Interventions to reduce bullying in health care organizations: A scoping review

Elizabeth Quinlan, Susan Robertson, Natasha Miller and Danielle Robertson-Boersma

Abstract
The problem of staff-to-staff bullying and its consequences in the health care sector has given rise to urgent knowledge needs among health care employers, union representatives, and professional associations. The purpose of this scoping review is to increase the uptake and application of synthesized research results of interventions designed to address bullying among coworkers within health care workplaces. The scoping review's methodology uses an adapted version of the Arksey and O'Malley framework to locate and review empirical studies involving interventions designed to address bullying in health care workplaces. The findings of the review reveal eight articles from three countries discussing interventions that included educative programming, bullying champions/advocates, and zero-tolerance policies. The reported evaluations extend beyond bullying to include organizational culture, trust in management, retention rates, and psychosocial health. The most promising reported outcomes are from participatory interventions. The results of the review make a compelling case for bullying interventions based on participatory principles.

Keywords
Canada–UK–Australia, health care workplaces, scoping review workplace bullying

Introduction
Healthy workplaces are sites where individuals are self-actualized through their productivity and organizational knowledge. Bullying among employees undermines the health of workers and workplaces. Workplace bullying has well-documented physical and mental health debilitating effects on employees, including post-traumatic stress, anxiety, depression, sleep disturbances, and suicide. Organizations also suffer as bullying results in increased absenteeism and stress-related leaves, poor performance, and unproductive time. One striking measure of managing bullying in health care workplaces puts the cost at approximately 5% of total operating budgets.

Singular acts of bullying may seem inconsequential, but its continuous nature makes it pernicious and distinguishes bullying from harassment, which can be a single action or event. Prevalence rates of workplace bullying vary considerably, but most research suggests that 10 to 20% of workers experience bullying in the workplace. In the health care sector, the rates are especially high. The variation in rates can be accounted for in part by reference to different types of measures used for self-reports while others are operationally defined. The majority of incidences are not reported to police or other authorities.

Although individual personality traits and characteristics play a role in explaining the impact of bullying, organizational cultures and structures have been found to significantly influence its frequency, intensity, and duration. In health care organizations that reflect an “ethic of care” in their formalized practices, rules, and procedures, the emotional work of direct caregivers is supported so that reciprocal caring relationships can fully develop. In such workplaces, caregivers have the autonomy to make decisions in “real” time so they are not abstracted from the particular needs of individual patients. In such work environments, caregiving is recognized as a complex set of functions in a context of unpredictability that calls for an elaborate communicative infrastructure to support social relations.

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between caregivers and their patients. In these settings, front-line caregivers have a greater level of job satisfaction.\textsuperscript{26} In institutional contexts where standardization logic prevails over the “ethic of care,” care providers are prevented from developing meaningful care relationships based on the full extent of their professional and practical knowledge, and the discursive processes that help secure mutual understanding between patients and providers are pre-empted.\textsuperscript{25,27–29} In downsized, under-staffed workplaces, care work is made more onerous and destabilized social relations among caregivers is one of the consequences.\textsuperscript{30}

The problem of workplace bullying and its consequences in the health care sector has given rise to urgent knowledge needs among health care employers, union representatives, and professional associations. Yet, research specifically focused on bullying interventions within the health care sector has not been mined for application to workplaces. For the research to be of use to knowledge users in situ, it must be holistically analyzed, interpreted, and synthesized. The purpose of this scoping review is to increase the uptake and application by health care managers and policy-makers of synthesized research results of interventions designed to address bullying in health care workplaces.

Searches for the scoping review indicate many different definitions of workplace bullying. While they all fall under the general rubric of repeated, sustained aggressive behavior within an interpersonal relationship,\textsuperscript{26,31–34} bullying does not have a single, universal meaning; it is assembled in multiple ways, mediated by social and material conditions. The definition congruent with the research on bullying and health care providers is as follows: workplace bullying is the systematic mistreatment of a subordinate or colleague by one or more individuals from the same group, over a frequent (at least once a week) and long period (at least six months) of time that can cause severe social, psychological, and psychosomatic problems in the victim. This article reports results of a scoping review identifying and examining the extent, range, and nature of interventions directed to workplace bullying, summarizing key findings, and identifying gaps in the literature.

**Methodology**

A scoping review is an ideal way to investigate advances in the field of intervention-based research on workplace bullying, as its methodology is designed to quickly and systematically identify the breadth of literature, clarify boundaries and definitions, summarize and disseminate research findings, and identify gaps in research evidence to guide subsequent primary research or a systematic literature review.\textsuperscript{35,36} Our scoping review’s methodology uses an adapted version of the Arksey and O’Malley’s\textsuperscript{37} framework, involving the following steps.

**Identification and development of the research questions**

The three research questions are as follows: What types of interventions addressing workplace bullying have been tested and evaluated? What are the outcomes? How are the outcomes measured and the intervention evaluated?

**Location, screening, and selection of relevant publications**

An information scientist guided preliminary searches to determine tentative terms and to establish the project’s initial universe and size, identify relevant databases and appropriate search strategies/terms, and advise on data management tools. Our preliminary searches revealed terms such as harassment and mobbing were inappropriate for the purposes of a review of interventions and consequently were discarded. The term “harassment” can be a single act or event of mistreatment, whereas bullying implies repeated mistreatment over a period of time. As such, bullying and harassment require different institutional responses and interventions. “Mobbing” was found much more commonly in studies emanating from European countries and as such was not used to direct the focus to literature emanating from non-European countries, in accordance with the focus of the scoping review on the latter set of countries in general, and the country of the author’s program of research in particular, where the regulatory framework has been much slower to develop. However, these search terms would serve well for a systematic review of the literature, which often is done following a scoping review.

The following terms were used to search six electronic databases of published scientific literature: “health care and bullying,” “health professions and bullying,” and “workplace bullying and health care.”

Our search capitalized on the databases’ search engines, permitting free-text searching and controlled vocabulary subject-descriptor-identifier searching. Besides standard Boolean/logical operators, most of the databases support “proximity” or “adjacency” searching to increase the range of retrievals. Other common features included the ability to: (1) search by specific elements, such as document type, language, and year; (2) “limit” or “separate-out” by “types” of materials, e.g. “peer-reviewed” versus “non–peer-reviewed,” books, chapters-within-books, book reviews, conference proceedings; and (3) group search results by “time”—in some cases, with visual maps/charts—to
peruse search results based upon the “evolution” of key search terms or concepts.

The review process (Figure 1) began with 508 sources, a combination of sources obtained from the databases, filtered for language (English), and other published literature found by bibliographic searches from key articles, or recommended by team members and other key informants. Refworks, an online research management, writing and collaboration tool, was used for storage of PDF copies of selected sources (see Appendix). A progressive series of three filters was then applied and we were left with 14 sources in total to review.

**Charting and organizing results**

The remaining 14 sources were analyzed by three team members. To organize our analysis, a data chart was developed with the following dimensions: context of the study, purpose and characteristics of the intervention, characteristics of the evaluation research design, and outcomes of the intervention. The sources were discussed at a team meeting. Guided by the research questions and our data charts, six sources were excluded (two articles, three dissertations, and one book) as they did not fit the criteria of an evaluated intervention directed to, or including bullying, and one source was found to deal with patient, rather than coworker assaults.

**Results**

Prior to filtering, our search of the literature uncovered two other reviews of workplace bullying literature, of which one addresses interventions; neither reported on the methodology used in their literature search. The first of the two reviews, by Rayner and Hoel’s, is a selective, not an exhaustive overview of the literature. The second, by Roberts et al., is short on the nature, contexts, and outcomes of interventions, despite their claim, “interventions are increasingly being developed.” This review, then, fills a gap by applying a rigorous scoping methodology to the literature on workplace bullying.

![Figure 1. Schematic of scoping results.](image_url)
The geographical locations of the eight articles cover three countries: Canada, Australia, and the UK. The narrow range of locations reflects the cultural specificity of the terminology used to describe the phenomenon. All but one of the eight journal articles were found in peer-reviewed journals. The deviating article was published in an industry magazine.

Only two articles provide a definition of bullying, despite one article’s coverage of the word’s etymology. The two definitions of bullying were examined for congruencies and differences. Both address the repeated, persistent nature of bullying. One definition is far more succinct, but the substantive differences are more notable. One specifies the deleterious consequences of the actions as “a hostile environment” and, in line with the World Health Organization’s (WHO) definition of bullying, incorporates the dimension of a power imbalance between the target(s) and perpetrator(s). The other does neither; but, qualifies bullying as “what a reasonable person would consider to be offensive, humiliating, intimidating, or threatening” in accordance with the WHO’s definition.

The workforces under study are in the health care sector in seven of the eight articles, one of which covers public sector workers in general, not solely health care workers (see Table 1). The anomalous article deals with retail workers and another unspecified population. Evidently, the article was included despite the search term “health care workers” because the occupation of the two populations was not identified in the abstract or keywords. While the article did not speak to health care workers per say, it was deemed worthy of review because of the paucity of articles with evaluated interventions directed to workplace bullying. Of those that reported the particular type of health care workers, the majority involved nursing and allied nursing occupations (3) or nursing supervisors (1). In four of the eight reviewed interventions, the workforce under study participated in the conception and execution of the intervention on a voluntary basis.

The interventions described in the articles were classified according to Sauter and Murphy’s four-tiered taxonomy of workplace interventions (see Table 1). Our careful reading corroborates Sauter and Murphy’s conclusion that while most interventions are readily classified at the individual/job-interface level, they are actually coordinated as programmatic initiatives at the higher levels of the employer/organizational or legislative/policy tiers. For instance, Crawford’s intervention with retail workers involved updating the “Dignity at Work” policy with a section on bullying with guidelines for managers, investigators, and supporters. Bourbonnais et al.’s intervention involves elements of the employer/organizational, such as changes to staffing, work organization, and communication protocols. Still others incorporate the implementation of zero-tolerance bullying policies.

Details of the interventions provided in the reviewed articles are given in Table 1. Interventions focusing on workplace bullying are few. Most were guided by the broader mandates of employees’ morale and psychological health, recruitment, and retention. In these

<table>
<thead>
<tr>
<th>Article</th>
<th>Location</th>
<th>Intervention type</th>
<th>Level of intervention</th>
<th>Evaluation metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bourbonnais et al.</td>
<td>Canada</td>
<td>Participatory</td>
<td>Employer/organizational</td>
<td>Psychosocial work health (psychological demands, decision, decision latitude, social support, rewards at work, psychological distress, burnout, sleeping problems)</td>
</tr>
<tr>
<td>Chima</td>
<td>United Kingdom</td>
<td>Nonparticipatory</td>
<td>Job/task level</td>
<td>Empowerment of champions</td>
</tr>
<tr>
<td>Collette</td>
<td>Australia</td>
<td>Participatory</td>
<td>Job/task level</td>
<td>Organizational culture</td>
</tr>
<tr>
<td>Crawford</td>
<td>United Kingdom</td>
<td>Nonparticipatory</td>
<td>Individual/job-interface</td>
<td>Psychological distress</td>
</tr>
<tr>
<td>Jury et al.</td>
<td>Australia</td>
<td>Participatory</td>
<td>Job/task level</td>
<td>Quality of work-life, individual and workplace distress and morale, participative decision-making, supervisor and peer support, goal congruence, work demands, role clarity</td>
</tr>
<tr>
<td>Meloni and Austin</td>
<td>Australia</td>
<td>Participatory</td>
<td>Individual/job-interface</td>
<td>Employee engagement, employee readiness for trust in management and organizational change</td>
</tr>
<tr>
<td>Pate and Beaumont</td>
<td>United Kingdom</td>
<td>Nonparticipatory</td>
<td>Legislative/policy</td>
<td>Trust in senior management, turnover rates</td>
</tr>
<tr>
<td>Stevens</td>
<td>Australia</td>
<td>Nonparticipatory</td>
<td>Employer/organizational</td>
<td></td>
</tr>
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</table>
latter cases, workplace bullying is included as an aspect of the more inclusive concerns of widespread organizational restructuring and cost-containment, ubiquitous hemorrhaging of health care workers, and degraded workplace cultures. In accordance with the mandates of the interventions, articles reporting the evaluation metrics include more than workplace bullying (see Table 2).

Survey items addressing bullying attend to individuals’ experiences and perceptions in all but one reported evaluation schema. For most, the resulting data capture the phenomenon of workplace bullying at the individual level. The exception is Pate and Beaumont42 with their single survey item, “I feel bullying is a problem within the organization.” The item was deliberately worded to capture perceptions of the extent of the problem from those who were or are targets and witnesses, as well as others who have come to know about the problem not through their own direct experience.

All but one intervention was driven by industry-wide or organizational interests. Bourbonnais et al.45 is the only researcher-initiated study. Others, judging by authorship of articles, are led by practicing clinicians or health care administrators without academic appointments. Perhaps not surprisingly then, three articles did not report their evaluation methodology. All five others use quantitative evaluative techniques to compare results of employee surveys, collected by mail or face-to-face interviews with the researcher, before and after the intervention. Only the research-driven study45 employed a quasi-experimental design with control and experimental groups, each located in different hospitals, and using previously tested instruments from the work-health literature with established validity and reliability.

**Intervention outcomes**

Two of the reviewed articles report unexpected outcomes (see Table 2). First, in Bourbonnais et al.’s45 quasi-experimental study, three findings were contrary to the hypotheses: psychological distress did not abate and both supervisor support and decision latitude decreased in the experimental group. The explanation offered by the authors for the unanticipated findings is the short time between the pre- and postintervention measurements. Most of the 36 interventions were not yet implemented by the postintervention data capture. Further, it was noted that the expectations of the interventions were especially high among caregivers and thus the surveys could be registering their dismay with their perceived limitations in decision latitude and supervisor support.

Second, Pate and Beaumont’s42 longitudinal study with 200 public sector employees also produced an unanticipated result. Although the intervention realized a decrease in bullying, the level of trust in senior management also decreased over the three years. The percentage of employees who “agreed” or “strongly agreed” to the 5-point Likert scale survey item, “I feel bullying is a problem within the organization” dropped from 50% to 22%. Yet, contrary to expectations, those reporting “poor” or “very poor” levels of trust in senior management increased from 25% to 32% between the pre- and postintervention measures.

The authors advance several explanations for the deviant result. First, congruent with Bourbonnais et al.’s45 explanation for their unexpected findings, Pate and Beaumont speculate that three years is insufficient for the effects of the intervention to be noticed by employees. Second, the available measures and models to examine complex, multi-dimensional social phenomena such as trust and bullying are under-developed. While the measure used to assess bullying had the advantage of capturing perceptions of the pervasiveness of the problem rather than individual experiences of bullying, as a single survey item, it nonetheless obscures distinctive dimensions of the phenomenon. A similar limitation holds for the single item measuring trust in senior management. As the authors argue, employees might consider the bullying intervention to be management’s “one hit wonder”: successful yes, but would require concurrent and similarly successful initiatives to raise their level of trust in management.

The most promising outcomes were from the participatory interventions, as discussed in subsequent paragraphs, illustrated in Figure 2, and detailed in Table 2. Intervention teams consisting of representatives from all units and levels of the workplace express the epistemological commitment of bringing multiple perspectives to the identified problem and subsequent intervention development and implementation. In Bourbonnais et al.’s45 study, an intervention team was established through voluntary recruitment of direct care providers (nurses, orderlies, and auxiliary nurses) and included representatives from the human resources department, unions, and nursing management. The team’s procedures were drawn from German health circles, which have otherwise reported stress-prevention consequences. The intervention team was given latitude to arrive at specific interventions; members were granted release time for team meetings and follow-up sessions in each of their respective work units to disseminate and gather comments from their coworkers. The measurable outcomes from Bourbonnais et al.,45 were (1) a significant drop in psychological demands and in the effort-reward ratio in the experimental and not the control group and (b) more favorable postintervention scores on all of the psychosocial factors in the experimental, compared to the control group.
<table>
<thead>
<tr>
<th>Study author(s)</th>
<th>Intervention type</th>
<th>Intervention level</th>
<th>Evaluation metrics</th>
<th>Methods</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bourbonnais et al.</td>
<td>Participatory</td>
<td>Employer/organizational</td>
<td>Psychosocial work health (psychological demands, decision, decision latitude, social support, rewards at work, psychological distress, burnout, sleeping problems)</td>
<td>Quasi-experimental design with pre- and post- (already validated) measures on control and experimental worksites. Logistic regression on two groups of dependent variables:</td>
<td>Significant drop in psychological demands in the experimental, but not the control hospital. Significant decrease in effort/reward ratio in experimental, but not in control hospital. Mean postintervention score for each of the psychosocial factors was more favorable in the experimental than in control, although no statistically significant different in decision latitude. All the above are expected findings. The unexpected findings were in experimental hospital, psychological distress did not decrease, and supervisor support and decision latitude decreased.</td>
</tr>
<tr>
<td>Chima</td>
<td>Nonparticipatory</td>
<td>Job/task level</td>
<td>Empowerment of champions</td>
<td>Not specified.</td>
<td>The champion role was positively evaluated by individuals, management, and organizational levels. Champions felt empowered, confident, and valued.</td>
</tr>
<tr>
<td>Collette</td>
<td>Participatory</td>
<td>Job/task level</td>
<td>Organizational culture</td>
<td>Pre- and postproject assessment used the best practices survey, with questions (closed and open) on retention, recruitment, and organizational culture (defined as continuum from culture of blame to reaction, to consolidation, to</td>
<td>Pre-intervention measures: 40% reported a culture of blame. Comparison between pre- and postintervention measures shows: (a) 40% “high risk” RNs drops to 28% (b) 23–24% respondents reporting “success</td>
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<tr>
<th>Study author(s)</th>
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<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crawford</strong></td>
<td>Nonparticipatory</td>
<td>Individual/job-interface</td>
<td>Psychological distress</td>
<td>Not specified.</td>
<td>No outcomes reported for first intervention. Second intervention outcomes: every employee who took advantage of the consultation broke down and cried during the consultation.</td>
</tr>
<tr>
<td><strong>Jury</strong></td>
<td>Participatory</td>
<td>Job/task level</td>
<td>Quality of work-life, individual and workplace distress and morale, participative decision-making, supervisor support, goal congruence, work demands, role clarity</td>
<td>Survey to measure the quality of work-life, individual distress, individual morale, participative decision-making, supervisor support, workplace morale, professional growth, workplace distress, recognition, goal congruence, peer support, excessive work demands, and role clarity. Specific survey questions not given.</td>
<td>The second cycle of the survey showed harmful behaviors decreased by 4% and respondents reported greater satisfaction in the actions taken upon their reporting of bullying. All other measures of workplace culture improved.</td>
</tr>
<tr>
<td><strong>Meloni and Austin</strong></td>
<td>Participatory</td>
<td>Individual/job-interface</td>
<td>Employee engagement, employee readiness for trust in management and organizational change</td>
<td>Three years (2005, 2007, and 2008) of employee satisfaction surveys with (n = 421, 660, 710 respondents) with five survey questions covered bullying. Other survey questions captured employee engagement: open, positive, optimistic about organization’s future, ready for change, ready to trust management.</td>
<td>All five measures of bullying improved over the three years. The percentage of “engaged” employees rose from 28% in 2005 to 37% in 2008. The number of informal allegations of bullying increased.</td>
</tr>
<tr>
<td><strong>Pate and Beaumont</strong></td>
<td>Nonparticipatory</td>
<td>Legislative/policy</td>
<td>Trust in senior management</td>
<td>Preintervention measures from surveys in 2001, 2002, 2003, and 2004, with response rates of 52–60%. Postmeasures in 2007 with response rates of 63% and 60%.</td>
<td>Drop in percentage of workforce that identified bullying as a problem from over 50% in 2004 to 22% in 2007, a statistically significant difference. No statistical difference across groups by age.</td>
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(continued)
Collette’s study with registered nurses (RNs) in 17 Australian hospitals was another participatory intervention. The “best practices team” consisted of 14 nominated RNs and management representatives. Bullying was not an explicit focus of the intervention, so the outcomes are expressed in terms of recruitment and workplace culture. RNs at “high” risk of leaving the workplace and the profession dropped from 40% to 28% with similar rates of increase in workplace culture indicated by high levels of trust in management, effective communication, and a desirable place to work. Further, the initiative of the best practices team to implement two “bullying advocates” was favorably reported on.

Jury et al.'s reported outcomes are equally impressive. Their large-scale, multi-site intervention granted autonomy to each district and division within the large 68,000-employee organization of Queensland Health to develop and implement their own action plans in response to the workplace culture survey results. Some of the resulting action plans included educating staff about harmful behaviors, increasing staff in decision-making through focus groups and forums, and improving communication processes. At the end of the three-year intervention, all 11 measures of organizational climate, six measures of supervisor support, and three individual psychological health measures showed improvement. Along with developing the commitment amongst the organization’s senior leadership, the authors credit the success of the intervention to involving the staff. “Ensuring staff are provided the opportunity to hear their results and contribute to strategies designed to improve them is a key to success when making a commitment to improving the workplace culture for 68,000 employees” (p. 376).

Meloni and Austin’s intervention, the fourth intervention that we class as participatory, was launched by forming a “Working Group” of employees nominated by their coworkers to “guide the rollout of the chosen strategies” (p. 93), although the details of how those strategies were chosen and by whom is not provided. Following the three-year intervention, all measures of bullying showed improvement: more employees were aware of the available support mechanisms, knew how to report bullying, and trusted that bullying would be appropriately handled if reported. The informal complaints of bullying increased as the authors’ expected because of the greater levels of general awareness of bullying among the employee groups. Similar to Collette and Bourbonnais et al., bullying was not the sole focus of the intervention or the evaluation. The results of the employee engagement dimension of the evaluation are in line with the above evidence of the intervention’s success: the percentage of employees who are openly positive, optimistic, and engaged about the...
organization’s future, ready for change, and to trust management rose from 28% to 37%.43

In contrast to the above-discussed four intervention studies, the nonparticipatory interventions had less striking outcomes. First is Stevens’ case study, initiated by nursing managers in a large Australian hospital. The strongest outcome of the top-down intervention was the marginal decrease in turnover of nursing staff from 28% to 22% within the first year and stayed constant in the three subsequent years. Second is Pate and Beaumont’s intervention with UK’s public sector employees, which focused on employees’ trust in senior management. The bullying intervention was primarily undertaken to restore employees’ confidence in managerial initiatives. Its two-prong strategy consisted of the dismissal of a number of “worst offending” senior employees following a top-down identification of the “offenders,” and implementation of a zero-tolerance bullying policy with compulsory training for all employees. As reported above, over the three-year period, the trust in senior management decreased, rather than to increase.

We resist unilaterally asserting the conclusion of superior outcomes from the participatory interventions due to the brevity and vague reporting in some of the articles. For instance, the only reported outcome from Crawford’s intervention, in which bullied employees were given the opportunity for confidential individualized consultations with the author, himself a psychotherapist, is that all who attended exhibited obvious signs of distress. Likewise, the limited reporting of Chima’s study furnishes no evidence substantiating the claim that the champion role was “positively evaluated by individuals, management, and organizational levels” and the champions themselves were “empowered, confident, and valued by staff across the organization” (p. 65).

Conclusion and recommendations for future research

In this review, we found many authors remarking on the paucity of workplace bullying interventions with published results. Finding only eight articles that meet the scoping criteria of tested, evaluated interventions in health care workplaces, the results of our scoping review substantiate their claims. We offer several plausible explanations for the scarcity. First, organizations are initiating their own research rather than turning to experts and academics to conduct analyses, precipitated by the problems of bullying, dwindling retention rates, and low employee morale coming to the attention of senior management. Another motivation for organizations to take up their own research is the burgeoning legislative changes related to workplace bullying. In addition to establishing complaint-based resolution mechanisms, many of these legislative instruments place responsibility on employers to maintain, as can be reasonably expected, a bullying-free work environment. As a result, human resource departments, unions, and professional associations have been engaged in creating and delivering staff training programs, expanding the scope of existing resolution structures, such as joint management-labor Workplace Occupational Health and Safety Committees, and implementing

![Figure 2. Intervention evaluation metrics.](image-url)
organizational level anti-bullying policies. Although not legislatively required, some workplaces then take note of the effects of these initiatives with “soft” measures and somewhat perfunctory assessment procedures. Significantly, the only Canadian intervention in our reviewed set of eight articles was set in Quebec, which pioneered the legislative protections for targets of workplace bullying by amending the Labour Standards Act in 2004. Legislative changes in other jurisdictions are similarly recent with the exception of Sweden, the first EU country to enact anti-bullying legislation in 1993. The Australian Model Work Health and Safety Act was finalized in 2011 and is yet to be implemented in all jurisdictions. In the UK, the Protection from Harassment Act was passed in 1997, which offers legal redress for workplace bullying. In the United States, the Healthy Workplace Bill has been introduced in some state legislatures but not yet enacted. In light of how recent legislative changes are, it is not surprising that all eight articles were published since 2000.

A second explanation for the scarce literature is the limited valid and reliable measures capturing the effects of interventions. Relatively, organizational research is problematic. Workplaces are complex, dynamic environments not well suited to traditional experimental research designs, arguably the gold standard for social scientific research. Abstract knowledge, in its creation and application in organizational contexts, has been found to be made “sticky” by workplace climate, imperatives, and structures. “Intervention science” takes place within the constraints of organizational life and rigorous, academic evaluations are not workplace priorities. Indeed, they can interfere with the day-to-day operations directed to the organizational mandates such as profit generation or service provision. Notably, only one of the eight reviewed articles used a quasi-experimental design. Perhaps the incompatibility of the workplace setting and the rigors of experimental designs accounts for the short time frame of the Bourbonnais et al.’s study. Indeed, the one year of elapsed time between pre- and postmeasures was the shortest of the reported timeframes: others were 15 months, three years, and four years. The authors in their companion article reveal that the battery of interventions was prematurely assessed after a year because some of the 56 specific interventions developed by the intervention team took longer to implement.

Additional hurdles to using experimental designs in organizational research are the thorny ethical questions, which arise when an intervention is thought to improve the workplace for employees. As Flannery argues, it is difficult to justify using control groups, who by definition are denied the interventions, when, in fact they could mitigate acute organizational dysfunction, individuals’ negative health outcomes, and all their attendant repercussions.

Although the above-delineated limitations to organizational research are appreciable, they are no reason for a moratorium on intervention evaluation research. The impediments to conducting organizational research, however, are reason to reassess our standards for evaluating the outcomes of the research. Perhaps the gold standard of experimental designs should not be unwaveringly applied—a logic that guided the authors in the semantic filtering for this review. The standards regarding reporting of interventions and their results, on the other hand, do need to be firm. Incremental advances in interventions and their evaluations necessitate detailed disclosure of intervention contexts, timeframes (duration, intensity, and frequency), type of data collected, analytical methods, and changes in organizational context coinciding with intervention (e.g., expansion of services, hospital closure). As noted above, details of the interventions and their evaluations in the reviewed studies were sparse.

Bullying in the health care sector, if left unchecked, will inevitably continue to exacerbate the existing recruitment and retention problems, which in turn have long-term economic consequences for health care systems. The published studies in this scoping review, albeit limited in number and details, are evidence of the value of the research to direct both future interventions and their evaluation procedures. The results of this review make a compelling case for interventions based on participatory principles and including employees from all levels of the organization in the co-creation of intervention goals and implementation as well as their evaluation strategies. Increasingly, legislative instruments, collective agreements, and other regulatory mechanisms are being used to address bullying in health care workplaces. To be fully operative, the decision-makers involved in the associated policy development, training programs, and intervention implementation need to be supported with relevant information. The scoping review is one step toward meeting these knowledge needs.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

References


Appendix

Following the elimination of seven duplicates, the remaining 501 were categorized into five different source types: books (26), conference proceedings (10), dissertations (23), journal articles (364), and gray literature (78). All sources were published after 1976, the year the term workplace bullying was introduced in the academic literature.

A progressive series of three filters was then applied. The first, the Global Filter, eliminated 45 sources that were not empirical studies, instead were methodological or theoretical. This first level of filtering was accomplished by reading the titles and when necessary, the abstracts, leaving a total of 456 sources.

The second level of filtering, “Semantics Filter I,” was applied by each of the research team members reading one-third of the 456 abstracts (journal articles and gray literature) and prologues and introductions (in books and dissertations) in order to determine whether an intervention was conducted. This second filtering left four books, no conference proceedings, three dissertations, 46 journal articles, and nine gray literature, for a total of 62 sources. Note the significant drop, from 456 to 62, attained by ruling out sources that did not conduct an intervention.

The third level of filtering, Semantics Filter II, was applied by each of the same three team members reading one-third of the remaining 62 full articles or dissertations and book chapters in order to locate only those sources in which the reported intervention was evaluated. At this final stage, we were left with 14 sources in total to review: three dissertations, one gray literature, one book and nine journal articles. All team members who had participated in the filtering process were responsible for reading and analyzing the remaining 14 sources (see “Charting and organizing results” section).