism as a requirement for career advancement may prevent bullying. Promoting anti-bullying policies, offering education to prevent academic bullying of healthcare employees, establishing an anti-bullying oversight committee, and institutional support for victims may lead to prevention and effective bullying management,

Study Synthesis Contd.

Source	Healthcare Discipline	Total Articles	Review Type	Critical Appraisal	Countries of Included Studies	Aims/Purposes
Halim & Riding, 2018	Medical Surgery	32	Systematic review	Y	Australia, Canada, China, Greece, Italy, Japan, New Zealand, Nigeria, Pakistan, Ireland, South Korea, Sweden, Taiwan UK, USA	To define prevalence and effects of bullying behaviour in the surgical workplaces internationally and to explore strategies against bullying.
Huang et al., 2018	Surgery	8	Systematic review and meta-analysis	Y	International Greece.	To collate prevalence and impacts of discrimination, bullying, and harassment in surgical practices and trainings
Johnson & Benham-Hutchins, 2020	Varied healthcare. Nursing, Ors, emergency, inpatient, and critical-care units	14	Systematic review	Y	International Countries are not specified.	To examine the influence of bullying behaviours on nursing practice errors
Lever et al. 2019	Healthcare and allied health workers overall.	45	Systematic review	Y	UK, Australia, Turkey, Italy, Portugal Norway, Denmark, Canada, Germany, USA, Bosnia and Herzegovina, China, Japan, Sweden,	To review both mental and physical health consequences of bullying for healthcare employees.
Lozano et al.,2021	Varied healthcare Mostly medical and nursing. Nursing assistance.	59	Systematic review	**Y**	International Countries are not specified.	To review the risk factors that result in increased burnout among physicians and nurses and the factors that prevent burn out and workplace violence. To explore the potential correlation between verbal and physical workplace violence and the symptoms resulting from burnout

Study synthesis continued.

Source	Explanation of Bullying	Prevention and Management
Halim & Riding, 2018	No clear explanation of the bullying process is given. The review points out that contextual factors such as workload, stress, long working hours and workplace may be the reasons behind bullying of staff.	Focus on prevention, rather than mitigating strategies, may help in prevention and management of bullying. Early education in medical schools, training about professional behaviours, methods for tackling mistreatment are perceived as ineffective and potentially damaging to victims. Early work into cognitive rehearsal programmes and operating room simulation may be useful, but their ability to improve the working. Culture in surgical departments has not been practically demonstrated.
Huang et al. 2018	Culture of bullying and hierarchy in the surgical workplaces are associated with bullying. A training apprenticeship approach that fosters certain bullying practices that are believed to be effective teaching and training strategies for apprentices may lead to bullying.	Emphasis on processes, implementation of a code of conduct and policies to prevent bullying of trainees by seniors may result in effective bullying management. Non-judgmental support at the workplace and skill assessment of supervisors are also critical for prevention and bullying management. Culture of bullying can be mitigated by creating awareness about bullying and offering online resources that provide knowledge to surgical trainees about bullying prevention and management.
Johnson & Benham-Hutchins, 2020	Work-environment, lack of communication and barriers to effective teamwork due to oppression of powerless individuals escalates bullying by causing anger which manifests bullying behaviours toward other members of group.	No specific prevention and management were discussed. Some suggestions regarding understanding bullying so as to create effective strategies and introduce interventions for mitigating bullying are noted.
Lever et al. 2018	The review did not directly discuss the explanation of bullying behaviours but discussed the impacts of bullying.	Creating awareness about bullying issues will lead to effective reporting of bullying to prevent and manage bullying. Senior leaders and management should focus on multiple measures including anti-bullying policies and effective reporting systems.
Lozano et al. 2021	Some high-risk factors lead to possible workplace violence. Personal, structural, and organisational factors (e.g., nature of work, self-regulatory mechanisms, self-efficacy etc.) may result in encountering violence,	Workplace violence could be addressed through a healthy work environment, support from colleagues, an effective institutional role in creating intervention programmes and a zero-tolerance policy. Training and building awareness may also prevent and manage bullying.

Source	Healthcare Discipline	Total Articles	Review Type	Critical Appraisal	Countries of Included Studies	Aims/purposes.
Samsudin et al. 2018	Medical/	18	Systematic review	Y	USA, Canada, India, Ireland, New Zealand, Japan, Pakistan, Canada, Turkey, Australia, Oman, Saudi Arabia, UK,	To explore bullying operation and measurement. To explore the impacts of bullying operations and measurement on prevalence rates. To explore the possibility of certain target characteristics and organisational factors associated with an increased risk of exposure to bullying. To study the impacts of bullying on victims and organizations.
Serafin et al. 2020	Nursing	31	Systematic review and meta-analysis	Y	Poland, Jordan, Turkey, USA, Taiwan, Greece, South Korea, Canada, Norway, Japan, Italy, Israel, Spain	To synthesise empirical studies which used Negative Act Q questionnaire (NAQ) to assess bullying of nurses by evaluating psychometric properties. To identify variables that are related to the bullying of nurses.
Shorey & Wong, 2021	Nursing	27	Qualitative systematic review—	Y	USA, Australia, UK, Pakistan, Iran, South Africa, Italy	To explore nurses' experiences of workplace bullying and prevention and the type of bullying which nurses face. To explore drivers of bullying and the impacts on bullied individuals. To explore how do nurses cope with bullying behaviours.
Stag & Sheridan, 2010	Nursing	18	Systematic review	N	Australia, USA, International, Netherland	To identify strategies and effective practices for preventing and managing workplace bullying of staff nurses.
Walker & Stones 2020	Varied healthcare context-First responders	Unspecified.	Systematic review	N	A range of Australian and International literature. Countries are not specified.	To examine International and Australian literature about workplace bullying behaviours in a health context from a management focus. To explore theory, behaviours, characteristics, impacts and prevalence of bullying. To investigate the perceived impacts of bullying on first responders' mental health.

Study synthesis continued

Source	Explanation of Bullying	Prevention and Management
Samsudin et al. 2018	Bullying is influenced by multiple individuals (e.g., age, gender, ethnicity) and occupational factors (e.g., clinical specialty). Power and hierarchy in the medical settings job-demands and lack of resources. May cause bullying	Awareness of bullying among junior doctors may prevent and manage bullying. Bullying prevention and management is also possible through creating an understanding of job demands and burden on doctors, bullying predictors and the impact of bullying on doctors,
Serafin et al. 2020	Individual characteristics, job stress, hierarchy, work environment, intent to quit nursing, and mental and physical health-related problems were identified as explanatory factors concerning bullying.	Supportive leaders and managers and educating nurses can prevent and manage bullying. Enhancing nurses 'skills and offering knowledge that will help them successfully navigate the hierarchy and work environment may lead to prevention and management of bullying,
Shorey & Wong. 2021	A lack of leadership skills for managing bullying, a tendency to practice power and control, competitive and hierarchal nature of the nursing profession may explain bullying. In addition, the oppression of nurses, toxic work environment, the difference in generational cultural beliefs, resilience and acceptance of the bullying culture may escalate bullying behaviours.	Prevention and management may involve managerial support to new nurses. Bullying can be prevented by education and awareness about bullying issues. Organisational focus on ensuring that nurses' code of conduct is practicing effectively may offer a safe environment for reporting bullying. Team building activities and regular unit-level group discussions to create anti-bullying strategies, education about conflict management in nurses' courses and curriculum are some other ways bullying may be prevented and managed,
Stag & Sheridan, 2010	An absence of a healthy work environment may escalate bullying behaviours,	Improved workplace culture, supportive leadership, effective communication and antibullying training can help. Cognitive rehearsal programmes that are designed based on nurses' responses may be effective in bullying prevention and management. Bullying behaviours may be managed through practicing the techniques learned during the cognitive rehearsal programmes.
Walker & Stones 2020	Review of literature using the ecological system model based on (Bronfenbrenner's ecological system theory) indicated culture and hierarchy at the macro level. At the micro and meso levels, colleagues and supervisors can encourage bullying by ignoring the issue or not taking action against the bullying.	Prevention and management can be facilitated by creating awareness about bullying and the scope of the bullying problems. Also, open communication, education about preventing and managing, training, and creating a positive environment for healthcare workers.

Appendix C: Scoping Review Data Extraction Table

Data Extraction Table Hyperlink (Ctrl+Click to open)

https://osf.io/sxct3

Appendix D: Information Sheet

Information Sheet for Participants

Waikato Management School
Te Raupapa

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Exploring role of work environment factors in the management of workplace bullying of New Zealand's junior doctors

I would like to invite you to participate in a doctoral research project exploring the role of work environment factors in the management of workplace bullying of New Zealand's junior doctors. Before you decide to participate in this study, I want to inform you why this research is being conducted and what it involves for participants. Please read this information sheet carefully. You are welcome to ask questions if further information is required. Participation in this study is voluntary. Your refusal or withdrawal at any stage of the research will result in no penalty or loss. Your participation in the study is greatly appreciated.

My name is Sarah Bashir. I am a PhD candidate at the School of Management, University of Waikato. My PhD study aims to explore the role of work environment factors in the management of workplace bullying of New Zealand's (NZ) junior doctors. The study focuses on explaining bullying and its management theoretically in the New Zealand's junior doctors. Study also focuses on identifying which important work environment factors junior doctors report that could shape the way bullying is managed in the New Zealand's junior doctors.

To gather data for this study, I would like to interview you face-to-face or online, depending on your preference. Before the interview, you will be requested to grant your consent. Each interview session will last for 45-60 minutes. During the interview, I will ask questions regarding your views on the explanations of bullying and its prevention and management (for example, your work environment and how bullying is managed in your workplace etc.). Please find the interview questions attached.

If, for any reason, you choose not to participate in the study, you will be allowed to withdraw from the study without giving a reason. You will be provided with the interview transcript for amendments. You can withdraw any time for up to three weeks after receiving the interview transcript. If you choose to withdraw from the study after the interview, all of your data (including hard and soft copies of the interview) will be immediately destroyed. I will ensure your privacy and confidentiality at all times. No identifying information about you will be declared at any stage. Soft copies of the data will be saved on my password-protected laptop and office computer. Only my supervisor and I will have access to the data. Hard copies of the data will be kept in a locked cabinet. Five years after the completion of this study, all data will be destroyed under the instructions of Waikato University.

This study has been approved by the University of Waikato Human Research Ethics Committee under approval HREC2021#56.

Please ask questions if any further information is required about the study.

If interested, you will be provided with a summary of the findings after the study.

If you need further information about this research project, please contact:

Sarah Bashir (Lead researcher)

Phone: 0800924528 (Please dial extension 4643)

Email : SB355@students.waikato.ac.nz

Professor John Oetzel (Chief supervisor)

Phone: 078379252

Email: john.oetzel@waikato.ac.nz

Appendix E: Interview Guide

Interview Guide

This study explores the explanations of bullying to assist in the prevention and management of bullying of New Zealand's (NZ) junior doctors. This aim can be attained by focusing on two objectives: (1) exploring why bullying happens and the bullying process among NZ's junior doctors and (2) identifying which important factors junior doctors report that could shape the way bullying is managed in the NZ medical workforce.

Opening questions

1. What is your role/ position within your organisation--where do you work?

2. How long have you been working in your current organisation?

3. Do you work full-time or part-time? How many hours per week do you work?

4. Can you tell me a bit more about your current role? What are your responsibilities in regard to your role (i.e. post-graduate year2 or PGY2; resident medical officers or RMOs; senior house officers or SHOs)?

5. Tell me what brought you here today?

Core Questions

6. How are you familiar with bullying in your workplace? Tell me your story.

Probes: An experience and/or example of bullying incidence, familiarity, or participants' views on bullying, what they mean by bullying as a bystander, bullied or their involvement in bullying management.

What do you think are the major causes of bullying in your workplace?

7. Tell me about your work environment—do you think your work environment is related to bullying?

Probes: Positive or hostile work environment, individual, organisational, social factors which lead to positive or hostile work environment etc.

Are there any other factors that you think are related to bullying?

8. What are your thoughts about your department's culture--do you think different departments in your workplace have different cultural and social values, norms and rules? If yes, how do you think it affects bullying and its management? How do these rules work?

Probes: Structurational divergence (i.e. consequences of presence of any contradictory social, cultural values and/or norms), identifying opposing structures, hierarchy, authority structures,

power dynamics, interpersonal relationships and negative or positive communication, team conflicts.

9. Do you have any examples of different departments with contradictory cultural and social units which lead to bullying?

Probes: Examples of contradictory structures and units, conflicts at individual, social, and organisational levels, repeated patterns of negative behaviours and communication, the cycle of negative behaviours

Closing questions

10. What does your organisation do to prevent and manage bullying in your workplace? Does Any training, annual discussions about bullying management, policy, or institutional support?

Probes: Bullying management in the healthcare sector in general and in the medical workforce,

11. Based on your experience, what do you think needs to be done in order to prevent and effectively manage bullying?

Probes: Further thoughts, roles of employees, managers, and leaders; national, institutional, organisational policies etc., and positive work environment.

12. Is it okay to contact you again if any further information is required? If yes, what is your most preferred way to contact you?

Appendix F: Consent Form

Consent Form

Waikato Management School
Te Raupapa

Exploring role of work environment factors in the management of workplace bullying of New Zealand's junior doctors

I have read the **Information Sheet for Participants** for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.
I also understand that I am free to decline answering any question and can withdraw from the study any time for up to three weeks after receiving the transcript of my interview. I agree to provide information to the researchers under the conditions of confidentiality set out on the Information Sheet.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: ____

Name: ____

Date: ____

Lead researcher's contact information:
Sarah Bashir
0800924528 (Please dial extension 4643)
sb355@students.waikato.ac.nz

Chief supervisor's contact information:
Professor John Oetzel
07838 4431
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Appendix G: Ethics Approval Letter

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

20 September 2021

Sarah Bashir
Waikato Management School
SB355@students.waikato.ac.nz

Dear Sarah

HREC(Health)2021#56 : Role of work environment factors in the management of workplace bullying of NZ junior doctors

Thank you for your detailed responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

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Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee