BULLYING IN THE HEALTHCARE WORKPLACE

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QUALIFICATION IN MASTER OF ARTS IN DISPUTE RESOLUTIONINDEPENDENTCOLLEGEDUBLIN

NOVEMBER, 2022

DissertationSubmissionForm

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DISSERTATIONTITLE:	Bullying in The healthcare Workplace
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WORD COUNT:	20,114
DUEDATE:	03.11.2022
DATESUBMITTED:	10.11.2022

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Acknowledgments

In the realization of this dissertation, I counted on the direct or indirect support of multiple people to whom I am deeply grateful. At the risk of unfairly not mentioning any of the contributions, I would like to express my thanks:

Dr. Richard Brophy, for his guidance, his encouragement. Here I express my gratitude.

To all friends and colleagues who directly or indirectly contributed or helped in the preparation of this study, especially Renata Costa and Katia, for the patience, attention, and strength they provided under challenging moments.

I must also thank my family for all the support, strength, and affection they have given me throughout my academic life and for preparing this thesis, which would have been impossible without their consent—my boyfriend Gearoid for walking by my side and for his patience and understanding.

I also want to thank all who were willing to help me carry out the surveys, both as interviewers and those who were ready to answer the survey. I thank you for your attention and patience; without you, collecting this data would have been impossible. Thank you very much.

Finally, I want to express my gratitude to all who made this dissertation possible in one way or another.

To all, my sincere and profound Thank You

Abstract

Background: Organizations are never impartial and are always motivated by socioeconomic considerations. Workplace harassment is likely to occur. Bullying hurts both the person and the group. Bullying at work is repeated, harsh, and traumatic abuse. These things could hurt the health of the professional. bullying in healthcare settings is widespread, and several factors contribute to professionals who are victims of bullying not reporting it.

Objective: Given the lack of research regarding underreporting of bullying in the healthcare sector, this study aims to identify the factors that prevent healthcare professionals from reporting bullying in the workplace in Ireland and Brazil. The paper informs readers about the prevalence of under-reporting of bullying in the healthcare environment and the barriers to reporting it

Methodology: Methods:A cross-sectional study with 19 questions and a 5-point Likert scale was made and put online so it would be easier to look at the data. Data were given based on the interpretivism of 52 care worker in hospital and home in Brazil and 52 care workers in nursing home and home care inIrealnd.

Conclusion: This systematic study provides reasonably solid evidence that workplace bullying is prevalent among doctors, nurses, staff, and patients, as well as the potential causes, harms, and factors contributing to underreporting bullying. This is especially useful given the limited knowledge we have about workplace bullying among healthcare professionals.

Keywords:Bullying; health workplace, underreporting, prevention, policy.

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Introduction

Organizations are never impartial and are always motivated by socioeconomic considerations. Workplace harassment is likely to occur. As a result, healthcare professionals must consider the dynamics, mechanisms, and causes of power inequality at work (Ironside, M.; Seifert, R.,2003).

According to this theory, workplace bullying worsens as more people are distracted by it and the victims' emotional and physical health, hurting individuals and organizations. When an adverse circumstance is combined with a future lawsuit for unfair termination, job compensation, or disability, the scenario worsens exponentially. It can occasionally be challenging to quantify and precisely describe other economic problems negatively influencing earnings. These factors cause a decline in quality, detrimental effects on the organization's reputation, and increasing errors and absenteeism, as well as the deterioration of client relationships as a result of a lack of consideration given to, among other things, their goals and commitments (Gumbus, A.; Lyons, B.,2011).

Bullying in the healthcare industry has been linked to gender, age, cultural differences, seniority, and qualification. According to research, most bullies are managers, supervisors, and coworkers (Hutchinson et al., 2010). Even though empirical studies have not yet classified bullying, gender can still be used for more in-depth individual analysis. (Leymann,1996)

Some individual traits of the victims may serve as possible workplace bullying triggers. Early research suggested that workers who faced workplace conflict also encountered comparable circumstances with their partners, families, and acquaintances. Because the findings are sometimes regarded as "victim blaming," the perspective of individual antecedents about workplace harassment has generated debate (Finne, L.B.;et al.,2011).Most scientists think that a personal propensity for acting as a victim or bully could not exist. However,

investigations seeking to identify personality types specifically susceptible to bullying are far from clear.

In order to draw attention to the significance of ethics in public administration, we will discuss how the organizational power dynamics associated with bullying in the workplace conflict with a concern for care and justice in public sector organizations (Burnier, 2003). In this essay, the topic of bullying in public health nursing programs is discussed. Some people believe that the nursing culture is characterized by submission, devotion, obedience, and hierarchy. In addition, it is said that the organizational structure utilized in nursing, which includes rank, uniform, and command structures, was inspired by the "masculine world of the military."

Through definition and measurement, the prevalence of workplace bullying is estimated (Johnson, 2009). The frequency reported by nurses in Portugal is 13%. In the U.S., between 27% and 31% (Johnson & Rea, 2009; Simons, 2008). In the U.K., 44% (Quine, 2001). In Australia, 50% to 57% (Rutherford &Rissel, 2004), and in Turkey, 21%. (Yildirim, 2009). According to statistics, healthcare professionals are more likely to be bullied at work (Zapf, Einarsen, Hoel, &Vartia, 2003). Workplace bullying typically affects two individuals (bully and target). However, it is now widely acknowledged that workplace bullying does occur (Hoel& Beale, 2006).

The institutionalized mistreatment of workers and harassment in the workplace have persisted and even increased over time. It would appear that health care organizations, both clinical and educational, are particularly vulnerable to bullying in the workplace due to the complexity of their organizational structures and the wide variety of responsibilities that their employees are responsible for (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Quine, 2003; Randle, 2003). Inadequate working conditions harm a company's bottom line (Johnson, 2009).

According to the findings of some studies, age, educational level, and gender are all potential factors in the genesis of bullying and its victims. The characteristics

of their targets and the positives and negatives associated with their actions may be considered by those considering whether or not to engage in the practice of cyberbullying. Consequently, some people are more likely to (e.g., women or junior employees).

Despite this, researchers have found a gender gap in positions of authority directly resulting from workplace discrimination. According to this point of view, aggression against minorities in the workplace is the same as any other form of bigotry, regardless of whether it is directed toward men or women. 10.2% of males and 4.3% of females in Norwegian healthcare personnel have reported having been abused, according to research that was conducted on this population (Eriksen, W.,2004).

Numerous research on how organizations developed treatments for avoiding and reducing bullying have been undertaken in recent years. However, this continues to be an issue in healthcare because these workers are subjected to animosity. These professionals deal with various people while performing their duties, including coworkers, patients, families, supervisors, and others. In order to provide a critical review of studies in the healthcare workplace connected to anti-bullying among health professionals in all sectors, this research intends to address that issue. Since bullying is a problem that has been discussed for a long time, the main focus is identifying the primary reasons why these individuals choose to keep quiet and not report these instances of bullying. There are several policies in place now that aid in resolving this issue. The study findings will be pertinent to students and health professionals interested in learning more about the topic.

1.1 Background of Issue

The global economy has changed in recent decades, increasing workplace competition and hostility and exposing workers to new dangers. Bullying, once a problem in schools, is now a problem in the workplace. Bullying harms both

individuals and groups. Bullying at work is repeated, severe, and traumatic abuse. These actions could harm the professional's health. These can impair the general health of these professionals and include depression, anxiety, gastrointestinal problems, hypertension, headaches, and sleep disorders. These behaviors may jeopardize patient care, teamwork, medical accuracy, and professional withdrawal (Al Omar, Salam, and Al-Surimi, 2019).

Over the past two decades, researchers have studied workplace bullying, including its causes, effects, and prevention. These nursing techniques are still widely used. These professionals do this because of their positions and authority, particularly nurses who must deal with multiple hierarchies that lead to systemic stress.

According to NHS, in 2019, 38% of healthcare professionals had experienced some form of bullying in the previous year. This figure may be even higher due to unreported cases. According to the research, despite the policies against bullying, many cases go unreported due to numerous factors. The global economic situation, which has caused many people to fear losing their jobs, a lack of education, and intimidation,plays a role, as does the fact that the system designed to prevent bullying frequently includes the bullies themselves.

Given this critical situation that health professionals face concerning bullying in their activities, it is necessary to follow policies for control, intervention, and treatment against bullying. These professionals need to be aware of the barriers against these acts because, in addition to the physical and psychological damage, recent research shows that these acts are increasing cases of suicide. Therefore, further research needs to be conducted into the system's flaws to develop more effective methods of combating these acts.

Policymakers, managers, and upcoming researchers looking for focused information can benefit from having a thorough understanding of these subject measures to enhance patient safety, staff health, and economic efficiency in medical institutions.

1.2 Problem Statement

This research was focused on the underreporting of bullying; despite more than two decades of research in which policies and codes to control bullying already exist, these measures are not enough to control and prevent these acts. Research has pointed to some reasons for underreporting, such as fear of bullying, the global economic situation, and lack of information. However, bullying still is a worldwide health problem, and effective measures should have been in place to break down these barriers; empowering staff to report bullying will prevent people from committing these acts of bullying.

As a result, the existing research does not clearly show why the barriers against bullying are not practical. Studies are carried out in different countries; therefore, most focus on the cause and consequences of bullying. The lack of information can be one of the leading causes of the lack of improvement of these preventive measures.

1.3 Aim and Objectives

Given the lack of research regarding underreporting of bullying in the healthcare sector, this study aims to identify the factors that prevent healthcare professionals from reporting bullying in the workplace in Ireland and Brazil. The paper informs readers about the prevalence of under-reporting of bullying in the healthcare environment and the barriers to reporting it. The article defines workplace bullying and why health care settings are susceptible to such misconduct. It also provides a step-by-step anti-bullying policy set out by the HSE and Workplace relation commission, which guides the individual on what action to take if they are bullied or witness bullying.

After reading this article, the reader can define what bullying is, differentiate between what is considered bullying and other harmful behavior, and discuss why bullying goes unreported and why it is increasing.

1.4 Research Questions

The primary research question of the study is:

What are the main barriers that health professionals face in not reporting bullying in Ireland and Brazil?

In order to assist this research question, the researcher has made three additional sub-questions:

1.What types of barriers exist to prevent bullying in the workplace?

2.What factors trigger bullying in the healthcare workplace?

3.What are the main consequences faced by staff who are bullied?

1.5 Research Significance

The primary goal of the research is to identify barriers to staff not reporting bullying. By identifying these factors, it will be possible to make changes to the system of bullying prevention implemented in institutions, health care providers will be able to distinguish bullying from other types of abuse and will have information on how to proceed if they are being bullied or witnessed. Staff will be provided with sufficient information about the importance of combating bullying, as it is a severe public health problem that can damage staff's physical and mental health.

This research will also alert institutions of the seriousness of bullying cases, in which their professionals need to learn how to identify and combat these acts and reassess their anti-bullying codes. This research will show the main factors preventing staff from reporting bullying and provide them with more information about the issue.

1.6 Dissertation road map

For easier comprehension and organization, the present academic dissertation is divided into seven sections.

Introduction

The purpose of this section is to provide a brief introduction to the research subject, the aims, and objectives, as well as personal backgrounds, beliefs, and contributions for healthcare professionals. Its purpose is to make it easier for readers to understand this research's purpose.

Literature Review

Those who read this chapter will have some understanding of what they are reading. The purpose of this chapter is to illustrate the reality of bullying in the healthcare environment. The study aims to identify factors that contribute to the persistence of this problem in these environments. In addition, it addresses the shortcomings of prevention and combat methods.

Research Methodology and Methods

In this chapter, the philosophy, approach, design, and ethical considerations underlying this research are explained.

Presentation of Data

All the results obtained from the survey elaborated to support this research will be presented in a visual and written manner in this chapter.

Data analysis and findings

A detailed descriptive analysis of the survey results is provided in this chapter to help you better understand them.

Discussion

An examination of the theory and literature related to the results is provided in this chapter.

Conclusions

On the basis of every procedure carried out during this study, this section consists of conclusions that this research accomplished.

2 Literature Review

2.1 Background

According to Rodwell and Demir (2012), bullying is a circumstance that happens over time and in which people perceive themselves as experiencing unpleasant behaviors and acts from others. One person or multiple people can do this when bullying victims find it difficult to defend themselves from the mistreatment.

According to Quine (2001), there are three common elements while bullying;

- A detrimental result in terms of feeling mistreated or frightened
- freaked out
- It is tenacious.

Several ways indicate employees' harmful and destructive behaviors toward their coworkers. Szutenbach (2013) said that it is challenging to understand how nurses can be empathic and caring with patients while bullying and attacking their coworkers.

2.2 Incidence of Bullying

Several authors have acknowledged workplace bullying as a severe problem that nurses must deal with (Murray, 2009). The incidence of nurse-to-nurse bullying

ranged between 14.7% and 21.7% in two Australian studies (Roche et al., 2010), and studies in the USA (Vessey et al., 2009) indicated rates of 23% and 27.3%, respectively.

In order to learn more about the prevalence and experiences of what these researchers called "moral harassment," a survey of 259 nurses in Brazil was conducted. Due to this, more than 40% of the respondents stated that they had encountered thisbehavior from coworkers.

According to Duncan et al. (2001), 286 Turkish nurses and 19% of Canadian nurses experienced workplace bullying in the preceding year (Yildirim, 2009). According to Quine (2001), 44% of the 1100 British respondents had experienced bullying in the previous year. Carter et al. (2013) surveyed 2,950 healthcare professionals regarding bullying and its effects in seven NHS trusts in the north-east of England. Twenty percent of the more than 600 nurses who participated in this study reported being bullied, and more than forty percent of the Dun employees observed bullying among their coworkers.

2.3 Causes of workplace bullying:

This systematic review revealed significant differences between organizational factors such as clinical specialty and individual factors such as age, gender, ethnicity, nationality, and height (Figure 2). According to Crutcher et al., the probability of encountering intimidation, harassment, and discrimination increased by 0.76 (95% confidence interval: 0.59 to 0.98) per year of age (2011). Similar to Chadaga et al. (2016), Bairy et al. (2007), J. Scott et al. (2008), and Hills et al., those under 30 were more likely to report negative work interactions (2012).

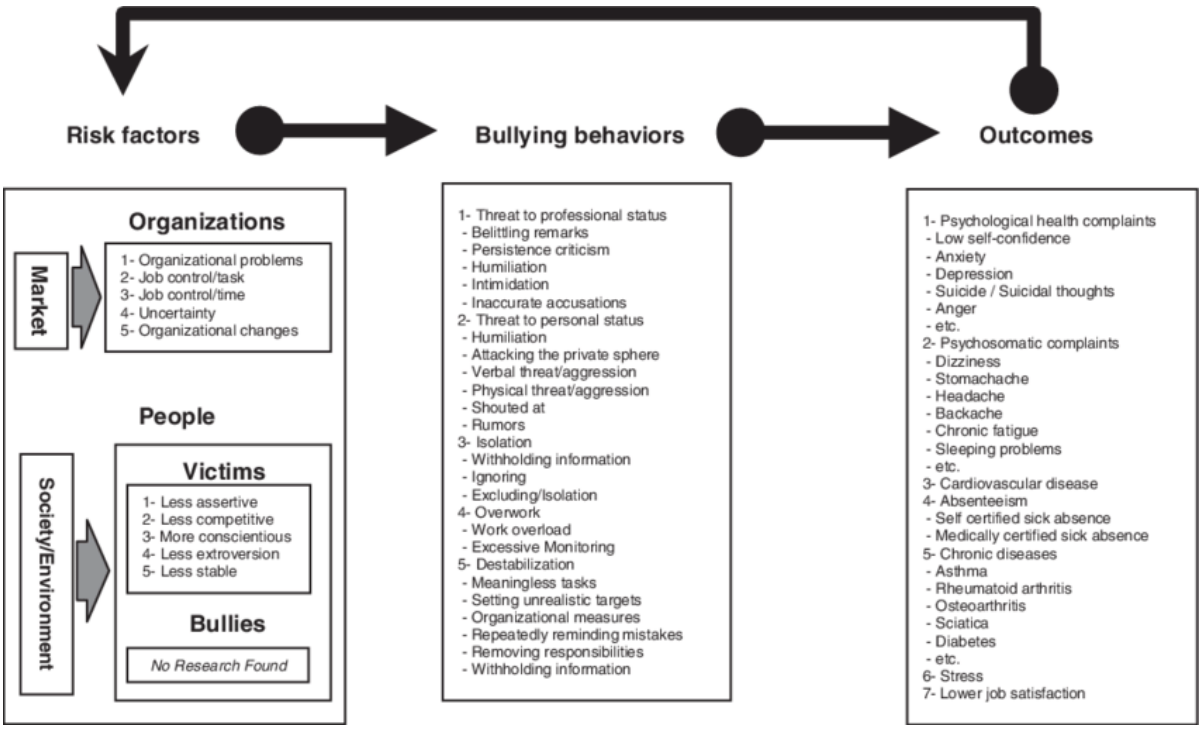


Figure 08: A model of workplace bullying based on the systematic review findings.

Ariza-Montes, Muniz, Montero-Simó, and AraquePadilla all came to comparable conclusions (2013). This observation may have an explanation if one considers that doctors, nurses, staff members, and younger patients are at the bottom of the medical food chain (Crutcher et al., 2011).

In addition, bullying is distinguished by an imbalance of power, which is frequently the result of deficiencies in medical education. Nevertheless, some authors contend that all medical profession members, including staff, patients, nurses, and others, are bullied because they incorrectly interpret criticism as "bullying" (J. Scott et al., 2008). (Ling et al., 2016). It's possible that being bullied in medical school will help you (Garling, 2008).

Others believe that bullying is more likely to occur in healthcare settings because healthcare professionals, nurses, staff, and patients lack experience in effectively managing conflicts in the workplace (Hills et al., 2012). In conclusion, maturation and age bring about shifts in perceptions and interpretations, which may help to

explain why older physicians are less likely to notice instances of bullying (Crutcher et al., 2011).

It was found in five different studies by Chadaga et al. (2016), Aykut et al. (2016), Fnais et al. (2013), Ling et al. (2016), and Hills et al. (2012) that female junior doctors are significantly more likely than male junior doctors to be bullied in the workplace (Ariza-Montes et al., 2013). According to the findings of some authors, men view harassment in the workplace as a form of management style, whereas women view it as a form of threat (Simpson & Cohen, 2004)

Some people believe that women should be held to stricter standards of behavior and should not abandon their traditional roles because doing so can lead to bullying and poor judgment (Babcock &Laschever, 2003; Gilbert, 2013). Harassment in the workplace can also be motivated by factors such as racism and nationality. According to Cheema et al. (2005), European doctors, nurses, staff, and patients were significantly less likely to be bullied than non-Europeans. Researchers Chadaga et al. (2016) found that there were significant differences in the incidence of bullying between white and non-white participants.

This disparity may be due to non-acculturation, the misinterpretation of certain behaviors as bullying, or cultural differences in personal and social vulnerabilities among employees of different ethnicities (Sabri et al., 2015). (Chadaga et al., 2016). There is a correlation between height and bullying in the workplace. According to Chadaga et al., bullying has been documented in the literature about children (Voss & Mulligan, 2000), but it has not been found in the literature about adults in the workforce (2016). People who are shorter than 5'8" are more likely to be the victims of bullying.

According to Dikmetas et al. (2011) and Al-Shafaee et al. (2013), medical rotations had a higher mistreatment index than pediatric or surgical rotations, respectively. The Job Demands-Resources (JDR) model postulates that clinical subspecialties have distinct job demands, resources, and stress (Van den Broeck, Baillien, & De Witte, 2011).

According to the study by Daugherty et al. in 1998, job demands were found to have a positive association with targets' reports of bullying, whereas job resources were found to have a negative association. In addition, specific subspecialties require more time and provide less emotionally and socially supportive work environments(Van den Broeck et al., 2011).

2.4Bullying Among Medical residents

Leisy and Ahmad (2016) discussed this in their systematic study on bullying among medical residents. They discovered that the main themes contributing to the prevalence of bullying were hierarchy, silence, incognizance, fear, acceptance or denial, and the legacy of abuse. Junior doctors, nurses, staff, and patients are at the bottom of the medical food chain, where authority is rigorously and immediately correlated to rank, and they rely heavily on their superiors for guidance and opportunities for professional growth. Many claims that scary teaching techniques are frequently used during their training years by those who think that "teaching by shame" to "toughen up" the young is an acceptable practice (K. M. Scott, Caldwell, Barnes, & Barrett, 2015). According to research, doctors, nurses, staff, and patients frequently believed that any harassment they faced was just a regular part of training (Coverdale, Balon, & Roberts, 2009), and they were unaware of what constitutes abuse.The majority of medical students and residents (74.5%) engage in humiliation, and even more (83.6%) are witnesses to it (K. M. Scott et al., 2015). Mistreatment is seldom questioned due to a culture of silence, a lack of perceived social support from coworkers and supervisors, and a fear of repercussions for reporting it. Twelve percent of medical residents reported having to report abuse to a supervisor (Leisy& Ahmad, 2016). This indicates that a learned pattern of abuse can persist for an extended time. According to Fnais et al. systematic .'s review and meta-analysis, 59.4% of medical students and residents have experienced harassment or discrimination. When healthcare providers, such as doctors, nurses, and other staff, as well as patients, are subjected to bullying, it can hinder their ability to

learn and provide safe care. There is evidence that doctors who are bullied are more likely to make fatal surgical errors (Paice&Smith, 2009).

Doctors, nurses, and staff may eventually lose empathy and ethics due to unfair treatment and unprofessional behavior from superiors and peers (Leisy& Ahmad, 2016; Moayed et al., 2006); collegiality and cooperation, which are essential for good teamwork and effective communication (Ekici&Beder, 2014); and inhibition of these factors. Bullying in the workplace has far-reaching effects on the healthcare industry and should be better understood by doctors, nurses, staff, and patients. To better understand the prevalence, risk factors, and consequences of workplace bullying among physicians, nurses, staff, and patients and identify potential interventions, synthesizing these data is necessary. Although Leisy and Ahmad (2016) and Fnais et al. (2014) have shed light on this issue among healthcare providers, they have not investigated the factors that contribute to workplace bullying nor developed a theoretical framework based on research in this field.

While Fnais et al. (2014) briefly discussed risk factors for hostile workplace behaviors that are not workplace bullyings, such as sexual harassment and gender and racial discrimination, Leisy and Ahmad (2016) investigated risk factors and outcomes for bullying among medical residents. The medical field is notoriously silent on the topic of workplace bullying, but gaining insight into the experiences of doctors, nurses, staff, and patients could shed light on the issue in other study populations with hierarchical structures, "tough" work cultures, and high job stress, such as military personnel. Workplace bullying can be challenging without a thorough understanding of the concept's definition, characterization, operationalization, and measurement. Although workplace bullying has been studied and addressed more than any other source of stress in the workplace over the past four decades (Einarsen, Hoel, Zapf, & Copper, 2003; Zapf, Einarsen, Hoel, &Vartia, 2003), it remains elusive to both researchers and practitioners. Its terminology, operationalization, and measurement, all of which relate to the frequency and duration of adverse events, continue to be

problematic (Zapf et al., 2011). Cowie, Naylor, Rivers, Smith, and Pereira (2002); Quine (1999); Einarsen, Hoel, Zapf, and Cooper (2011).

Even when employing the Negative Acts Questionnaire, researchers use various methods to assess workplace bullying, including the behavioral experience method, self-labeling, a fixed cut-off point, and the "Leymann criterion" (Zapf et al., 2011). Estimating the frequency of workplace bullying is hampered by the fact that distinct assessment strategies yield divergent results (Zapf et al., 2011).

2.5 Power and bullying

Bullying's persistent nature can hurt those who are the targets psychologically and physically, leading to eventual disease and unemployment (Kivimäkia& Virtanen, 2003). It has been demonstrated that bullying is detrimental to businesses, as it results in lower production (Yamada, 2000), higher turnover (Yamada, 2000), and decreased commitment (Yamada, 2000). (Yamada, 2000). Estimates suggest that addressing bullying in the workplace will cost organizations approximately 5% of their annual operating budget (Waldman et al., 2004). The majority of what we know about bullying in the workplace has been gleaned from organizational psychology up until this point. According to Zapf and Einarsen (2005), bullying can be defined as "an amplification of conflict between peers that stems from shared characteristics and institutionalized practices that foster aggression." [Citation needed] (Vardi& Weitz, 2004). When parties are engaged in a struggle for power, conventional theories of power and conflict (Conrad, 1983) assert that they will resort to bullying tactics. Consequently, many people have suggested using HRM and ADR to settle disagreements (Harvey et al., 2009).

In contrast, conflict-based explanations of workplace bullying reflect normative, individualistic conceptions of power and obstruct a more comprehensive examination of less obvious organizational dynamics. Bullying in the workplace is a serious issue that needs to be addressed. Given the contemporary theoretical

currents surrounding executive power, these overly simplistic interpretations of bullying come across as outdated (Callon& Latour, 1981).

Bullies frequently resort to using nonverbal communication and verbally threatening their victims. Bullies put on an act of confidence through their nonverbal and prosodic behaviors because they are trying to hide the pain of a "false self" with an uncertain sense of self-worth. This act is designed to conceal the pain. People who suffer from low self-esteem and need constant affirmation from others are more likely to engage in bullying behavior (Einarsen et al., 2009). The victims of bullying are subjected to tactics such as "belittling," "professional humiliation," and "failure to recognize outstanding work," all of which have the potential to have a detrimental impact on the victims' mental health (Randle, 2003, p. 399).

Confusion, humiliation, fear, and an odd commitment to the bullying encounter are some of the feelings that victims of bullying experiencedue to the complicated and convoluted tone of voice and body language exhibited by bullies. People who are bullied frequently internalize the nuances of a bully's words and actions, which gives the bully more power than is warranted in the situation. If the bully is successful, the victim will feel unable to escape the situation despite their desire. This was the conclusion reached by one of the people who participated in the study.

Those who study bullying rarely consider the role of authority in the phenomenon. Executive power is a fascinating topic because of the modern workplace, characterized by rapid change, long hours, mistrust, contempt, and disengagement (Wornham, 2003).

The study of previously unknown organizational power sources is gaining popularity to comprehend better organizational behavior and influence organizational practice (Fletcher, 1992). Regrettably, public administration research has not paid enough attention to nurses, preferring to focus on middle managers in more traditional government agencies. The bullying research has

not included analyses of power relations (Farmer, 2008). Despite this, the nursing profession can contribute to research topics. First and foremost, it is essential to note that most nurses are employed by the public sector, providing an essential service to the general population. Considering the nature of nursing can shed light on essential components of public administration theory concerning equity, compassion, and work (Burnier, 2003). Third, nursing education can help one better understand democratic procedures and the challenges that may stand in the way of their expansion. In addition, there is a school of thought that contends democracy ought to be understood in a broader sense as a way of life and that there ought to be a shift in the emphasis placed on how individuals interact with one another and live in public administrative settings. This is the case because, for example, how we communicate with one another at work can directly and significantly impact how we think and behave in other aspects of our lives. Exceptions do occur.

2.6 Bullying behaviours

Bullying is characterized by various behaviors, both of which can vary in frequency and severity. In their UK study, Carter et al. (2013) identified the following as the most typical bullying behaviors that healthcare personnel encountered:

- Having beliefs and opinions disregarded
- Coworkers hidetheknowledge that could harm their performance
- Receiving assignments with unrealistic or impossible deadlines or due dates
- Being made fun of or humiliated at work
- Removing and replacing essential areas of responsibility with smaller or more difficult duties

The instability of an individual's personality or emotional state, which makes them more prone to experiencing and acting on negative emotions, is a common

explanation for bullying behavior (Moayed et al., 2006). After looking at the data, this is not always the case. Dick and Rayner concluded that the escalated conflict model of bullying proposed by Einarsen (1999) was not made worse by verbal abuse (2004). One of the lesser-known but more common forms of bullying was verbal abuse. According to the findings of research carried out by Dick and Rayner (2004), bullying typically begins with a task attack (such as withholding information, over-monitoring, or assigning unimportant tasks), progresses to a personal attack (such as belittling, criticism, humiliation, and malicious rumors), and then concludes with stigmatization. According to the findings, interpersonal conflict in the workplace is not the root cause of bullying the workplace; rather, workplace assaults may be the root cause. In addition, harassment in the workplace can be exploited for political advantage (Ferris et al., 2007; Salin, 2003a).

An example of bullying, which is a form of abusive political influence, is when one person gains control over another through intimidating behavior or physical force (Eisenhardt & Bourgeois, 1988). The inappropriate use of formal authority is an example of micropolitics (Mintzberg, 2003). The practice of bullying, which can be understood as a form of "rent-seeking" to gain an advantage over a rival, is almost universally regarded as a negative phenomenon (Salin, 2001). Both options are forcing one's will or using one's political influence (Mintzberg, 2003).

Bullying in the workplace is frequently viewed as an abuse of formal authority originating from a position of authority within the organization (Vredenburgh&Brender, 1998). This viewpoint asserts that correlations have been established between bullying, chaotic workplaces, and authoritarian or strict leadership styles (Roscigno, Lopez, & Hodson, 2009; Salin, 2003a). Actors are believed to illegally abuse their positional power for bullying purposes,following the theory that bullying power is defined by legitimate authority or resource control (Conrad, 1983). With this justification, the strategic leader bullying theory has been presented as a rational managerial action to influence employee behavior and performance in limited ways (Ferris et al., 2007).

2.7 Perpetrators and targets of Bullying

According to the research, two primary groups of nurses engage in bullying: experienced nurses working in a particular ward or healthcare setting and those in management positions above the victim (Hoel and Cooper, 2000). Coworkers can engage in bullying behavior (Sauer, 2012). According to Yildirim, same-gender bullying is rising in workplaces where one gender predominates (2009).

However, there was no connection between bullying behaviors and the number of years nurses had been practicing their profession, according to this study, which indicated that job overload contributed to bullying behaviors bullied more than any other medical staff member, and Wilkins (2014).

Bullying was most commonly perpetrated by a supervisor or manager in the same work group, followed by peers in the same work group. Bullying rules and organizational support structures are affected by this (Carter et al., 2013).

2.8 Root causes of bullying

According to Sauer (2012) and Quine (2001), bullying behaviors were influenced by organizational culture, including hierarchical management and a lack of employee empowerment.

Bullying is a learned behavior, according to Szutenbach (2013). Mentors and preceptors bully students and newly licensed nurses, socializing them with the idea that they will bully their coworkers in the future (Randle, 2003).

Bullying has also been linked to workplace culture. Interviewees indicated settings where verbal abuse was frequent, and employees were afraid to speak up for fear of being targeted themselves. Bullying cultures that are not challenged send a strong message to employees that such behavior is acceptable if not accepted(Carter et al., 2013).

According to Baltimore (2006), certain nursing professors abuse their authority, take pride in their superiority, and manipulate students and junior staff. According to Wilkins (2014), bullying often begins early in a nursing student's education. Baltimore says many individuals lack self-awareness and self-identify as assertive or passionate when their actions are called out. As a result, bullying in universities continues, and nurses accept this behavior as the standard.

2.9 Impacts of Bullying

Burnes and Pope (2007) found that bullied people experience feelings including worthlessness, insecurity, and fear. They experienced feelings of being exposed, undermined, and powerless as a result. According to Sauer (2012), who noted that bullying could cause employees to resign from their professions and employment, these reactions were corroborated. If a nurse is subjected to this kind of behavior regularly in their new place of employment, they will learn that this will happen to them within the first year of their registration. Rodwell and Demir (2012) found that the most significant effects of bullying were psychological distress and depression in the victims. In addition to, Yildirim, Quine (2001), Burnes and Pope (2007), and Burnes and Pope (2007) all supported these findings (2009).

Murray (2009) also observed the beginning of chronic medical conditions and the emergence of psychosomatic symptoms such as migraines, eating disorders, sleep abnormalities, and recurring nightmares. According to Yildirim (2009), some bullied employees have gone so far as to attempt suicide and show symptoms of post-traumatic stress disorder. Not only does bullying affect the people who are bullied, but it can also affect how an organization functions. Burnes and Pope (2007) found that over thirty percent of bullied people withdrew from specific tasks at work, decreased their dedication to work, and many cut back on the amount of time they spent there. This was done in order to avoid interaction with the bully. If the environment in which medical care is provided is hazardous, patients may be affected (Sousa, 2012). They might experience feelings of incompetence and stupidity at work, become flustered, and make

errors that put patients in danger when bullied. Even though these studies did not specifically investigate the impact of bullying among staff members on patient care, somepresented findings in this field. According to Carter et al. (2013), a number of the participants in the study who were bullied stated that their inability to concentrate and adequately think through patient operations and responsibilities negatively impacted their performance. Bullied workers were more likely than other staff to be involved in adverse events such as prescription errors and patient injuries from falls, as discovered by Hesketh et al. in 2003. These researchers also found that bullied workers were more likely to be involved in similar problems. According to the findings of research that Burnes and Pope conducted in 2007, bullied nurses demonstrated lower levels of desire and dedication to their jobs. They also took more time off work due to illness, resulting in lower workplace staffing levels.

2.10 Catastrophizing and Bullying

Catastrophizing, as a cognitive and emotional reaction to suffering, has been the research subject for over twenty years. Catastrophizing, also known as a "exaggeratedly negative attitude toward noxious stimuli," can be seen in some people with chronic pain, as described by Sullivan's definition. In chronic pain, catastrophizing is to "maximize proximity or request assistance or sympathetic responses from others." Catastrophizing can also be used to "maximize proximity or request assistance from others." People who engage in catastrophizing report less pain and suffering due to their behavior. People who tend to exaggerate pain may be wired so that they will always do so (Patterson, 2004).

Catastrophic thinking is characterized by an exaggerated perception of danger and a helpless feeling of responding to the perceived threat. When someone is in much pain, their reasoning, their feelings, and the significant social influences in their lives probably all contribute to the catastrophic thinking that occurs (Edwards et al., 2008). After considering the presence of distress symptoms,

Lackner and Gurtman found significant associations between catastrophizing and interpersonal problems in two separate studies, as stated in the research carried out by Edwards and colleagues (2008). They said people who lied about their pain "required support and caretaking" (p. 597). People more prone to catastrophic thinking are more likely to be affected by five factors that Patterson (2004) identified as contributing to chronic pain. Catastrophizing is linked to severaladverse outcomes, including decreased use of the affected body part, emotional distress, physical pain, the belief that treatment must be physical, psychological reinforcement for not improving, and the belief that treatment must be physical. Catastrophizing is a significant factor in pain outcomes' short-term and long-term prediction (Edwards et al., 2008). Even though relationships can offer emotional support, they are not particularly helpful in relieving physical discomfort. To put it in the simplest terms possible, language is everything (Angela Carter, n.d.). To restate our primary point differently, those prone to catastrophizing tend to fixate on the worst-case scenario, exaggerate the significance of the event, and believe they have no control over it. When bullying occurs at a place of employment, there are three parties involved: the victim, the bully, and the dispatcher (i.e., the victim).

The victim role and the so-called "victim mentality" will be rendered obsolete if no one to whom the bully can direct their aggression. The authors consider bullying a form of catastrophizing because of its common characteristics, which include the tendency to overthink, exaggerate, and feel powerless. Compliments are the starting point of every interaction. When one party helps another in relatively well-defined ways, there is a "transaction" between the parties (Bernes, 2007). "Transactions" are "the units of social interaction," as defined by Bernes (2007, page 29), and they consist of both verbal and nonverbal communication with one another. The use of emoticons like and, parenthetical phrases like (sigh), and capitalization, which give the impression that I am shouting, are all examples of nonverbal cues incorporated into the email. Nonverbal cues such as facial expressions, eye contact, smiles, frowns, and body language all play a significant

role in facilitating communication. Prosody, which is also referred to as intonation, is a method of communication that is very effective. Interpreting the meaning of the words that were spoken. According to Leisy (2016), comprehension of a speaker's meaning and the identification of their social relationship with the speaker's audience can be aided by paying attention to the speaker's use of prosody. The majority of the information conveyed to an audience is done so without using words.

2.11 Actions and Interventions to combat bullying in the healthcare workplace

Recognizing bullying is the initial step in combating it (Murray, 2009). This behavior may go unnoticed by the recipient because it is tolerated at their employment. Peers and superiors may criticize the individual's heightened sensitivity, personality conflicts, or management style. The nurse must know potential warning signs and symptoms, such as eating problems, anxiety, and sleep abnormalities. To prove what happened, it's essential to keep track of when and how the bullying occurs and any witnesses who may have witnessed it. Every NHS organization must have a workplace bullying and harassment policy that employees may use to report harmful behavior (NHS Confederation, 2006). According to Burnes and Pope (2007), one of the significant challenges in combating bullying is that the people who should be in charge of stopping or preventing these behaviors are frequently the ones who engage in them. In Quine's study from 2001, over 70% of the bullied participants attempted to end the bullying, yet only 22% were happy with the outcome. Coworkers' failure to step in when they see a colleague being bullied contributes to the bullying continuing.

According to Wilkins (2014), bullies frequently hinder or restrict workplace communication, and some coworkers choose not to report bullying out of concern that they will be labeled as troublemakers and that their concerns won't be taken seriously. Wilkins emphasized the idea of hope as a strength in preventing

bullying (2014). According to this study, nurses who experienced high levels of hope acted and had confidence that a bullying scenario would be handled. Hope is a concept that enables people to see problems as challenging rather than threatening, which enables them to survive hard circumstances (Frankl, 1984).

Humor was another quality noted, and humor frequently went hand in hand with optimism. With this mindset, nurses viewed bullying from a stance that encouraged looking for potential solutions. Pessimistic employees exhibited fewer coping mechanisms and found it challenging to come up with solutions for their problems. Nurse supervisors must set an example for their team by acting professionally and being encouraging and constructive, according to Becher and Visovsky (2012). The staff is responsible for treating one another with dignity, strengthening communication, and resolving problems as soon as they arise.

According to Murray (2009), being silent or taking no action in the face of bullying can encourage it to happen again. Bullies frequently exhibit this behavior in the past, so instead of dealing with it, management may move the bully to other company sections where the same behaviors persist.

2.12 Underreporting bullying

It is said that these paramilitary influences contributed to the formation of a culture in the workplace in which insult and humiliation are accepted as necessary components of on-the-job training (Turney, 2003). It is commonly held that nursing is a subordinate profession because it is dominated by female employees, particularly when contrasted with the medical field, which is dominated by male employees (Timmins, 2005). Over the past few decades, an increasingly managerial and bureaucratic structure centered on effectiveness, predictability, and calculability has been layered on top of these traditional nursing approaches (Hutchinson et al., 2006c). In healthcare, organizations that put a greater emphasis on transactions rather than relationships tend to place a greater emphasis on output and compensation (Parry & Proctor-Thomson, 2003).

It's possible that empathy isn't as important as efficiency, obedience, and looking out for number one. Most descriptions of the issue focus on a power imbalance; however, there is no agreement on what constitutes bullying in the workplace. Escalating cycles of hostility between individuals can potentiallyaffect this power structure (Einarsen, 1999). Some believe that conflict is the outward manifestation of one party's attempt to dominate another party (Zapf & Gross, 2001). In agent-based theories of bullying, which traditionally emphasize conflict, power is regarded as a means by which actors exert control over other people (Harvey et al., 2009).

This viewpoint holds that it is acceptable to manipulate and control employees through bullying to achieve organizational objectives. Few authors have explored how these identities and subjectivities are constructed, despite the prevalence of conflict- or micropolitically-based descriptions of bullying's power dynamics in the workplace (Hutchinson et al., 2006). From a Foucauldian standpoint, Lutgen-Sandvik (2006) argued that the power dynamics involved in workplace bullying could be understood as governmentality, which shapes identities and subjectivities. The authors centered their alternative theory of workplace bullying on abusive organizational policies and structures. According to these authors, traditional theories of bullying fail to account for the influence that is kept secret. Furthermore, power dynamics in bullying have been interpreted differently, emphasizing institutional factors rather than conflict or authority abuse (Salin, 2003). According to this theory, unsafe environments can contribute to bullying and social or procedural injustice (Zapf &Einarsen, 2005).

Actual or threatened physical violence on the job has been linked to a rise in political opportunism and even dictatorship (Salin, 2003; Mitchell& Ambrose, 2007). Harassment is an emotional response to the stresses of globalization, increased expectations for productivity (Vickers, 2006), poorly designed jobs, and chaotic workplaces(Salin, 2003). People who want to move the focus away from workplace bullying and toward understanding the importance of organizational climate have stated that a culture that tolerates bullying may encourage it (Baillien et al., 2009).

Workplace relationships and networks are seen to provide chances for the abuse of personal authority in bullying-friendly workplaces (Clegg, 1989; Hutchinson et al., 2006;). (Einarsen, 1999). (Roscigno, Lopez, and Hodson,2009) investigation into the social and organizational causes of bullying also highlights the part that organizational disorder plays in promoting social vulnerability and rivalry that creates more opportunities for bullying. Similarly, it has been suggested that competitive settings can lead to instances of social or procedural injustice that may be perceived as bullying (Hutchinson et al., 2006). Bullying is frequently seen as a sensible and legitimate strategy for "going ahead" in workplaces with a competitive culture (Hutchinson et al., 2009).

Several academics have compiled integrated theories and viewpoints on the nature of organizational-powered necessary research in this field by tracing the origins of distinct traditions and the development of modern notions of power.

Bullying of nurses, doctors, staff, and patients hurts patients, nurses, the profession, and the organization (Hartin et al., 2018). Bullying puts nurses, doctors, staff, and patients at significant risk of experiencing psychological, physical, emotional, and social consequences. Anxiety, despair, exhaustion, burnout, and insomnia are health issues linked to bullying among nurses (Hartin et al., 2018).

According to an NHS survey on bullying in the healthcare sector, 2.7% and 14.3% reported that someone in authority had bullied them. Hence, the highest rates of bullying were against you (14.3%), and the lowest rates were related to teasing behaviors against people they did not have a good relationship. In the same study, participants were asked about barriers to reporting bullying. The answers were: 13.9% of those who had experienced bullying believed that no action would be taken, 11.7% did not want to be seen as troublemakers, 11.7% thought that age was a barrier to reporting, and 10.5% were worried that things could get worse. According to the survey, although the staff was aware that they were being bullied, factors such as seniority, a culture of driving in the workplace, and a lack of effective countermeasures were barriers to staff not reporting these

unacceptable acts. Another survey conducted at Sry Lank in 2022 concluded that bullying is not being reported and is becoming increasingly common in healthcare.

Other reported adverse effects include lowering the standard of care, impairing nurses' ethics, making them less willing to go to work, having less professional confidence in their ability to do their jobs, having low self-esteem, making them feel helpless, lacking motivation, having poor job satisfaction, and having isolation from workplace activities.

Additionally, healthcare organizations must deal with the negative effects of bullying nurses, including unpleasant work environments, greater turnover rates, absenteeism, decreased productivity, and recruitment issues (Hartin et al., 2018).

2.13 Policy of Bullying by HSE (The Health Service Execitive) And WRC (The worlplace Relation Comission)

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The HSE (The Health Service Executive) states that the purpose of the anti-bullying policy is to safeguard employees in the healthcare industry from harassment by both employee or non employee (patients, service users, suppliers, contractors, and visitors and covers anyone the staff come into contact with in the workplace). They define bullying and other forms of inappropriate behavior. Professionals should be aware of what constitutes bullying behavior.

Employees and employers have a crucial role to play in combating bullying. Basically, the employer is responsible for conducting work activities to prevent any inappropriate behavior or conduct that could endanger the employee's health and safety. Additionally, they must provide training, instruction, and supervision. In order to fulfill the employer's responsibilities, it is necessary for the employer to be aware of the hazards in the workplace, assess the risks associated with these hazards, and have a written evaluation of any risks that may affect the employee's health and well-being, both individually and as a group.

In accordance with the HSE's dignity policy, a person who is being bullied should communicate with a support person within the organization, such as a member of HR or the occupational health service, who will offer them support and direction on how to acquire psychological support. This process should be confidential. The approach to bullying has two stages, described as informal and formal. In the informal stage, a In the informal stage, a support person will speak with the perpetrator about his behavior and advise the victim not to tolerate it. After the assessment, if it is determined that the employee is a victim of bullying, a manager from a different department who has no connection to either party will meet with both parties to discuss the situation. There can be multiple meetings for these workers. The complaint will move on to the formal step if the issue is not handled by this point, where it will be reevaluated to determine whether the victim is genuinely being bullied or acting inappropriately in some other way. At this point, the offender—who may or may not be an employee—may be subject to disciplinary action. The HSE anti-bullying policy tries to combat bullying informally by offering the employee any help they require and, if the situation progresses to an informal stage, by providing a mediation service.

Mediation is an informal, voluntary, and confidential process that can be introduced at any stage of conflict resolution, so it is recommended that it is introduced as early as possible. The third party is the mediator, who should be impartial and will work together with the parties to try to reach a solution that is acceptable to both parties involved in the conflict and try to re-establish a good relationship between them. Mediation is the best way to avoid formal proceedings.

The Workplace Relation Commission (WRC) guides combating bullying in the workplace, and under its guidelines, communication is the initial step in attempting to resolve disputes. WRC encourages disputes to be resolved in the workplace as early as possible when conflicts arise and provide a mediation service as an alternative means of resolving disputes. This process helps not only individual but also group conflict, as often in the workplace, differences between groups can trigger conflict.

HAS (Health and Safety Authority) has developed anti-bullying guidelines under the statutory power of the Bullying Act 2005. It protects all employees operating in Ireland. The principle of the Act is to ensure that employees have a workplace free from risks to their health and safety. The Hsa aims to support employees experiencing bullying and has an open communication system with the public, who can request its help by telephone or written request. Like other existing policies, after a bullying report, an investigation is carried out to identify whether bullying or other misbehavior occurs. After an assessment, the HSA can advise the individual on action to be taken, but the HSA is a neutral body. It can also assist the employer in advising both on how best to resolve disputes in the workplace.

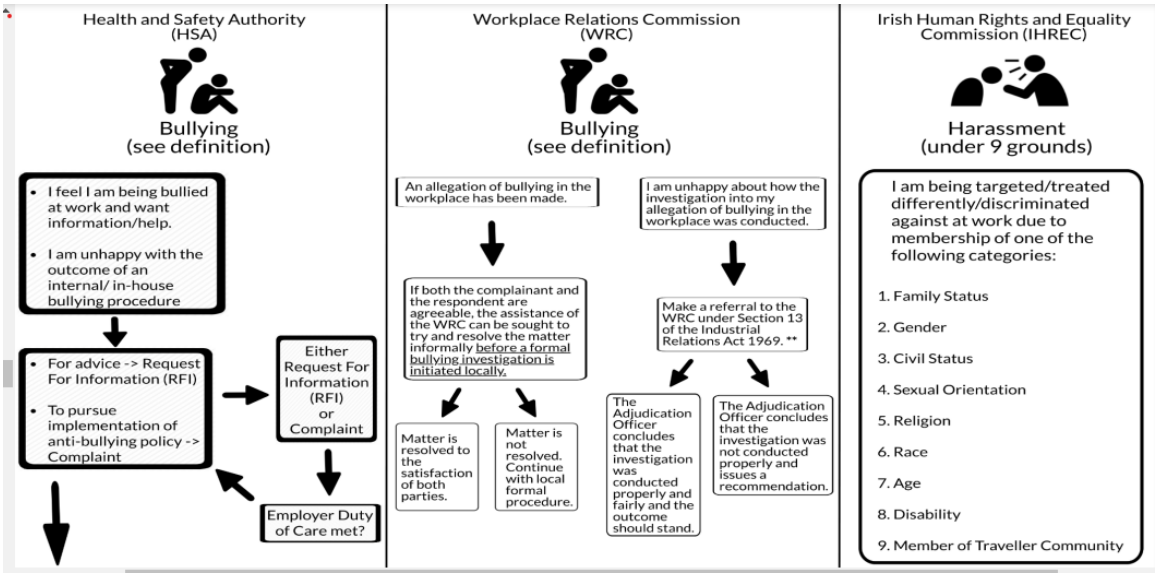


Figure : Role of HSA & WRC in the Prevention of Workplace Bullying

3. Research methodology and methods

3.1 Introduction

In some publications, the words "methodology" and "methods," which are related to research, may be used incorrectly. Understanding the distinctions between the two ideas is crucial. The term "methodology" relates to the technique or philosophies that the research will take, which is more closely related to understanding the purposes for which the study has been carried out. On the other hand, the term "method" refers to the strategies and practices that will direct the gathering of data and its analysis, such as surveys, observation, or interviews, all of which support and add to the knowledge already known about a subject (Saunders, M. et al., 2009).

This chapter's goal is to go into great detail regarding the strategies and procedures used to conduct this study on the Barrier to underreporting of bullying in the healthcare sector . It will be easy to recognize and understand all the elements involved in data collection, analysis, and interpretation of the research issue in this chapter. The methodology chapter will cover subjects including philosophies, approaches, tactics, choices, sample size and type, data gathering techniques, and data analysis te chniques.

3.2 Research design

According to Saunders et al. (2009), a research's "methodology" can also be related to an onion because it must go through various steps in order to be produced and understood about a specific subject. Research philosophy, research strategy, research methods, time horizon, data collecting, and data analysis are the six parts of the authors' model of research technique.

According to Fetters, Curry, and Creswell (2013), research with an analytical goal is carried out with the goal of exposing the breadth and complexity of the numerous cause-and-effect connections that are already in place. The prime aim of causal examinations is the study of a scenario or a particular issue, with the overriding goal being an attempt to explain the patterns of correlations that exist between the several variables under consideration (Fetters, Curry and Creswell,

2013). In research initiatives that employ a causal study design, experiments are by far the most prevalent and significant form of data collecting.

The research onion in the current study may be illustrated in the following way:

- Research approach: inductive
- Research philosophy: interpretivism;
- Research strategies and choices: survey/questionnaire under a mixed methods;
- Time horizon: cross-sectional;
- Data collection: self-selection;
- Data analysis: online survey

3.3 Research Approach

This research was conducted to investigate bullying in the health sector in Ireland and Brazil. The authors (Saunders, M. et al., 2009) claim that there are two main approaches that can be employed in research: the deductive method and the inductive approach. While the deductive approach is linked to the creation of a theoretical or conceptual structure that will later be supported by data. On the other hand, an inductive technique is used when the goal of the research is to explore the data, generate hypotheses from it, and then compare those theories to the literature. Any preconceived theories or conceptual framework may be utilized in this second type of approach.

Cramer-Petersen, Christensen, and Ahmed-Kristensen (2019) propose the abductive method as a means of addressing the issues that arise from the deductive and inductive approaches. The deductive method is criticized for an unclear methodology for establishing a hypothesis when testing a theory (Evans, 2013). Inductive reasoning, however, is more challenging because no predetermined amount of empirical data can immediately make a hypothesis possible (Feeney, Hayes, Heit, 2014). In this regard, the use of abductive reasoning, which takes a pragmatic stance, allows one to sidestep these disadvantages, therefore making it the third feasible alternative that can be considered because it doesn't have any of these drawbacks.

The researcher has chosen to incorporate inductive research in this case after carefully considering the three methodologies described above because there are no hypotheses or specific theories used in this study. The only goal of this study is to comprehend the significant prevalence of bullying in the medical community. The audience's data will be the single source of information used by the researcher, who will then analyze it to find the answers to her research problem.

3.4 Research Philosophy

In addition to the nature of the research study, the assumptions underlying it, and one's level of expertise, several factors should be considered. Contribution to the philosophy of research. There are three main types of positivism: pragmatism, interpretivism, and positivism. Essentially, positivism is based on the premise that the only reliable form of knowledge is the kind of information that is obtained from observation (the senses), including measurements. As Goldkuhl (2012) points out, positivism adheres to the premise that it is the only kind of knowledge that can be trusted. A researcher who does research following the positivistic philosophy of positivism is restricted in his or her role to only collecting and interpreting data by his or her judgments and observations.

It is essential to understand that research philosophy refers to an association of beliefs and assumptions that are related to how knowledge is developed. This is a very accurate definition. Essentially, the research philosophy refers to the efforts made by the author(s) of the study to develop knowledge in a specific field, addressing a specific problem in a particular theme (Saunders, M. et al).

It is noted that the authors (Saunders, M. et al., 2009) distinguish assumptions based on their ontological, epistemological or axiological characteristics when they are associated with assumptions related to reality. A researcher's philosophical choice influences the author's understanding of the research

questions and interpretation of the findings, and human knowledge or values influence the research process.

In this study, a philosophical approach associated with interpretivism was selected because it involves the study of culture without any cross-cultural focus, without any value influence, using qualitative data collected through a questionnaire and open-ended questions, and since professional feelings, perceptions, or opinions will be the basis for the research.

3.5 Strategy and choice

The process of evaluating a project requires the collection of information from all of the relevant sources. Solutions to this problem were found in the study (Meshram and Pandey, 2018). Data may be used in various ways (Meshram and Pandey, 2018). As a result of the collection, two distinct categories can be distinguished. Data collection methods include both secondary and primary methods.

Meshram and Pandey (2018) define secondary data as data that has already been published in books, journal articles, or periodicals that have already been presented to the general public. It is possible to reduce time, effort, and financial expenditures by collecting secondary data.

The research strategy is linked to the manner the data will be gathered to better represent the aim of the study, such as theory, participant count, and literature evaluation. The method used in the current study will involve sending an online questionnaire to medical professionals who currently work in or have previously worked in nursing homes in Dublin. Responses will be voluntary and anonymous. This approach was adopted in an effort to assess the respondent's viewpoint and relate the responses to the material that was accessible.

The questionary will allow the researcher to collect a qualitative data, using open and close question related to the subject that will enable the researcher to collect sufficient data to associate with the literature reviewed and draw a conclusion.
Regarding the choices, the author is able to choose between mono method or mixed-method analysis. The first method uses qualitative or quantitative approach, while the second method mentioned uses both quantitative and qualitative method.

Intending to achieve the objectives of the present dissertation, the quantitative and qualitative research were used to conduct the study. The characteristic of qualitative research is to collect information that are not measurable or quantifiable, related to thoughts patterns, attitudes and behaviour, while the quantitative method aims to classify features and quantify what was observed, generating a numerical or statistical data (Langkos, 2014).

3.6Time Horizons

In terms of the duration of the study, there are two different types of time horizons that can be utilized: cross-sectional time horizons and longitudinal time horizons. An analysis that is cross-sectional means that observation and data collection were carried out during one specific moment in time, as is usually the case with surveys. A longitudinal study, on the other hand, describes the observation and collection of data over a period of time, usually weeks, months, or even years, in order to look for patterns or to investigate specific phenomena.

A cross-sectional study was chosen for the present study, as the results would be analyzed at a specific time for the dissertation to be completed

3.7 Research Limitations

Research limits are obstacles and constraints that must be overcome while conducting research (Martí, Serrano-Estrada, and Nolasco-Cirugeda, 2019). It is common for researchers to encounter such roadblocks, which impede their

progress and prevent them from confirming their findings. In the following paragraphs, we discuss some of the potential roadblocks a researcher might encounter during their research.

In this study, some limitations were found during data collection, including a small sample size, a lack of reliable data, and a lack of helpful bibliography materials. Since most professionals didn't respond to the questionnaire for whatever reason, the sample size was a limitation. Because some professionals may be intimidated or afraid to participate due to exposure to a work-related issue, the sample size could be smaller. Therefore, it's pertinent to emphasize that the whole process was anonymous and voluntary.

Since there are many materials on bullying in the healthcare workplace, including definitions, causes, consequences, and policies, the absence of a helpful bibliography can be considered a limitation during the research process, as there are not many studies that address barriers professionals face when reporting bullying.

3.8 Ethical Considerations

According to the author, ethics is a philosophy that investigates how individuals act, how they assess their actions, and how they create rules to justify those behaviors. Establishing rules for research, analyzing and evaluating the findings, and putting punitive measures in place are the three core tenets of ethical research (Adams, G. and Berzonsky, M. , 2004). "Research ethics, therefore, relates to questions about how the researcher formulates and clarifies the research topic, designs the research and obtains access, collects data, processes and stores data, analyzes data, and writes up the research findings morally and responsibly," claim Saunders et al. in their 2009 study.

The research was conducted according to ethical standards without prejudice. It was designed to collect the necessary information from the available literature and from participants who answered the questionnaire with complete reliability.

The researcher presented a detailed literature review along with secondary information associated with the topic. During the data collection process, all information gathered was thoroughly examined to identify factors that that prevent health professionals from reporting bullying incidents. No personal information was requested from respondents. A confidential pattern will be followed to obtain responses to this study and will not be published in any other social media other than in this document.

It is the goal of this research to contribute to society in a way that provides a better understanding of the subject, with a particular focus on the definition, causes, consequences, prevention, and barriers that are encountered by these professionals in the fight against bullying in their work environment.

3.9 Data Collection and tecniques

The internet makes everyone's life easier since society depends on it. This technique allows for a more accurate monitoring of the target population than conventional methods. When conducting online surveys on multiple platforms, graphs, tables, and other data visualization techniques can be created. These techniques make it easy and quick for the author and the reader to analyze the data.

In order to participate in the research, participants were only required to fill out a questionnaire, which was distributed on social networks between October 2nd and November 20th via a link to the social network and an email sent to the target audience for the study. Researchers targeted nurses and healthcare professional who work or have worked in nursing homes, hospitals, and home care in Ireland and Brazil.

Nineteen closed-ended, multiple-choice questions were included in the questionnaire. The questions were designed to cover a range of themes relevant to the various impacts, difficulties results in reporte bullying in the healthcare

workplace. For the most accurate data analysis, every question was marked as required.

After checking the "Agree" box on the consent form, which was the first section of the questionnaire and contained all the necessary information, purposes, research intent, confidentiality, ethical considerations, and data disclosure, the participant could proceed to the subsequent sections of the questionnaire. The purpose of this study was to gather healthcare professionals who are employed in the field of health care and have been in some way a victim of bullying as a result. In spite of decades of discussion, bullying is still an important public health issue, therefore the purpose of this study is to examine how it is dealt with in healthcare settings. After all, there is a reason why professionals do not disclose this inappropriate behavior in the workplace.

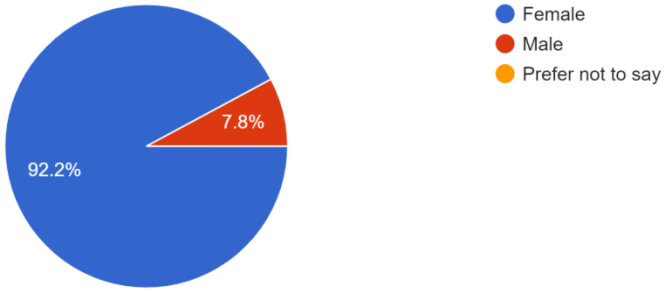
4. Finding and analysis

4.1 Demographics

Question one is about Gender of the respondents .Question two is about the nationality of the respondents. In this regard, we collected plenty of data From the response to the survey, Brazilian female respondents were more and in Ireland there are a mix of nacionality the female were the largest respondents.

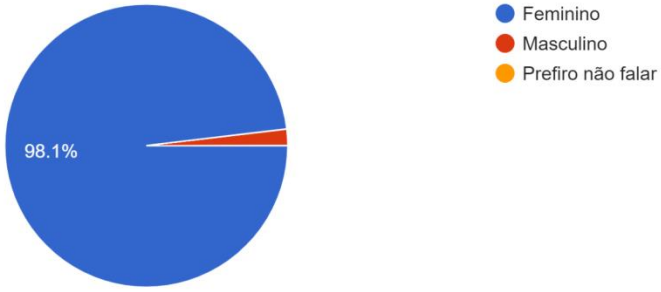
1-Gender

51 responses



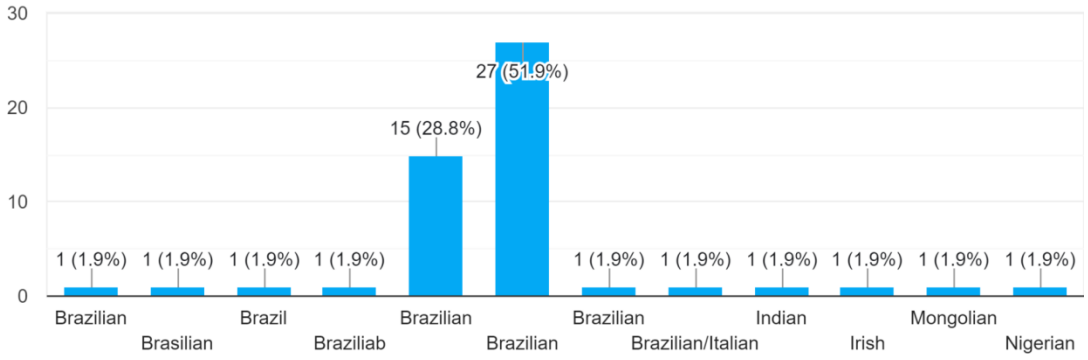
1-Genero

53 responses



2- What's your nationality?

52 responses



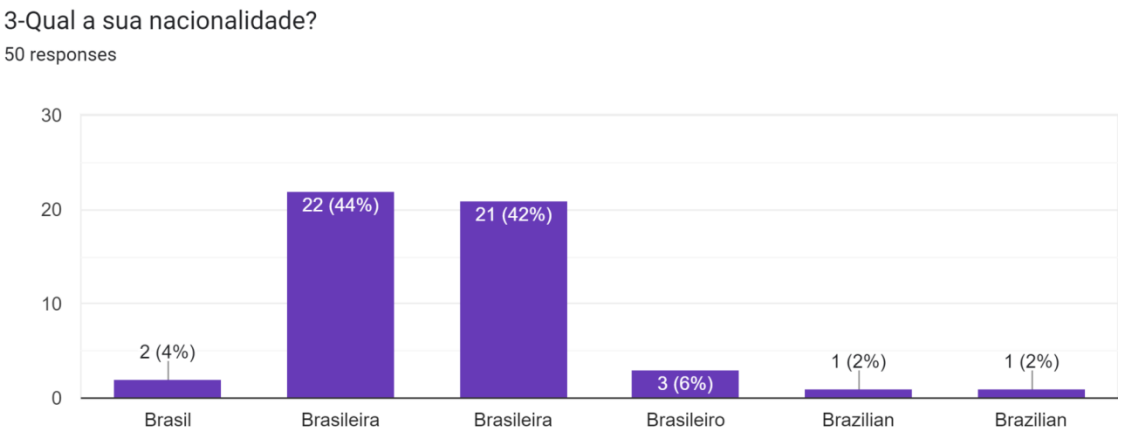
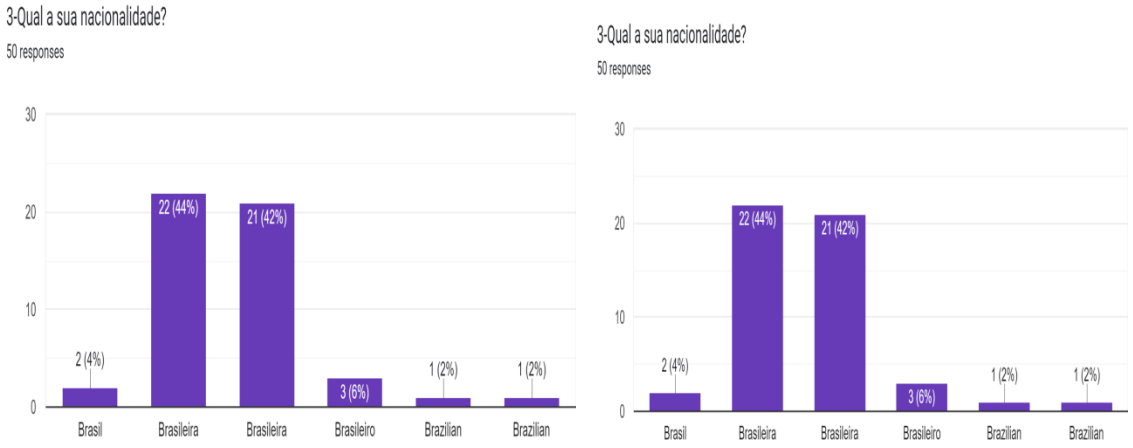


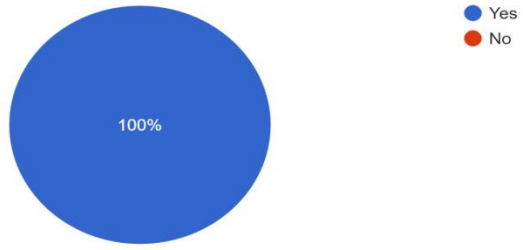
Figure 03:Question one and two graphic

The third question is about the healthcare profession, and the fourth is about what type of the work respondents are doing, While question number five is all how long the professionals have worked or are now working in the healthcare sector. Options included less than a year, one to three years, and more than three years.



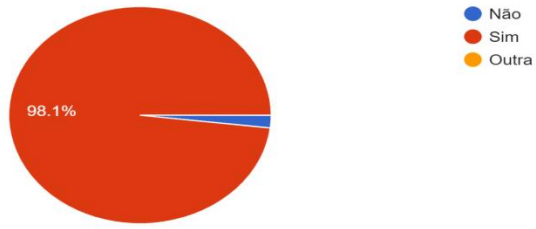
3-Are you a healthcare professional?

50 responses



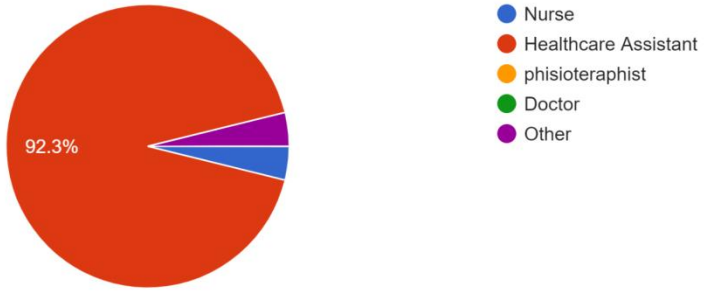
2-Você é profissional da area de saúde?

53 responses



4- What area do you work in?

52 responses



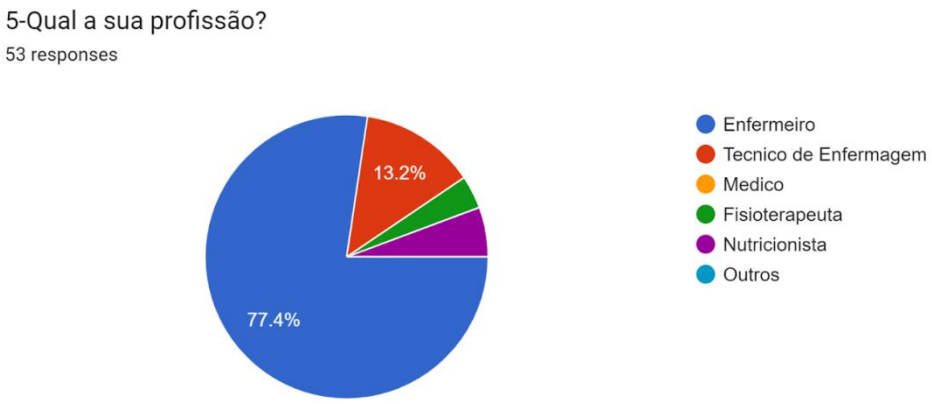


Figure 04: Questions three, four, and five graphics

Questions six is about where the respondents works . As my research is conducted in two contries such as Brazil and Ireland . So, Respondents were Brazillians and from Ireland but different nacionalities.

Question seven is about the place where respondents were workingIn Ireland the majority of respondents (63.5%) work in nursinh home and (34.6%) work in home care. In Brazil, most respondents work in hospitals (66%) and (17%) in other health related sectors .Question eight is the research from the respondents that from where they listened about bullying or does it ever happened wityh them . This question will help us to find in which places bullying was common. In both countries over 70% of the professionals had heard of bullying.

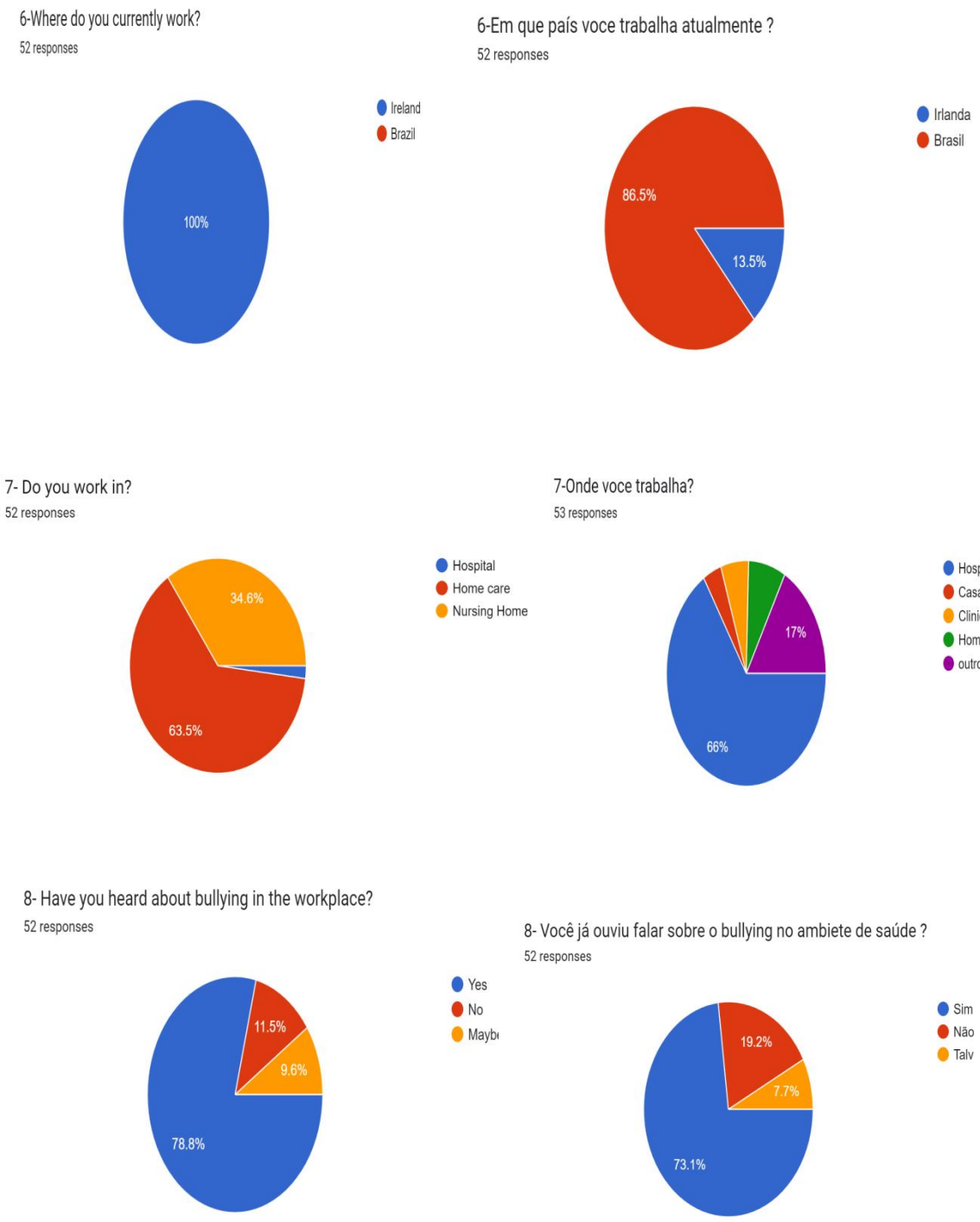
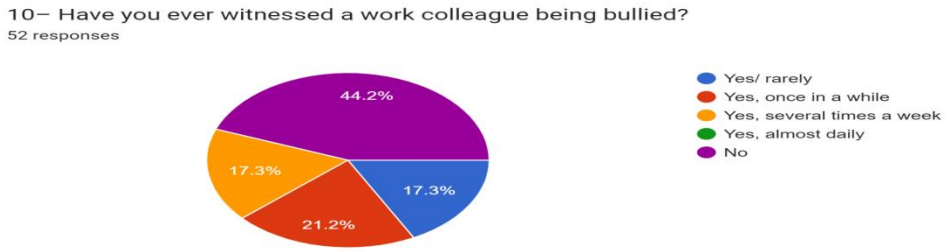
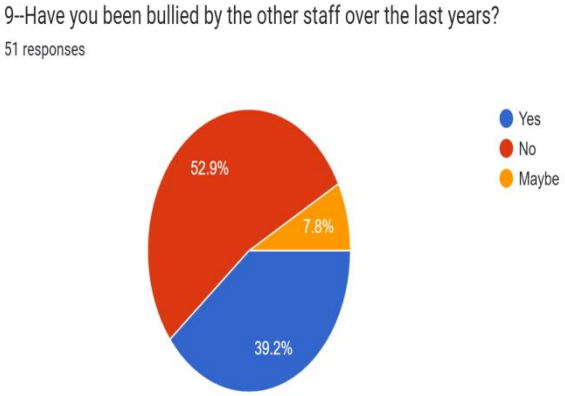


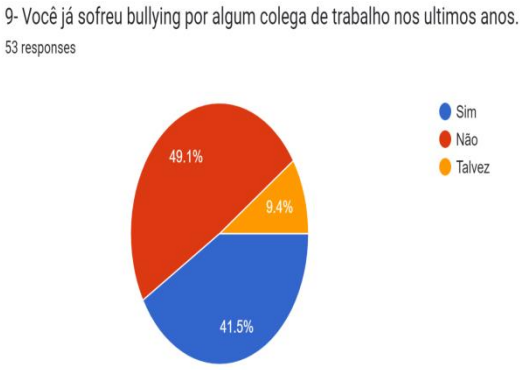
Figure 05: Graphic of questions six, seven, and eight

4.2 Prevalence of bullying

Question nine is about the recent bullies faced by the respondents or by their staff. In Ireland approximately 39.2% of professionals have already been victims of bullying and in Brazil 41.5% have already suffered bullying, the difference between the two countries is only 2.3%. This shows that the reality of bullying is still very present in the health care environment. Question ten is about the witnesses of the bullying . According to the graph we can see that 55.8% of respondents have experienced some form of bullying in Ireland and in Brazil 56.6% of professionals have had the same experience.This question will help us to find the ways with which bullying is more common and the purpose behind being getting bullied .







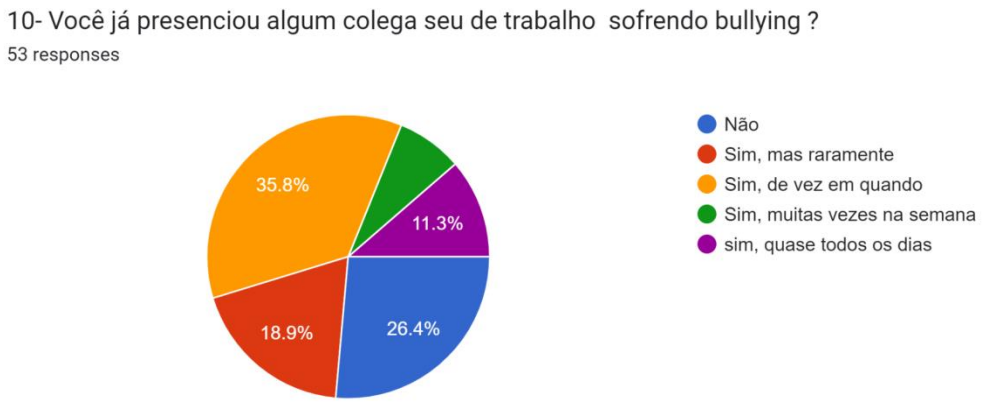


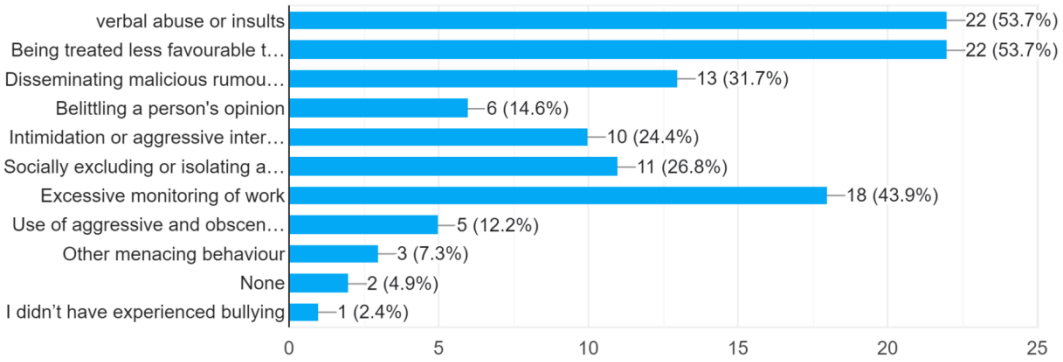
Figure 06: Graphic of questions nine and ten.

4.3 Prevalence of negative behaviours and bullying policies

Question eleven is about experience of getting bullyied with respondents . This question was investigated to get to know what type of bullying i.e; verbal non verbal , simply, modes of bullying were estimated. In Irlanda, verbal abuse or insults and being treated less favorably were the most frequent types of bullying with approximately 53% of each behavior, in this question, the respondent could choose more than one question. And in relation to Brazil the highest indices were other threatening behaviours with 27.7%, followed by spreading malicious rumours with 17% and intimidation and aggressive interactions with 14.9%. Question twelve is an investigation from the respondents that if they are aware from the policies or codes which they can use if they get bullied. In Ireland, 51.9% of professionals don't know that there are codes and regulations against bullying. 28.3% of Brazilian respondents said they were unaware of these protocols.

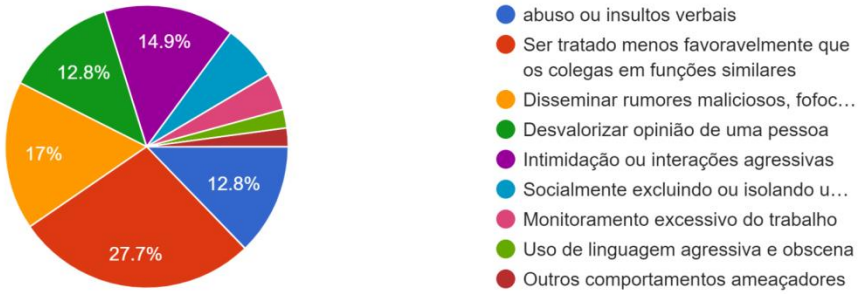
11- What kind of bullying have you experienced? Workplace bullying is repeated inappropriate behaviour, direct or indirect, whether verbal, physic...e individual's right to dignity at work(WCR, 2021)

41 responses



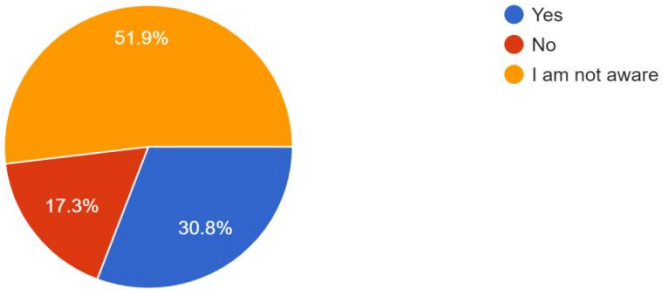
11- Qual tipo de bullying você já presenciou?

47 responses



12- Does the company you work for have a bullying policy or code?

52 responses



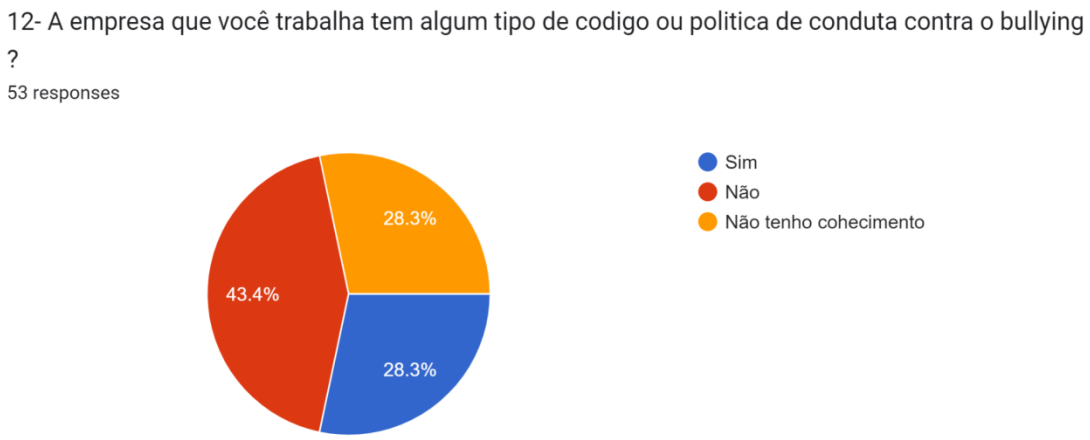


Figure 7: Graphic and question eleven and twelve.

4.4 Reporting of bullying

Question thirteen is related to those who were witness or being bullied if they report it to the responsibe. This question is more about sharing the personal experiences . This question developed indirectly an enthusiasm in respondents that if they ever get bullied he can report to eradicate this negative thing. In fourteenth question, an investigation from the respondents resulted to find out the post of the persons who are responsible for bullying. We can see that in Ireland, the number of people who reported cases of bullying was higher than in Brazil. I believe that because the economic situation in both countries is very different, employers submit themselves to this type of abuse because losing a job is not an option. Different from Ireland, where there is a shortage of workers in some sectors, in Brazil, many qualified professionals don't have jobs.

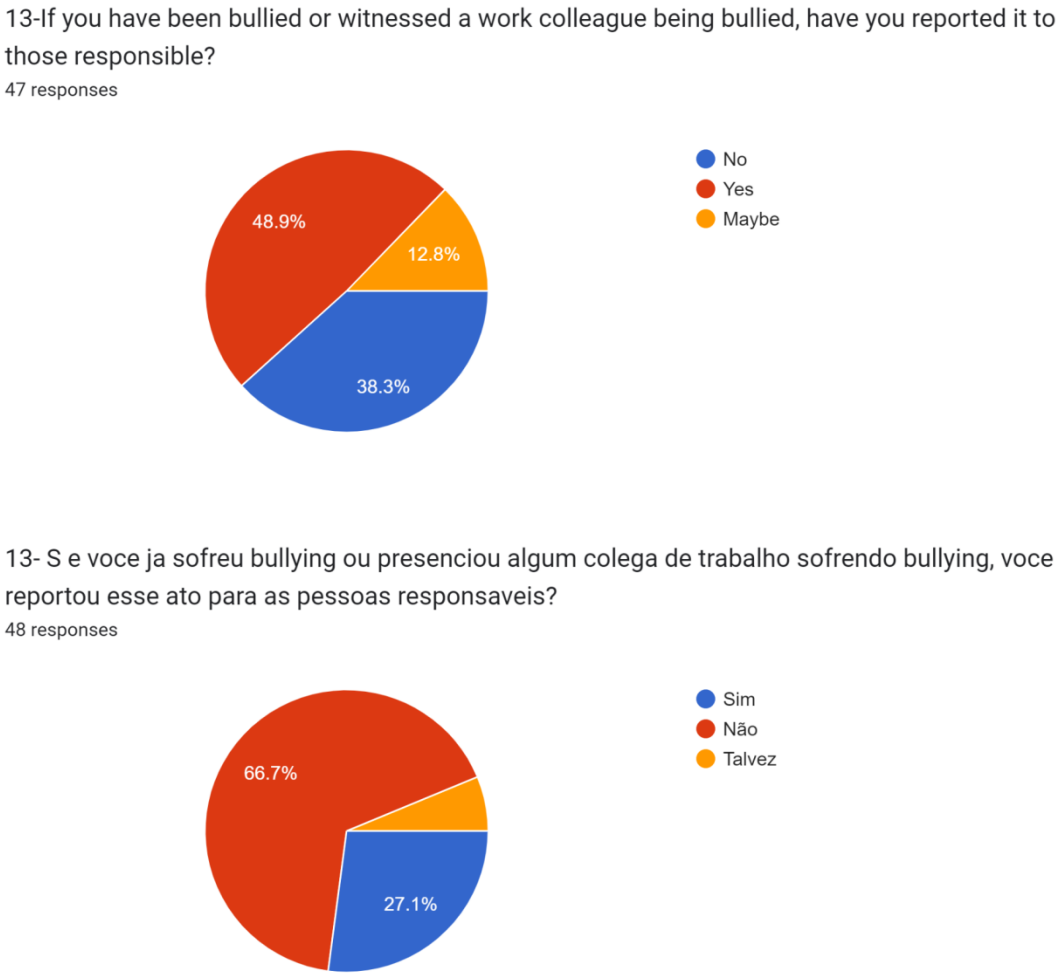
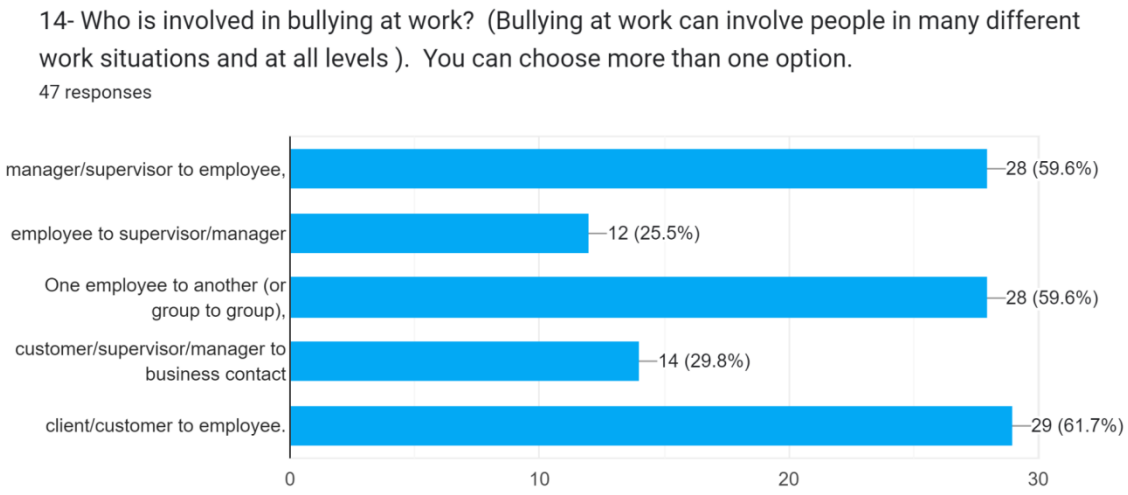


Figure 8: Graphic and question thirteen

The fourteenth question aims to identify the main perpetrators of bullying in the healthcare environment. These professionals face many barriers to reporting these types of bullying. Mainly because often those responsible for resolving bullying problems are the aggressors themselves. As observed in many surveys, managers, supervisors, and coordinators are the main perpetrators of bullying. According to the graph below, the staff-to-staff ratios were highest in Ireland and Brazil, followed by managers and supervisors.



f

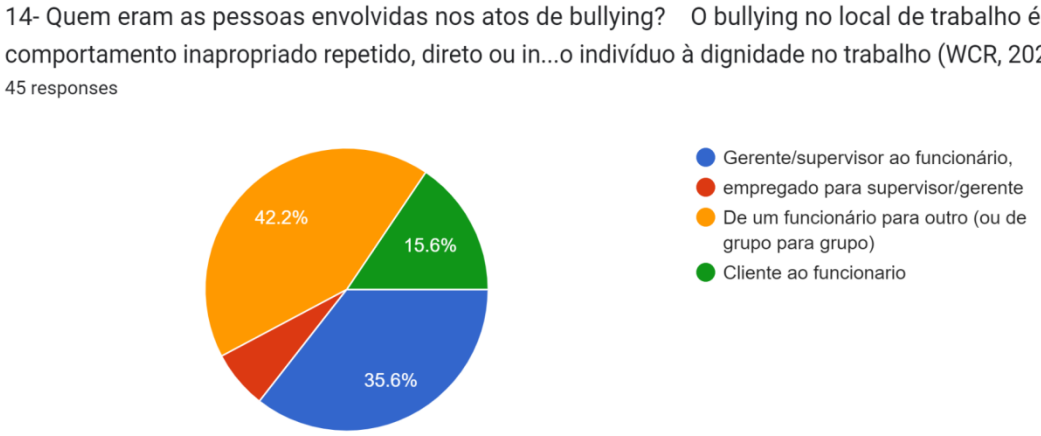
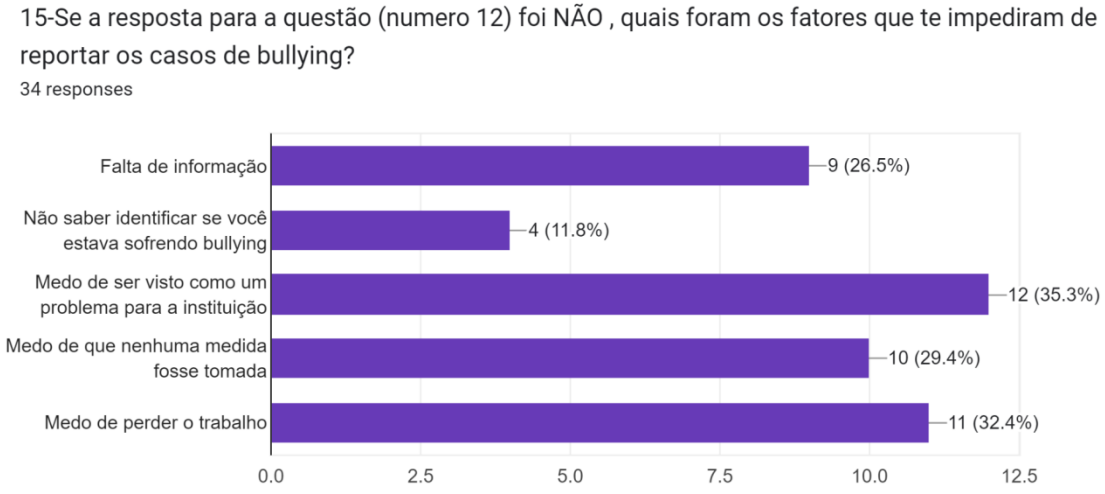


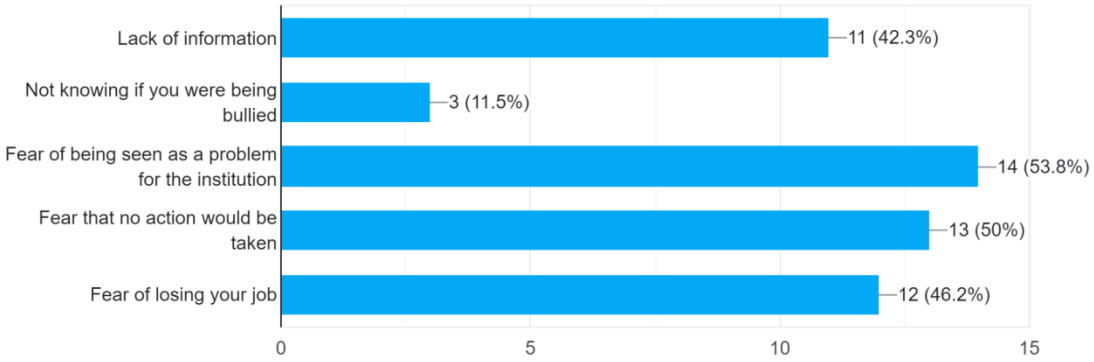
Figure 9: Graphic and question fourteen

Fifteenth question is linked to thirteenth and fourteenth that if they did not reported about bullying in the organization , then what was the reason behind not reporting against bullying. They had the option of selecting more than one response to this question, and in both nations, the major obstacles these professionals faced were fear of being perceived as a problem by the institution, followed by worry of losing their jobs and that no action would be taken. Question sixteenth is carried out as a result of ‘yes’ in the thirteen and fourteen question.This question was done in the result of the inspection of the organizational responding status against bullying. Unfortunately, both countries experience high levels of bullying, and neither leadership nor educational system has taken any steps to stop it.



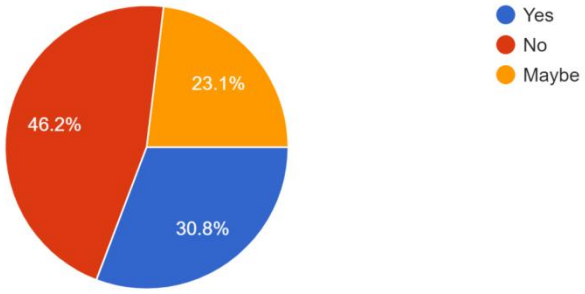
15-If the previous answer was NO (question 12), what led you not to report it? You can choose more than one option.

26 responses



16- If the answer YES to question 12, did your company help you to solve the problem?

26 responses



16- Se a resposta para a (questão numero)12 foi SIM, a empresa tomou alguma medida ?

22 responses

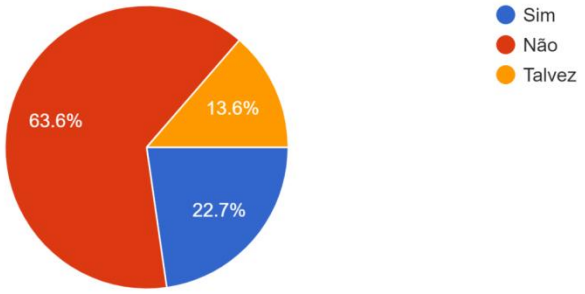


Figure 010: Graphics of questions fifteen and sixteen.

The primary goal of the current study is to analyze the difficulties and disagreements that may result from a staffing shortage; as a result, the Likert scale was used on questions nine through thirteen to range responses from one extreme to another, making it possible to gather and analyze data more accurately.No complaints or comments concerning access issues or incorrect question interpretations were made during the data collection procedure. All 52 participants in our sample are healthcare professionals from various nursing homes and Home Care in Dublin, Ireland, and 53 healthcare professionals from Brazil, all working in Home care and hospitals, all meet the criteria for the target population.

The Surveys from protégées had the same questions as discussed above.
Quantitative research, such as percentages and frequencies, and qualitative descriptions, typically intended to help illuminate the relevance of the investigation's core topic, can immediately facilitate and give data analysis and interpretation. It is vital to comprehend each question's goal, the reasoning behind its creation, and how it was constructed about the available research and data.
Data analysis is the process of gathering and comparing literature with the knowledge that has been collected. As well as summarizing, stating, and interpreting what the study population has said, it also considers what the research can understand.

Question seventeen was about the consequences of bullying, which covered less productivity, less confidence, fear, want to stay away from the work environment, physical or mental problems, and lack of confidence. HSA has developed anti-bullying guidelines under the statutory power of the Bullying Act 2005. It protects all employees operating in Ireland. The principle of the Act is to ensure that Respondents can choose more than one option. According to the graph below, the highest rate was feeling less confident at work, with 51.1% (25), followed by wanting to stay away from work with 55.8% (24) and having one's life affected there was the lowest with 30.2% (17). This picture is slightly different in Brazil, as the highest rates were for psychological

symptoms, such as feeling scared and stressed, at 51.1% (17), less productive, and lack of confidence at 39.5% (17).

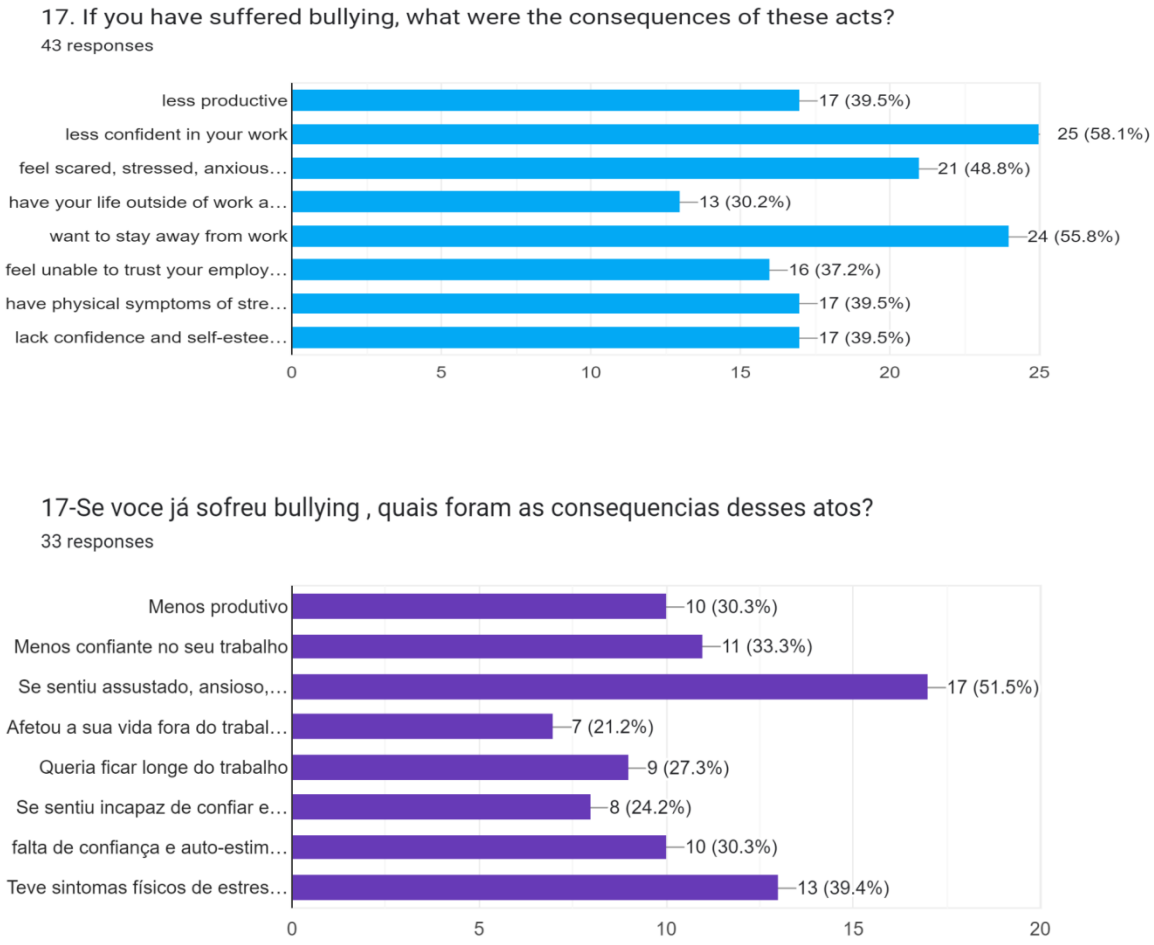
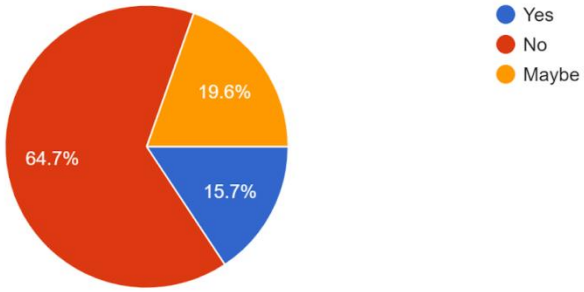


Figure 11 : Graphics of questions seventeen

Question eighteen is about whether organizations are providing anti-bullying training to these employees, As we can see in the graph below in Ireland 64.7% of respondents do not receive any guidance against bullying and in Brazil this figure was slightly higher at 73.1%. Finally, question nineteen concerns how confident these employees feel about reporting bullying. According to the current survey in Ireland, 41.2% of respondents do not handle confidence in reporting these misbehaviors, and in Brazil 36,5% don't feel confortable to report bullyng behavior.

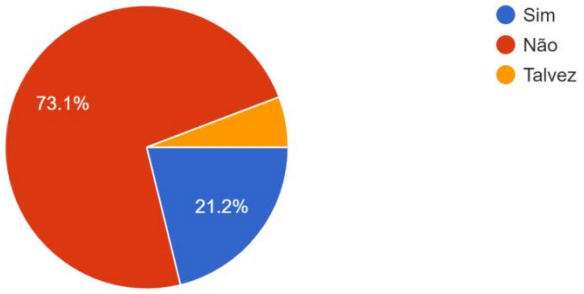
18- Did your company give you the necessary information to combat bullying in your institution?

51 responses



18- Você recebeu orientação sobre o combate do bullying na intituição em que você trabalha?

52 responses



19-Do you feel confident in reporting cases of bullying?

51 responses

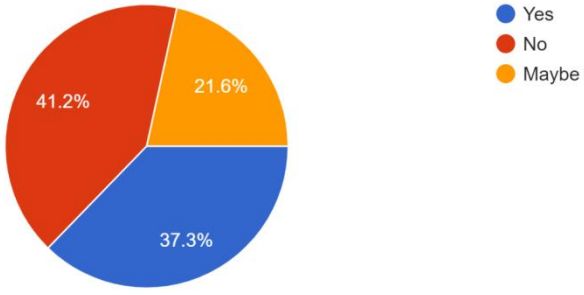




Figure 11 : Graphics of questions eighteen and nineteen

5 Discussion

Bullying affects a large number of healthcare professionals, which makes it a significant public health issue. This type of behavior has been studied for decades to create strategies to combat it, but these strategies have not proven effective. Several factors, including gender, culture, seniority, and qualifications, contribute to the continued presence of this type of behavior in these environments, according to this study.

Leisy and Ahmad (2016) discovered that the rates of harassment experienced by medical residents were comparable. According to previous research (Matthiesen&Einarsen, 2010) and this systematic review, the study's design appears to have a significant impact on the prevalence rates of bullying. According to this comprehensive study, workplace bullying among patients, nurses, employees, and other medical professionals decreased as the operational definition became more stringent.

Despite this heterogeneity, a closer look at the definitions of terms used by authors of studies included in this systematic review revealed that they all similarly described bullying behaviors, i.e., as negative and aggressive workplace

behaviors from superiors, coworkers, and subordinates that are primarily psychological and have the effect of humiliating, frightening, or punishing the target. In other words, bullying is defined as hostile and aggressive workplace behaviors from superiors, coworkers, and subordinates that have the effect of According to those who were among the first in their fields, terms such as bullying, mobbing, harassment, victimization, emotional abuse, and workplace violence are frequently interchangeable. Because of this, neither of the studies incorporated into this systematic review was carried out by either.

According to the findings of the research, bullying in the workplace is common. The prevalence of bullying in the workplace varies depending on the operationalization and measurement of negative interactions. This study aimed to identify the barriers that prevent health professionals from reporting instances of bullying. Health professionals are under pressure because they are in charge of other people. They are essential to the proper delivery of healthcare, both when the process runs smoothly and when it does not, are at the core of this apparent pandemonium. Nurses are an essential and critical part of the healthcare team because they utilize their knowledge, abilities, and experience to care for each patient's unique and changing requirements. Nurses make up the majority of the healthcare workforce in the country. Although the complexity of healthcare and many other factors significantly impact the quality and safety of care, nurses are frequently held responsible for patient harm, even though other clinicians, healthcare providers, and unique aspects of the care system in which they work frequently play more significant roles. In some ways, the system is doomed to fail, and it does so frequently, leaving nurses to provide care at the "sharp edge." (Bowling, N.A.; at al.2006).

Bullying manifests itself explicitly in this category because threats and physical aggression, no matter how slight, may occur. In this category, embarrassing and humiliating situations are described as shouting and invasions of privacy via phone calls, e-mails, and letters, among others. According to the study, verbal abuse is the most common form of bullying. A WHO study found that 39.5% of

healthcare professionals in Brazil, 32.2% in Bulgaria, 52% in South Africa, 47.7% in Thailand, 27.4% in Portugal, 40.9% in Lebanon, and up to 67% in Australia had experienced verbal abuse in the past year. According to the survey carried out in Ireland, 53.75% of the interviewees pointed out verbal abuse and being treated less favorably as the most frequent types of bullying. In Brazil, other threatening behavior (27.7%), followed by bullying and physical aggression (14.9%), and verbal abuse was the third most frequent with 12.8%. The method that was applied to determine the prevalence rates of bullying in the workplace also played a role in the outcome. The behavioral experience method produced significantly better results than the self-labeling method with a predetermined definition in the 2009 meta-analysis conducted by Nielsen. The behavioral experience method uses a scoring criterion to determine whether an individual is a bully or not, regardless of how the individual perceives the treatment they receive; in contrast, the self-labeling method may exclude individuals who have a high tolerance for harsh treatment. Behavioral experience method (Barmes, 2016).

Workplace bullying affects one's ability to do their job and job satisfaction, ultimately resulting in burnout and job discontent. In addition, the high levels of stress and unpleasantness that accompany persistent bullying may disrupt sleep, make it difficult to concentrate, create a loss of confidence and excitement at work, and raise the likelihood of accidents and medical errors. The detrimental effects mentioned by the studies in this systematic review are alarming because they could have an impact on learning and seriously jeopardise the health and safety of patients, which is even more concerning given that doctors, nurses, staff, and patients are frequently the ones who treat and manage patients first (Paice& Smith, 2009).

In addition, bullying is distinguished by an imbalance of power, which is frequently the result of deficiencies in medical education. Nevertheless, some authors contend that all medical profession members, including staff, patients, nurses, and others, are bullied because they incorrectly interpret criticism as

"bullying". It's possible that being bullied in medical school will help these professional to improve .

Others believe that bullying is more likely to occur in healthcare settings because healthcare professionals, nurses, staff, and patients lack experience in effectively managing conflicts in the workplace. In conclusion, maturation and age bring about shifts in perceptions and interpretations, which may help to explain why older physicians are less likely to notice instances of bullying.

Some people believe that women should be held to stricter standards of behavior and should not abandon their traditional roles because doing so can lead to bullying and poor judgment. Harassment in the workplace can also be motivated by factors such as racism and nationality. According to Cheema et al. (2005), European doctors, nurses, staff, and patients were significantly less likely to be bullied than non-Europeans. Researchers Chadaga et al. (2016) found that there were significant differences in the incidence of bullying between white and non-white participants. According to the study by Daugherty et al. in 1998, job demands were found to have a positive association with targets' reports of bullying, whereas job resources were found to have a negative association. In addition, specific subspecialties require more time and provide less emotionally and socially supportive work environments(Van den Broeck et al., 2011).

The examples show how these socially constructed rules can influence interpersonal interactions, form subjectivities, and meaning, and affect how people perceive and interact with one another. Our analysis demonstrates how workplace relationships have evolved to accommodate negative organizational power dynamics. As a result of anti-bullying policies, workplace relations became more stable and entrenched. These particular "rules of the game" can justify bullying. Under duress, actors may justify their participation in or tolerance of bullying by asserting that it is inevitable, widespread, or average.

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resources were found to have a negative association. In addition, specific subspecialties require more time and provide less emotionally and socially supportive work environments(Van den Broeck et al., 2011).

It is essential to recognize bullying as a problem before you can tackle it. Individuals who suffer from bullying may not notice it because it is tolerated at their workplace. A nurse must be able to identify warning signs and symptoms, such as eating problems, anxiety, and sleep disorders. Peers and superiors may criticize the individual's heightened sensitivity, personality conflicts, or management style. You should record the bullying, including when, how, and who witnessed it, to prove what happened. Employees must be able to report harmful behavior through a workplace bullying and harassment policy in every NHS organization. Burnes and Pope (2007) argue that one of the biggest challenges in combating bullying is that the people who ought to be stopping or preventing bullying are often the ones who engage in it. A coworker's failure to intervene with bullying leads to the bullying continuing. According to this survey, managers and supervisors are responsible for 28 (59.6%) bullying cases in Ireland and 35.6% in Brazil. According to the bullying policy, professionals in this position are responsible for educating and combating bullying in health institutions.

Some co-workers do not report bullying for fear of being labeled as troublemakers and that their concerns will not be taken seriously because bullies often hinder or restrict communication in the workplace. Another quality nurses emphasized was humor. With this mindset, nurses viewed bullying from a stance that encouraged the search for possible solutions. With humor often paired with optimism, nurses viewed bullying from a positive perspective. It was challenging to find solutions to problems for pessimistic staff because they exhibited fewer coping mechanisms. The nursing supervisor must set a good example by acting professionally, encouraging, and constructively. All staff members should be treated with dignity, communication should be strengthened, and problems should be resolved immediately.

The Health Service Executive (HSE) has an anti-bullying policy. They define bullying and other forms of inappropriate behavior. The policy covers both employees and non-employees in the healthcare industry. It aims to protect staff from harassment by all those who come into contact with them. Employers and employees have a crucial role to play in combating bullying. Employers must be aware of the hazards in the workplace, assess the risks associated with these hazards, and have a written evaluation of any risks that may affect the employee's health and well-being.

The first step in battling bullying is to recognize it (Murray, 2009). Due to the recipient's employer's tolerance of this behavior, they might not even notice it. Each NHS organization must have a policy against bullying and harassment in the workplace that staff members can use to report harmful behavior (NHS Confederation, 2006). The fact that those who should be in charge of ending or preventing these behaviors are frequently those who engage in them, as stated by Burnes and Pope (2007), presents one of the major obstacles in the fight against bullying. Only 22% of the bullied participants in Quine's 2001 study reported being satisfied with the outcome, despite the fact that over 70% of them tried to stop the bullying. Bullying is facilitated by coworkers who do not intervene when they observe a colleague being bullied.

This study found that nurses with high levels of hope acted with confidence in how a bullying situation would be handled. People can survive difficult circumstances when they can see problems as challenges rather than threats by having hope (Frankl, 1984).

The staff is accountable for treating one another with respect, enhancing communication, and finding quick solutions to issues. Inaction or silence in the face of bullying, according to Murray (2009), can encourage it to happen again. Instead of dealing with it, management may transfer the bully to other departments within the company where the same behaviors are still present. Bullies frequently exhibit this behavior in the past.

According to this study, bullying in healthcare settings is widespread, and several factors contribute to professionals who are victims of bullying not reporting it. According to professionals working in Ireland in the nursing home and home care and Brazilian health professionals, institutions do not provide sufficient guidance on combating bullying, and most are unaware of the policies implemented by the institutions.

Another key finding was that professionals who reported bullying did not receive assistance from their organizations in resolving the conflict created by bullying. For individuals in Brazil, where the socioeconomic situation is more critical than in Ireland, the fear of losing a job is among the most relevant reasons not to take any action against bullying.

According to Murray (2009), being silent or taking no action in the face of bullying can encourage it to happen again. Bullies frequently exhibit this behavior in the past, so instead of dealing with it, management may move the bully to other company sections where the same behaviors persist.

6 Conclusion and recommendations

The quality of the evidence from this systematic review may be graded as moderate after the modified NOS's methodological evaluation of the included studies. The results of this systematic study thus offer relatively solid proof of the prevalence of workplace bullying among doctors, nurses, staff, and patients and its potential causes and harmful effects. This is especially helpful given our limited knowledge regarding workplace bullying among doctors, nurses,staff, and patients. Due to the heterogeneity of the terms, definitions, operationalization, and methodologies used to study workplace bullying among healthcare professional, the results of this systematic review suggest that, despite four decades of research, workplace bullying remains challenging to quantify. Even though these findings are credible, given the meticulousness with which the systematic review was conducted, it is essential to note that the review has

limitations. This systematic review was restricted to English-language articles to facilitate quality assessment, so evidence from research published in languages other than English could not be examined. In addition, the local library could not be included in the database search because it did not have an Embase subscription. This is unfortunate, as the study may not have included important papers from European researchers, as research on workplace bullying originated in Scandinavia (Einarsen et al., 2003). The search utilized information from five other significant databases, including Medline, Web of Science, Scopus, PsycINFO, and the Cochrane Library, so the probability of this occurring is extremely low. The exclusion of grey literature may have led to publication bias,andeven though, as stated previously, this was likely mitigated by searching multiple significant databases, including Scopus, which indexes grey literature (Bonato, 2016).

Due to temporality ambiguity (Delgado-Rodriguez &Llorca, 2004), recall bias (Bowling, 2005), and reporting bias, the strength of the evidence for the findings may be weakened because the included studies were all cross-sectional in design, used self-administered questionnaires, and asked questions about a sensitive topic (Delgado-Rodriguez &Llorca, 2004). The authors of all included studies made every effort to conceal the identities of study participants, which may have reduced reporting bias. Additionally, the benefits of this systematic review must be highlighted. First, this review collected crucial information regarding the correlations of workplace bullying, which have not yet been tested for medical professionals, nurses, staff, and patients. In addition, a review of the terminology, definitions, operationalization, and methodologies used to assess workplace bullying among physicians, nurses, staff members, and patients was presented. This review will shed light on the current understanding of workplace bullying among physicians, nurses, staff members, and patients and help to direct future research. The MOOSE guidelines were adhered to assess the included studies' methodological quality; numerous large databases were searched, extensive search terms were employed, and established quality

assessment tools were used. In addition, care was taken to ensure the accuracy and quality of this systematic review. The systematic review determined that workplace bullying negatively affects individuals and healthcare organizations, affects young doctors, nurses, staff, and patients worldwide, and is influenced by various personal and professional factors. Because bullying is typically not reported, this is alarming (Bairy et al., 2007). Given the complexity of workplace bullying and the inadequacy of our current understanding of this phenomenon, additional research is required. Doctors, nurses, employees, and patients must be aware of workplace bullying to maintain good health. We can prevent and mitigate this phenomenon's burden, predictors, and effects by gaining a deeper understanding.

The problem of workplace bullying persists despite increased awareness, policies, training, and organizational interventions, and considerable barriers prevent employees from reporting incidents. Given current economic challenges, bullying in healthcare delivery and organization may increase as research suggests that bullying rates typically rise during restructuring, budget cuts, and organizational changes, and there are some early indications that bullying rates may be rising. There are implications for healthcare workers, managers, and policymakers as a result of these findings. It is essential to develop interventions targeted at the most problematic negative behaviors based on knowledge of the most prevalent behaviors. Organizations can monitor the prevalence of negative behaviors by using questionnaire tools like NAQ-R23. Bullying was witnessed by several members of staff and could be designed interventions to promote bystander intervention and teach skills to challenge the behavior.

Further research is needed to identify evidence-based workplace bullying interventions, as only a few studies evaluate their efficacy. In this study, bullying and negative behaviors persist in healthcare; it was demonstrated that experiencing and witnessing negative behaviors is related to employee health, well-being, and organizational commitment, and identified critical barriers to

reporting bullying. Increasing the healthcare workforce's well-being is essential to removing these barriers and evaluating interventions to reduce negative behaviors in the workplace.

7 Reflection

Having experienced bullying in Brazil and Ireland, the development of this research was of significant importance to me. This process reminded me of my nearly 12 years working in the health field.

The health professional faces many challenges in executing his activities. Caring for another person with an illness already generates enormous pressure because, often, the patient's life is under their care; no matter how minor the error, it can cause considerable damage to the patient's and their families lives.

During my time as a nursing home healthcare assistant, I thoroughly understood how the Irish healthcare system works. I have also worked in home care in Ireland and Brazil's health care system for the last three years. My experience as a nurse spans almost ten years. During this experience, I gained insight into the health systems of both countries concerning policies, factors, and causes of bullying.

The high incidence of bullying in the healthcare environment is attributed to many factors, including cultural differences, gender, seniority, economic situation, years of experience, power, and especially the failure of anti-bullying policies.

The topic of bullying has been discussed for decades, starting in schools and spreading to the workplace. Unfortunately, these professionals are often unaware of the behaviors characterized as bullying. , doing these acts is considered normal in these environments and difficult to combat.

It is of great importance that health professionals know how to recognize these acts of bullying because the consequences of these acts affect the health, professional and personal life of these individuals, which can have severe consequences such as suicide. Professionals must become knowledgeable

about policies against bullying to know how to act when appropriate. Nowadays, the internet is making life easier for everyone. We can find all the policies against bullying developed by WRC and HAS on the official websites of these institutions.

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List of Appendices

Appendix 1: Ethics Form

Form A: Application for Ethical Approval **Undergraduate/Taught Postgraduate Research**	
This form should be submitted to the module leader for the relevant initial proposal and/or the relevant supervisor is the proposal has already been accepted. Please save this file as *STUDENT NUMBER_AEA_FormA.docx*	
Title of Project	Bullying in the healthcare workplace
Name of Learner	Iracema de Araujo
Student Number	51718561
Name of Supervisor/Tutor	Richard Brophy

Check the relevant boxes. All questions must be answered before submitting to the relevant lecturer / supervisor. Note: only one box per row should be selected.

Item	Question	Yes	No	NA
1	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	☒	☐	
2	Will you tell participants that their participation is voluntary?	☒	☐	
3	Will you obtain written consent for participation (through a signed or 'ticked' consent form)?	☒	☐	
4	If the research is observational, will you ask participants for their consent to being observed.	☐	☐	☒
5	Will you tell participants that they may withdraw from the research at any time and for any reason?	☒	☐	
6	Will you give participants the option of not	☒	☐	☐

Item	Question	Yes	No	NA
	answering any question they do not want to answer?			
7	Will you ensure that participant data will be treated with full confidentiality and anonymity and, if published, will not be identifiable as any individual or group?	☒	☐	
8	Will you debrief participants at the end of their participation (i.e., give them a brief explanation of the study)?	☒	☐	
9	If your study involves people between 16 and 18 years, will you ensure that passive consent is obtained from parents/guardians, with active consent obtained from both the child and their school/organisation?	☐	☐	☒
10	If your study involves people less than 16 years, will you ensure that active consent is obtained from parents/guardians and that a parent/guardian or their nominee (such as a teacher) will be present throughout the data collection period?	☐	☐	☒
11	If your study requires evaluation by an ethics committee/board at an external agency, will you wait until you have approval from both the Independent College Dublin and the external ethics committee before starting data collection.	☐	☐	☒
12	If you are in a position of authority over your participants (for example, if you are their instructor/tutor/manager/examiner etc.) will you inform participants in writing that their grades and/or evaluation will be in no way affected by their participation (or lack thereof) in your research?	☐	☐	☒
13	If you are in a position of authority over your participants (for example, if you are their instructor/tutor/manager/examiner etc.), does your study involve asking participants about their academic or professional achievements, motivations, abilities or philosophies? (please note that this does not apply to QA1 or QA3 forms, or questionnaires limited to market	☐	☐	☒

Item	Question		Yes	No	NA
	research, that do not require ethical approval from the IREC)				
14	Will your project involve deliberately misleading participants in any way?		☐	☒	
15	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		☐	☒	
16	Does your project involve work with animals?		☐	☒	
17	Do you plan to give individual feedback to participants regarding their scores on any task or scale?		☐	☒	☐
18	Does your study examine any sensitive topics (such as, but not limited to, religion, sexuality, alcohol, crime, drugs, mental health, physical health, etc.)		☐	☒	
19	Is your study designed to change the mental state of participants in any negative way (such as inducing aggression, frustration, etc?)		☐	☒	
20	Does your study involve an external agency (e.g. for recruitment)?		☐	☒	
21	Do your participants fall into any of the following special groups? *(except where one or more individuals with such characteristics may naturally occur within a general population, such as a sample of students)*		☐	☒	
			☐	☒	
			☐	☒	
			☐	☒	
			☐	☒	

If you have ticked any of the shaded boxes above, you should consult with your module leader / supervisor immediately. **You will need to fill in Form B Ethical Approval** and submit it to the Research & Ethics Committee **instead** of this form. There is an obligation on the researcher to bring to the attention of the Research & Ethics Committee any issues with ethical implications not clearly covered by the above checklist.	
Iconsiderthatthisprojecthas**no**significantethicalimplicationstobebroughtbeforetherelevant Research & Ethics Committee. I have read and understood the specific guidelines for completion of Ethics Application Forms. I am familiar with the codes of professional ethics relevant to my discipline (and have discussed them with mysupervisor).	☒
Name of Learner	Iracema de Araujo
Student Number	51718561
Date	Click or tap here to enter text.
I have discussed this project with the learner in question, and I agree that it has no significant ethical implications to be brought before the Research & Ethics Committee.	☐
Name of Supervisor/Lecturer	Richard Brophy
Date	Click or tap here to enter text.

Appendix II: Informed Consent FormEnglish

BULLYING IN THE HEALTH CARE WORKPLACE

Thanks for taking the time to fill out this form. All data is stored in a password-protected electronic format. Your responses will be confidential and we do not collect identifying information such as your name, Email address, or IP address. The survey's questions will focus on the Under-reporting bullying in the workplace.

The results of this study will be used for scholarly purposes only and may be shared with academic Staff in IC. There are approximately 19 questions to be answered, requesting an estimated 5- 7 minutes - completion time.

Your participation is voluntary and you:

May decide to withdraw from the research study at any time without explanation. You have the right to request that any data you have supplied be withdrawn/destroyed. Have the right to decline to answer any question asked of you. Have the right to have your questions about the study answered.

This research is being carried out by Iracema de Araujo as part of a Degree in Master of Arts in Dispute Resolution at an Independent College. The study is being conducted under the supervision of Dr. Richard Brophy and has been granted ethical approval by Independent College.

Appendix III: Surveys in English

1-Gender

- Female
- Male
- Prefer not tosay

2-What'syour nationality?

3-Are you a health care professional?

- Yes
- No

4-What area do you workin?

- Nurse
- Healthcare Assistant
- phisioteraphist
- Doctor
- Other

5-How many years have you been working in the health care sector?

- less than 6 months
- less than 1 year
- less than 5 years
- more than 5 years

6-Where do you currently work?

- Ireland
- Brazil
- Other: _____

7-Do you workin?

- Hospital
- Home care
- Nursing Home

8-Have you heard about bullying in the workplace?

- yes
- No
- Maybe

9—Have you been bullied by the other staff over the last years

- Yes
- No
- Maybe

10–Have you ever witnessed a work colleague ebeing bullied?

- Yes/rarely
- Yes,once in a while
- Yes,several times a week
- Yes,almost daily
- No

11-What kind of bullying have you experienced?

Workplace bullying is repeated inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could be reasonably regarded as undermining the individual's right to dignity at work(WCR, 2021)

- verbal abuse or insults
- Being treated less favourable than colleagues in similar roles
- Disseminating malicious rumours, gossip or innuendo
- Belittling a person's opinion
- Intimidation or aggressive interactions
- Socially excluding or isolating a person within the work environment
- Excessive monitoring of work
- Use of aggressive and obscene language
- Other menacing behaviour
- Other

12-Does the company you work for have a bullying policy or code?

Yes

- [ ] No
- [ ] I am not aware

13- 13-If you have been bullied or witnessed a work colleague being bullied, have you reported it to those responsible?

- [ ] No
- [ ] Yes
- [ ] Maybe

14-Who is involved in bullying at work?

(Bullying at work can involve people in many different work situations and at all levels).

You can choose more than one option.

- manager/supervisor to employee,
- employee to supervisor/manager
- One employee to another (or group to group),
- customer/supervisor/manager to business contact
- client/customer to employee.

15-If the previous answer was **NO** (question 12), what led younot to report it?**You can choose more thanone option.**

- Lack of information
- Not knowing if you were being bullied
- Fear of being seen as a problem for the institution
- Fear that no action would be taken

- Fear of losing your job

16- If the answer **YES** to question 12, did your companyhelp you to solve theproblem?

- Yes
- No
- Maybe

17. If you have suffered bullying, what were theconsequences of these acts?

- less productive
- less confident in your work
- feel scared, stressed, anxious or depressed
- have your life outside of work affected
- want to stay away from work
- feel unable to trust your employer or the people you work with
- have physical symptoms of stress such as headaches, backaches, sleep problems
- lack confidence and self-esteem in yourself and your work

18- Did your company give you the necessary information tocombat bullying in your institution

Markonlyoneoval.

- Yes
- No
- Maybe

19- Do you feel confident in reporting cases of bullying

- Yes

- No
- Maybe

Appendix IV: Informed Consent Form English

BULLYING NO AMBIENTE DE SAÚDE

Obrigado por ter reservado um tempo para preencher este formulário. Todos os dados são armazenados em um formato eletrônico protegido por senha. Suas respostas serãoConfidencial e não coletamos informações de identificação como o seu nome,endereço de e-mail ou endereço IP. O questionario tem focus na subnotificação do casos de bullying no local de trabalho.Os resultados deste estudo serão utilizados apenas para fins acadêmicos e poderão ser compartilhados com acadêmicos e funcionarios em DCI.Há aproximadamente 19 perguntas a serem respondidas, solicitando um tempo estimado de 5 a 7 minutos - tempo de conclusão. Sua participação é voluntária e você: Pode decidir retirar-se do estudo de pesquisa a qualquer momento sem explicação. Você tem o direito de solicitar que quaisquer dados que tenha fornecido sejam retirados / destruídos. Tem o direito de recusar responder a qualquer pergunta que lhe for feita.Tem o direito de ter suas perguntas sobre o estudo respondidas.Esta pesquisa está sendo realizada por Iracema de Araujo como parte de um Mestrado em Resolução de Disputas da Faculdade Independent em Dublin. O estudo está sendo conduzido sob a supervisão do Dr. Richard Brophy e recebeu a aprovação ética do Faculdade Independent Dublin/Irlanda.

Appendix V: Survey in Portuguese

1-Genero

- Feminino
- Masculino
- Prefironãofalar

2-Você é professional da area de saúde?

- [ ] Não
- [ ] Sim
- [ ] Outra

3-Qual a sua nacionalidade?

_____

4- Há quantos anos você esta trabalhando na area saúde?

- [ ] Menos de 6 meses
- [ ] Menos de um ano
- [ ] Menos de 5 anos
- [ ] Mais de 6 anos

5-Qual a sua profissão?

- Enfermeiro
- Tecnico de Enfermagem
- Medico
- Fisioterapeuta
- Nutricionista
- Outros

6-Em que país voce trabalha atualmente ?

- Irlanda
- Brasil

7-Onde voce trabalha?

- Hospital
- Casa de idoso
- Clinicas
- Home care
- outros

8 Você já ouviu falar sobre o bullying no ambiete de saúde ?

- Sim
- Não
- Talvez

9- Você já sofreu bullying por algum colega de trabalho nos ultimos anos

- Sim
- Não
- Talvez

10- Você já presenciou algum colega seu de trabalho sofrendo bullying ?

- Não
- Sim, mas raramente
- Sim, de vez em quando
- Sim, muitas vezes na semana
- sim, quase todos os dias

11- Qual tipo de bullying você já presenciou?

- abuso ou insultos verbais
- Ser tratado menos favoravelmente que os colegas em funções similares
- Disseminar rumores maliciosos, fofocas ou insinuações
- Desvalorizar opinião de uma pessoa
- Intimidação ou interações agressivas
- Socialmente excluindo ou isolando uma pessoa dentro do ambiente de trabalho
- Monitoramento excessivo do trabalho
- Uso de linguagem agressiva e obscena
- Outros comportamentos ameaçadores

12- A empresa que você trabalha tem algum tipo de codigo ou politica deconduta contra o bullying ?

- Sim
- Não
- Não tenho cohecimento

13- S e voce ja sofreu bullying ou presenciou algum colega de trabalho sofrendobullying, voce reportou esse ato para as pessoas responsaveis?

- Sim
- Não
- Talvez

14- Quem eram as pessoas envolvidas nos atos de bullying?
O bullying no local de trabalho é um comportamento inapropriado repetido,direto ou indireto, seja verbal, físico ou não, conduzido por uma ou maispessoas contra outra ou outras, no local de trabalho e/ou no curso do emprego,que poderia ser razoavelmente

considerado como prejudicando o direito doindivíduo à dignidade no trabalho (WCR, 2021).

- Gerente/supervisor ao funcionário,
- empregado para supervisor/gerente
- De um funcionário para outro (ou de grupo para grupo)
- Cliente ao funcionario

15-Se a resposta para a questão (numero 12) foi **NÃO** , quais foram os fatoresque te impediram de reportar os casos de bullying?

- Falta de informação
- Não saber identificar se você estava sofrendo bullying
- Medo de ser visto como um problema para a instituição
- Medo de que nenhuma medida fosse tomada
- Medo de perder o trabalho

16- Se a resposta para a (questão numero)12 foi **SIM**, a empresa tomoualguma medida ?

- Sim
- Não
- Talvez

17-Se voce já sofreu bullying , quais foram as consequencias desses atos?

- Menos produtivo

- Menos confiante no seu trabalho
- Se sentiu assustado, ansioso, estressado, depressivo
- Afetou a sua vida fora do trabalho
- Queria ficar longe do trabalho
- Se sentiu incapaz de confiar em seu empregador ou nas pessoas com quem você trabalha
- falta de confiança e auto-estima em você e em seu trabalho
- Teve sintomas físicos de estresse como dores de cabeça, dores nas costas, problemas de sono

18- Você recebeu orientação sobre o combate do bullying na intituição em que você trabalha?

- Sim
- Não
- Talvez

19- Voce se sente confiante em reportar os casos de bullying ?

- Sim
- Não
- Talvez