Prevalence of Workplace Bullying of Trainee Doctors in the Western Cape, South Africa: An Exploratory Descriptive Study

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PLAGIARISM DECLARATION

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Abstract

Objective

The researcher's main objective is to explore the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. The focus of this study is on the subjective perspectives of trainee doctors who identify themselves as victims and/or witnesses of workplace bullying.

Participants

A total of 194 trainee doctors (3rd year students and higher) participated in this research study from medical faculties at two universities in the Western Cape, South Africa.

Study method

A quantitative non-experimental ex post facto design was used for this research. Also, a non-probability convenience sampling technique was used to collect data. An invitation with the self-report questionnaire has been sent electronically to participants which include measuring instruments such as the Negative Acts Questionnaire (NAQ) and the Work Harassment Scale (WHS). Data was then analysed by means of descriptive statistics.

Main finding

Although a high incidence of workplace bullying has not been reported in this study, the research results still indicate the occurrence of workplace bullying of trainee doctors in the Western Cape province of South Africa.

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Conclusions

This research created awareness, contributed to the body of knowledge, and provides a basis for future researchers to elaborate on and further this study. It is important to take into consideration that the study could not determine the causes and/or evidence for the occurrence of the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. Recommendations to medical faculties and hospital management are discussed. Strengths and limitations of this study should also be taken into consideration when utilising the results of this study.

Keywords: workplace bullying, trainee doctors, prevalence, South Africa, Western Cape

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Prevalence of Workplace Bullying of Trainee Doctors in the Western Cape, South Africa: An Exploratory Descriptive Study

Workplace bullying in the medical field, specifically of trainee doctors is a global occurrence. This statement is evident based on various international findings that will be discussed. Llewellyn et al. (2019), found that half of the trainee doctors in their research study reported to be bullied whereas 15-19% reported sexual harassment. The respondents in this study are trainee doctors in their first- or second year of medical training in New South Wales (NSW) and the Australian Capital Territory (ACT). Llewellyn et al. also states that respondents who experienced bullying or sexual harassment, reported that incidents occurred less than monthly. However, approximately 15% of respondents in their study reported more frequent incidents (monthly, weekly, daily). This also supports the study of Askew et al. (2012) who found that 25% of participating doctors in the Australian medical workforce reported that they have experienced continuous bullying behaviours in the last 12 months.

Furthermore, a high prevalence of 20% to 50% of persistent bullying has been found among residents in Saudi Arabia where second-year trainee doctors are more vulnerable to bullying (Alahmari et al., 2020). Moreover, in the United States graduate medical education programmes, 48% of residents reported being bullied in the previous year and 66% of trainees experienced at least one type of bullying (Chadaga et al., 2016). In addition, Hussain and Rahim (2014) conducted a study on postgraduate medical trainees in tertiary care hospitals in Peshawar, Pakistan. They have found that 89% of all the participants were victimised or victims of some type of bullying.

What is more, it seems that workplace bullying is more likely to occur in the surgical environment. This is supported by the study conducted by Iqbal et al. (2020) who found that 68% of their respondents in operational theatres indicated that they were bullied and 47.6%

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indicated they were frequently bullied. What they also found is, it is more likely for women to experience bullying in comparison to men (83% versus 58%). Women tend to experience bullying more frequently than men (51% versus 18%). This finding is consistent with Ling et al. (2016) who found that trainees and females experience significantly high levels of bullying; the prevalence rate for overall trainees is 64% and 57% for females. All these studies were conducted in a variety of countries, which indicate how common workplace bullying of trainee doctors is. Therefore, one needs to investigate the prevalence of workplace bullying of trainee doctors in the Western Cape province of South Africa.

Problem statement

Limited studies have been found about workplace bullying, specifically of trainee doctors in the medical field in South Africa, which initiated the researcher's interest in this topic. However, a recent study has been conducted by Fakroodeen (2020) on final year medical students at the University of Cape Town in South Africa. This researcher found a high prevalence of 86.8% respondents who reported to be bullied, whereas 63.2% experienced bullying a few times or frequently. Other research has also been conducted by Erasmus (2012) on the unreasonable hours that medical interns need to work in South Africa, this will be discussed in more detail later in this study.

Regarding workplace bullying in general, Cunniff and Mostert (2012) found that 31.1% of workplace bullying acts have been reported in South Africa across different geographies and sectors such as financial, mining, government, manufacturing, academic and call centres. Furthermore, Kalamdien (2013) investigated the nature and prevalence of workplace bullying in the Western Cape of South Africa in two distinct workplaces, namely Power Group and the South African National Defence Force (SANDF). He found that between 30% and 50% of respondents in both workplaces reported that they have been bullied. This study found higher prevalence of workplace bullying at the SANDF which could possibly be due to the existing

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hierarchical bureaucracy culture. This can be related to the medical field where research has indicated that academic hospitals tend to be hierarchical and bureaucratic in nature (Leisy & Ahmad, 2016). This results in the existence of power imbalances in the medical field which will be further discussed in the literature review. Moreover, Visagie and Havenga (2012) found with the use of a self-report method that 27% of employees reported being bullied over the previous 6 months in the South African mining industry. Based on these studies, the issue of workplace bullying is a serious concern in many industries. Apart from recent research conducted by Fakroodeen (2020), no studies which specifically relate to workplace bullying of trainee doctors in the medical profession have been found.

What also precipitated the researcher's interest, was a video recording that has been released by a trainee doctor in South Africa, namely Yumna Moosa. She released a YouTube video in 2016 that went viral on social media about being sexual harassed by her supervisor, being bullied and her experience of racism as well as sexism in the work environment (Moosa, 2016). This video consists of Moosa sharing her personal experience of workplace bullying by her senior supervisor during her internship. She recorded interviews between her and management when she reported these incidents. The recordings indicated how her complaints were discarded and how the behaviour of the supervisor was not perceived as a problem. Although, this video is based on an individual's subjective experience, it can still be considered as a concerning matter. Further investigation is necessary should sexual harassment, sexism, racism, and bullying possibly be tolerated and normalised in a work environment.

Based on the meetings that Moosa recorded, she was instructed to throw away her medical internship logbook which contained evidence of her two-year supervised medical work and feedback about harassment. However, she did not throw this away, which resulted in Moosa not being signed off, based on reasons such as her clinical performance not being satisfactory, and her mismanagement of patients. These recordings illustrate clear factors of bullying since she is

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being ‘punished’ by senior management for not doing as she was instructed to do which negatively impacted her future career prospects. Based on her unfortunate experience, Moosa indicates that she no longer wants to be a doctor, which is very concerning. This requires much attention since many other trainee doctors might also experience this, which could result in the decline of much needed medical doctors in South Africa. This is evident in the Econex (2015) report, which indicated a shortage of medical doctors in South Africa. This report states that during the Hospital Association of South Africa (HASA) conference in 2014, Econex revealed that South Africa only had 60 doctors per 100 000 citizens in 2013, in comparison with the world average which was 152 doctors per 100 000 citizens. Therefore, this raises a concern whether workplace bullying could contribute to the shortage of doctors.

This study is much needed based on what has been discussed thus far. Industrial psychologists and human resource practitioners should intervene if workplace bullying occurs in clinics or hospitals or academic environments. The reason being is that this could have negative consequences for trainee doctors, clinics or hospitals or academic environments as an organisation, as well as for society. On the individual level, research indicates that psychological distress and mental health problems are highly associated with workplace bullying. This is supported by Fakroodeen (2020) who found an association between final year medical students who experienced bullying, and an increase in psychological distress. Other researchers found that workplace bullying is strongly related to symptoms of post-traumatic stress and mental health problems (Nielsen & Einarsen, 2012). Based on this, one can argue that workplace bullying negatively affects the emotional and physical well-being of trainee doctors. This would then spill over to the organisation and manifest itself as poor performance, higher incidence of intentions to leave, burnout, low levels of job satisfaction, low organisational commitment and low levels of motivation and morale. Employees are more likely to engage in counterproductive behaviour (Dhar, 2012 & Nielsen & Einarsen, 2012). This would then result in high costs for the

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hospital or clinic due to unproductive and demotivated medical staff, damages caused by counterproductive behaviour and the replacement and training of new doctors (Dhar, 2012).

What is more, workplace bullying also results in medical errors, poor quality patient care and a threat to patient safety and patient mortality (Wild et al., 2015). The reason being is that bullying cause trainees to not feeling competent in their abilities, they lose confidence in themselves and they cannot communicate effectively or ask for assistance from superiors when needed (Wild et al., 2015). This is very concerning because workplace bullying not only poses a threat to the well-being of trainee doctors and the clinics or hospitals or academic environments as an organisation, but also for patients' safety and care. It is therefore imperative for industrial psychologists and human resource practitioners to intervene to provide a safe and healthy work environment which is required according to section 8 of the Occupational Health and Safety Act legislation (Boshoff, 2020). This act states that the employer must, where reasonably practical provides and maintain a healthy and safe environment to employees without risks. Additionally, medical errors and litigation cases can result in high costs for the hospital due to poor quality patient care and safety (Leisy & Ahmad, 2016).

On the societal level, one can argue that high intentions to leave could also mean that trainee doctors decide not to practice anymore, which could have an enormous impact on society due to the loss of great potential medical doctors and the increase of the unemployment rate. In addition, workplace bullying culture is perceived as part of the medical field which could also persuade doctors to rather leave the profession (Scott et al., 2015). Therefore, based on what has been discussed thus far, the researcher argues that workplace bullying of trainee doctors in South Africa has not been sufficiently addressed based on limited research being found on this topic specifically. Due to time and cost constraints, the researcher will not be able to conduct a study that can be generalised to South Africa. However, the researcher will conduct an empirical study to determine the prevalence of workplace bullying among trainee doctors in the Western

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Cape province of South Africa. This study could inspire future researchers to investigate prevalence of workplace bullying in other provinces of South Africa.

Aims and Objectives

The researcher's main aim is to explore the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. The focus of this study is on the subjective perspectives of trainee doctors who identify themselves as victims and/or witnesses of workplace bullying and how they perceive to be affected by this. This study aims to gain insight on the prevalence of workplace bullying of trainee doctors in the Western Cape and strives to contribute to the body of knowledge, and to inspire future researchers to elaborate on the findings of this study. This inspired the following research questions:

- Investigate how bullying affect victims on the work, physical, emotional, and affective domains.
- Investigate whether participants perceive themselves to be overworked.
- Explore what the most frequent experienced negative acts and degrading and oppressing behaviours are.
- Investigate possible recommendations for the medical faculties and hospital and/or clinic management to monitor and manage bullying of trainee doctors rationally and purposefully.
- Investigate research conducted on workplace bullying of trainee doctors in the Western Cape, South Africa.

Based on the research questions, the following research objectives have been formulated:

- Gain insight on how bullying affect victims on the work, physical, emotional, and affective domains.
- Gain awareness of whether participants perceive themselves to be overworked.

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- Determine the most frequent experienced negative acts and the most degrading and oppressing behaviours.
- Make recommendations to the medical faculties and hospital management to monitor and manage bullying of trainee doctors rationally and purposefully.
- Contribute to the body of knowledge of workplace bullying of trainee doctors in the Western Cape, South Africa.

Review of relevant literature

Definitions of workplace bullying

Many terms in academic research have been used interchangeable to define workplace bullying. There is no universal agreed upon term since many different definitions have been provided by different researchers as seen in Table 1. Workplace bullying is best defined by Kalamdien (2013) where he refers to workplace bullying as situations where one or more victims experience persistent and repetitive harmful, negative, or hostile acts by one or a group of individuals in the workplace over a period of at least six months. Once-off isolated incidents or conflicts that arise between two equal powerful individuals are excluded. He also states that the victim feels helpless and defenceless; the intention of the perpetrator is considered insignificant. This definition will be used for the purpose of this research.

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Table 1

Different terms and definitions by different researchers

Reference	Term	Definition
Brodsky (1976)	Harassment	Repeated and persistent attempts by a person to torment, wear down, frustrate, or get a reaction from another person; it is treatment which persistently provokes, pressures, frightens, intimidates or otherwise causes discomfort in another person.
Thylefors (1987)	Scapegoating	One or more persons who during a period of time are exposed to repeated, negative actions from one or more other individuals.
Matthiesen, Raknes & Rro¨ kkum (1989)	Mobbing	One or more person's repeated and enduring negative reactions and conduct targeted at one or more persons of their work group.
Leymann (1990)	Mobbing/ Psychological terror	Hostile and unethical communication that is directed in a systematic way by one or more persons, mainly towards one targeted individual.
Kile (1990a)	Health endangering leadership	Continuous humiliating and harassing acts of long duration conducted by a superior and expressed overtly or covertly.
Wilson (1991)	Workplace trauma	The actual disintegration of an employee's Fundamental self, resulting from an employer's or supervisor's perceived or real continual and deliberate malicious treatment.
Ashforth (1994)	Petty tyranny	A leader who lords his power over others through arbitrariness and self aggrandizement, the belittling of subordinates, showing lack of consideration, using a forcing style of conflict resolution,

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Table 1 (continued)

Different terms and definitions by different researchers

Reference	Term	Definition
		discoursing initiative and the use of non-contingent punishment.
Vartia (1993)	Harassment	Situations where a person is exposed repeatedly and over time to negative actions on the part of one or more persons.
Bjo¨rkqvist, O¨ sterman, & Hjelt-Ba¨ ck (1994)	Harassment	Repeated activities, with the aim of bringing mental (but sometimes also physical) pain, and directed towards one or more individuals who, for one reason or another, is not able to defend themselves.
Adams (1992b)	Bullying	Persistent criticism and personal abuse in Public or private, which humiliates a person.

Note. Adapted from "Harassment and bullying at work: A review of the Scandinavian approach," by S. Einarsen, 2000, *Aggression and Violent Behavior,* 5(4), p.382. Copyright 2000 by Elsevier Science Ltd.

Although, there is no agreed upon definition among researchers, these different terms all highlight the same themes such as power imbalances, aggression, duration/frequency, and intention of the perpetrator to cause harm. (Branch & Murray, 2015; Jacobson, et al., 2014; Samnani & Singh, 2012). The following section will focus specifically on these themes to define workplace bullying more holistically.

Firstly, power imbalance refers to the formal power structure of an organisation. In other words, workplace bullying often occurs in an organisation with a rigid hierarchy structure where it is highly likely that the perpetrator would be in a high and powerful position whereas the victim

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would usually be in the lower rank. This is supported by Huang et al. (2018) since they have found that the medical field tends to be a hierarchical and highly competitive profession. They also indicate that an apprenticeship-style training approach is what causes trainee doctors to be mistreated. Moreover, Jacobson et al. (2014) conducted a study to compare different bullying behaviours across cultural dimensions. These authors focused specifically on three cultural dimensions, namely assertiveness, in-group collectivism and power-distance. Power distance is like power imbalance and is defined as "the degree to which members of an organisation and society encourage and reward unequal distribution of power with greater power at higher levels" (Jacobson et al., 2014, p. 58). They claim that organisations that have a high level of power distance would increase power imbalances which encourages workplace bullying. Based on these findings, one can argue that this can be inferred to the medical field in South Africa as well. A work environment that is hierarchical and bureaucratic, tends to support and respect those in higher positions more in comparison with those in lower ranks. Therefore, it is highly likely that senior superiors can abuse their authoritative power since junior trainee doctors are dependent on them for career advancement or to be signed off to become a professional medical doctor.

Secondly, aggression is perceived as an extreme form of assertiveness that is unwanted by the individual (Jacobson et al., 2014). These authors suggest that organisations that have a highly assertive culture tend to display aggressive behaviour, which encourages workplace bullying behaviour. Furthermore, Bradley (2015) found that 31% of doctors experience rude, dismissive and aggressive (RDA) communication on a daily or weekly basis to which junior doctors are exposed. What they have also found is that culture and hierarchy is one of the factors that contributes to RDA communication, which causes emotional distress, substance abuse, and demotivated doctors. Based on this, one can argue that RDA communication stems from a highly assertive culture that could also encourage aggression and workplace bullying

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behaviour. This could contribute to a vicious cycle and result in negative consequences. Examples of negative consequences on the individual, organisational and societal level has been discussed previously in terms of why the prevalence of workplace bullying should be a concern for industrial psychologists and human resource practitioners.

Thirdly, frequency refers to the number of times that the workplace bullying occurs whereas duration refers to how long the behaviour is experienced (Samnani & Singh, 2012). There is no agreed upon criterion among researchers for the frequency or duration for workplace bullying. It has been suggested by Branch and Murray (2015) that workplace bullying occurs when an individual experiences several negative behaviours repeatedly over a period of about six months. Additionally, Branch and Murray (2015) suggest that a single episode of negative behaviour is not considered to be bullying unless that singular action is continuous and poses a threat for the receiver. Based on these findings, the researcher argues that this would depend on how the victim perceives and defines workplace bullying. One can argue that the severity and occurrence of bullying behaviour does not necessarily depend on the duration or frequency of these negative acts. Instead, it depends on the subjective perspectives of the victims, which is explored in this study with the use of self-reported questionnaires.

Lastly, the intention of the perpetrator refers to whether the perpetrator's actions was intended to cause harm. Kalamdien (2013) states that the perpetrator might be unaware of the negative affects his actions and behaviour might have on others. He explains that it is more important to focus on whether the behaviour is harmful and unwelcomed by the target. One can agree with this since the perpetrator might perceive his own behaviour as acceptable since this has been institutionalised as the modus operandi. In other words, the perpetrators' behaviour might never be addressed which becomes part of the culture. Furthermore, the intention of the perpetrator also depends on the receiver's perception in terms of what he or she regards as

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bullying. Therefore, this research focused on how the receiver perceives negative behaviour from others that is harmful and unwelcome.

Types of bullying behaviours

It is important to keep in mind that workplace bullying comes in different forms. In the integrative review of Bartlett and Bartlett (2011), they have identified work related, personal, and physical/threatening categories of workplace bullying which will be discussed. In the work-related category, they have found workloads, work processes, evaluation, and advancement behaviour. These behaviours have been further elaborated in Table 2. The main goal in this category is where the perpetrator prevents the victim from career advancement. One can argue that this type of behaviour could occur in the medical field, especially in a hospital that tolerates workplace bullying. For example, in the video recording of Moosa (2016), senior management have prevented her from career advancement by refusing to sign her off to practice as a medical doctor based on unfair and untrue criticism of her performance. This is supported by Samsudin (2020b) who found procedural, interactional, and distributive injustice by superiors to increase the likelihood of workplace bullying since trainee doctors might feel mistreated or victimised.

Table 2

Work-related Bullying Behaviours

Work-related		
Workload	**Work Process**	**Evaluation and Advancement**
Work Overload	Shifting opinions	Excessive Monitoring
Removing Responsibility	Overruling Decisions	Judging work Wrongly
Delegation of Menial Tasks	Flaunting Status/Power	Unfair Criticism
Refusing Leave	Professional Status Attack	Blocking Promotion
Unrealistic Goals	Controlling Resources	
Setting up to Fail	Withholding Information	

Note. Adapted from “Workplace bullying: An integrative literature review,” by Bartlett and M.E. Bartlett, 2011, *Advances in Developing Human Resources*, 13(1), p.73 Copyright 2011 by SAGE Publications.

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In the personal category, they have found indirect and direct types of bullying behaviour. Physical and threatening behaviour occur mostly in the direct category. These behaviours have been further elaborated in Table 3. Based on this, one can argue that personal types of bullying also occur in the medical field. In the video recording of Moosa (2016), the following behaviours illustrated examples of personal bullying: Firstly, senior management belittled her by telling her that she is acting like a 'spoilt brat' and 'she must grow up'. Secondly, senior management told Moosa that if someone does not want to drink with them during lunch time then no department would want them. This is a form of isolation or exclusion since they do not take into consideration that she is Muslim and prefers not to drink. Lastly, they have also threatened and manipulated her by instructing her to throw her logbook away if she wants to be employed by future employers. In another study where the sample consisted of perioperative nurses, surgical technologists, and unlicensed perioperative personnel, indicated that being ignored is the most frequent negative act occurring (Chipps et al., 2013). This study also found that 27% of the respondents indicated that yelling is the most disruptive behaviour in the Operating Room (OR). All these behaviours are clear examples of personal bullying.

Table 3

Personal Direct and Indirect Bullying Behaviours

Personal	
Direct	**Indirect**
Verbal Attack / Harassment	Isolation
Belittling Remarks	Ignoring
Yelling	Excluding
Interrupting other	No communication
Persistent Criticism	Gossip
Intentionally demeaning	Lies
Humiliation	False Accusations
Personal Jokes / undermining	

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Table 3 (continued)

Personal Direct and Indirect Bullying Behaviours

Personal	
Direct	**Indirect**
Negative Eye Contact / Staring	
Intimidation	
Manipulation	
Threats	

Note. Adapted from "Workplace bullying: An integrative literature review," by J.E Bartlett and M.E. Bartlett, 2011, *Advances in Developing Human Resources*, 13(1), p.73-75. Copyright 2011 by SAGE Publications.

Witnessing workplace bullying behaviour

Research indicates that individuals who merely witness bullying behaviour in the workplace are also negatively affected such as those being targeted. This is supported by Sims and Sun (2012), who found that those that have witnessed bullying, reported increases in symptoms of emotional and physical strain, however it is less severe than those being directly targeted. Furthermore, it has been found that the wellbeing of witnesses of workplace bullying are more likely to be affected if they are low in the trait of optimism, if they lack social support from their co-workers or if their supervisors do not have a supportive leadership style (Sprigg et al., 2018). Based on this, one can suggest that witnessing bullying behaviours in the workplace could also negatively affect trainee doctors on the individual level. In other words, if they observe their colleagues being mistreated by their supervisors, it will have a negative impact on them as well.

Other researchers, Salin and Notelaers (2018) found that witnesses of workplace bullying behaviour have reported lower job satisfaction, commitment, and higher turnover intentions. They have also found that witnessing workplace bulling behaviour is seen as a violation of the psychological contract. In other words, witnesses feel betrayed or upset with the organisation and not only with the perpetrator. This supports the aforementioned statement that workplace

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bullying not only affects individuals on the individual level, but this spills over to the organisation in terms of lower job satisfaction and commitment and higher turnover intentions. This is also supported by Sims and Sun (2012) who found the exact same outcomes. Additionally, they have also found that witnessing bullying behaviour results in negative workplace attitudes. Therefore, one can argue that a workplace bullying culture in the workplace not only affects victims but also witnesses of workplace bullying. These individuals perceive that the organisation and management provide no support or safety, which could result in other counterproductive behaviour. Therefore, respondents who identified themselves as witnesses are included in this study.

The risk factors and outcomes of workplace bullying of trainee doctors on individual, organisational and societal levels

For the purposes of this research, one must be aware of what the possible risk factors and outcomes are for workplace bullying toward trainee doctors on individual, organisational and societal levels in order to have a holistic understanding.

Risk factors on individual level

Demographics such as age, gender, race, culture, hours worked, and perceived work overload will be explored to determine whether there are specific risk factors for individuals to be targets of bullying.

Age

In terms of age, international studies have reported that medical trainees younger than 30 years, specifically 21-29-year-old are more likely to experience workplace bullying (Chadaga et al., 2016). This is also consistent in the Western Cape province of South Africa. For instance, in the study of Cunniff and Mostert, (2012), it has been found that younger employees are more

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likely to experience workplace bullying. Based on these findings, one can argue that this could be because young individuals who enter the workplace have low job and pay status which makes them vulnerable targets of bullying. Furthermore, as discussed in the section defining workplace bullying, due to the hierarchy that exists in the medical field, it results in trainee doctors having less power since they are dependent on seniors for teaching and career advancement. However, it has also been argued that young trainee doctors are incompetent or misguided in handling conflict at work and may perceive any type of negative behaviour as bullying (Hills et al., 2012). One can also suggest that senior doctors are more respected than trainee doctors which deems it acceptable for them to treat trainee doctors harshly. Therefore, it has been suggested by researchers that young trainee doctors between the ages of 21-29 are more likely to experience workplace bullying since this age group tends to be more vulnerable. Therefore, the researcher explored whether this age group of trainee doctors is consistent in this study.

Gender

In terms of gender, it has been found consistently in international studies that female trainees experience more bullying behaviour than male trainees (Aykut et al., 2016, Chadaga et al., 2016; Fnais et al, 2013**;** Hills et al., 2012, Ling et al., 2016, Llewellyn et al., 2019). This is also supported by Colenbrander et al. (2020) who found that female trainee doctors experience the medical field to be male-centric as they are given limited opportunities, felt ignored by male supervisors or felt uncomfortable as doctors in general are mostly referred to as “him” or “he”. In a recent study conducted by Fakroodeen (2020) in the Western Cape province of South Africa, the same finding has been made where black female medical students are more likely to experience workplace bullying. Furthermore, Chadaga et al. (2016) found that the medical field continues to be male dominant. However, it has been found in the Western Cape province of

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South Africa that men are more likely to be bullied in different sections (Cunniff & Mostert, 2012).

Other researchers found no differences in terms of bullying observed between sexes, age groups, country of medical qualification or employment sector (Askew et al. 2012)**.** This finding is also consistent with Kalamdien (2013) in the Western Cape province of South Africa**,** where he found no specific difference in workplace bullying between men and women. Therefore, based on the different findings, one can argue that gender does not necessarily play a role in determining who is more vulnerable in terms of being bullied since it is not consistent in research studies. The researcher argues that the type of work environment and culture could play a bigger role in workplace bullying.

Race groups

In terms of racial differences, Chadaga et al. (2016) found that non-white trainee doctors were more likely to report workplace bullying than white trainee doctors. They found that non-white trainees tend to be more vulnerable when it comes to bullying due to discrimination and cultural differences. As mentioned previously, this is also consistent in the Western Cape province of South Africa where it has recently been found that black female medical students are more likely to experience workplace bullying (Fakroodeen, 2020). This has also been found in the study of Cunniff and Mostert (2012) where black employees' experience more workplace bullying in comparison to white, coloured, and Indian employees. In contrast, no differences have been found by Kalamdien (2013) between different racial groups. His study was conducted in the Western Cape; therefore, one can argue that findings might differ in provinces of South Africa. Diversity is considered a very important aspect in organisations since South Africa is known as a multicultural rainbow nation.

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Culture

Culture is an important social concept that needs to be taken into consideration when one wants to understand workplace bullying. The reason for this is that medical institutions consist of a variety of individuals and each one brings their own cultural background to the workplace (Jacobson et al., 2014). What this means is that different individuals have different interpretations and perceptions of workplace bullying. For example, it has been found by Imran, et al. (2010) that many junior doctors in Pakistan experience workplace bullying. However, they state that these individuals are taught from a very young age to obey authority figures without question, which becomes internalised in adulthood. What this means is that cultural values of trainee doctors can explain the acceptance or resistance of bullying behaviour in the workplace. However, for the purpose of this research, the main concern is the acceptance of bullying behaviour since this can become normalised in the culture of an organisation. This is supported by Samnani (2013), where he proposed that employees reconstruct or reinstruct bullying behaviours in the workplace based on Festinger's (1957) consistency theory. This theory explains that when one experience inconsistency between one's own values and observed behaviours, one tends to experience discomfort. In other words, when one observes mistreatment in the workplace, one can reconstruct that behaviour and rationalise it as normal behaviour to minimise discomfort. Based on this, one can argue that workplace bullying is very subjective because it is based on the perspective and the cultural values of an individual, which influences how a victim of bullying interprets negative behaviours. Future researchers can use Festinger's consistency theory to determine whether trainee doctors reconstruct or reinstruct bullying behaviours from their supervisors and how this contributes to the institutionalisation of workplace bullying behaviour.

What is more, workplace bullying is an interpersonal occurrence; therefore, the two relational cultural dimensions known as power distance and collectivism can also explain the acceptance

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or resistance of workplace bullying (Samnani, 2013). These two dimensions are part of Hofstede's (2011) cultural dimensions which can be used to differentiate national values, beliefs, and attitudes. This will be briefly explained according to Hofstede (2011). Power distance refers to the extent to which individuals in less powerful positions accept and expect that power be distributed unequally in an organisation. Collectivism refers to large in-groups that are interdependent and loyalty is perceived as of utmost importance. Samnani (2013) has found that employees high in collectivism and power distance are less likely to be resistant towards bullying in the early stages. For instance, he explains that a collective individual would rationalise bullying behaviour from a supervisor as being the best interest for the performance of an organisation. In contrast, an individualist individual would not allow bullying behaviour at his or her own expense since he or she takes care of themselves (Samnani, 2013). In other words, these two relational dimensions would play a huge role in terms of whether trainee doctors would tolerate bullying behaviours in the work environment. Therefore, future researchers can use Hofstede's (2011) relational dimensions of power distance and collectivism to determine whether this is consistent in the medical field, specifically in the Western Cape province of South Africa.

Hours Worked and Perceived Work Overload

Hussain and Rahim (2014) conducted a study to determine the prevalence of bullying among postgraduate medical trainees in tertiary care hospitals in Peshawar. They have found that more than 80% of participants have indicated that they perceive their workload and their current working schedule affecting them severely. Many of these participants feel that this makes their work environment more stressful since there is no standardisation of their work hours and some doctors are forced to work beyond their competence. In the Western Cape province of South Africa, Erasmus (2012) reported that medical interns work up to 200 hours of overtime per month due to the shortage of medical staff in South Africa. It has been found that in the case of

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trainee doctors that work overtime of 80 hours, it was unpaid and involuntarily. Erasmus (2012) states that if these trainee doctors would refuse to work these long hours, they fear that they would not be signed off to practice as doctors. This is very concerning since these acts can be perceived as forms of bullying because of forced labour and the degrading treatment of interns.

Therefore, one should take the Basic Conditions of Employment Act (BCEA) into consideration with regards to working time and overtime (Erasmus & Du Toit, 2020). Section 9 of the BCEA states the maximum normal working time for an employee below the threshold is 45 hours per week. What this means is that the employee can work a maximum of nine hours in any day if the employee works for five days or fewer in a week and eight hours in any day if the employee works on more than five days in a week. Furthermore, Erasmus and Du Toit state that the maximum permissible overtime as per section 10 of the BCEA is 10 hours in a 7-day week. Therefore, the researcher asked participants to indicate whether they feel that they work longer hours than required in clinical rotations or any time spent in the wards of hospitals or clinic and whether they perceive it as reasonable. Similar question has been posed to participants in terms of overtime work; whether they are required to work overtime and if they feel it is reasonable. The reason for investigating trainee doctors' perception of hours and overtime worked could influence doctors in feeling overworked which could have negative results on individual, organisational and societal levels. For example, feeling overworked can result in mental strain such as burnout or depression as well as higher intentions to leave the profession, low levels of job satisfaction and organisational commitment. This could then result in trainee doctors no longer wanting to pursue a medical career which leads to a shortage of medical staff. Therefore, this study investigated whether there is a link between working long hours and perceived workload and how it possibly can affect the individual, the organisation and society.

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Outcomes on individual level

Bartlett and Bartlett (2011) found in their integrative research study that workplace bullying can have dire consequences on an individual in their work, physical, emotional, and affective domains as seen in Table 4. Many literature studies of workplace bullying indicate that these four domains are important to investigate when doing research on workplace bullying. These four outcomes have been explored in this research to determine whether trainee doctors do experience any of these symptoms in those categories. However, research indicates that the emotional and affective domains are more likely to occur on individual outcomes which will be further discussed.

Table 4

Individual Impacts of Workplace Bullying

Individual impacts of workplace bullying			
Work	Physical	Emotional	Affective
Absenteeism	Chronic Disease	Psychological health/Psychological effects	Anxiety
Burnout	Headaches	PTSD	Concentration
Career Impact	Health decrease	Suicide	Easily upset/tenseness
Concentration Loss	Increase smoking, alcohol and drug use/abuse		Fear
Errors in Workplace	Medical costs		Humiliation
Income Loss	Physical Health		Impatience
Intolerance of Criticism	Sick time		Isolation feeling
Lower job Satisfaction	Sleep disruption		Motivation
Loss of time due to worrying	Sleep-inducing drugs		Powerlessness
Morale			Sadness
Performance/ Productivity			Self-confidence

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Table 4 (continued)

Individual Impacts of Workplace Bullying

Individual impacts of workplace bullying			
Work	Physical	Emotional	Affective
Quit/Thinking of quitting			Social interactions outside of work
Social interactions inside work			Stress
Work hours			
Commitment Lower			

Note. Adapted from "Workplace bullying: An integrative literature review," by J.E Bartlett and M.E. Bartlett, 2011, *Advances in Developing Human Resources*, 13(1), p.77 Copyright 2011 by SAGE Publications.

As discussed previously, the affective and emotional domains are most severely affected in individuals. This is supported by international research which indicates that workplace bullying has severe psychological impacts on victims. Askew et al. (2012) found an association between those who experienced bullying and poor mental health. This is also consistent with the finding by Nielsen and Einarsen (2012) who found that bullying is most strongly related to symptoms of post-traumatic stress and mental health problems. What they have also found is that those suffering already from mental health problems are also more likely to experience workplace bullying. However, they have found no association between targets' exposure to bullying and sleep difficulties as well as core self-evaluations. Based on this, one can argue that individuals might not be consciously aware of the fact that they are being bullied in the workplace because they are not educated on this matter nor know what the processes are in dealing with this type of behaviours.

As discussed previously, the medical field is known for poor mental health and suicide ideation among medical students (Slavin, 2016; Ward & Outram, 2016). This is supported by Rotenstein et al. (2016) who reported 27.2% prevalence of depression or depressive symptoms

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and 11% of suicidal ideation among medical students. This indicates that trainee doctors are at high risk for depression and suicide ideation which can be caused or worsened by workplace bullying. A study was conducted to examine the longitudinal relationships between workplace bullying and depressive symptoms among junior physicians across a one-year follow-up and a longer follow-up period (Loerbroks et al., 2015). They found that depressive symptoms increased after one year and after three years. However, they also found that those suffering from depressive symptoms have reported workplace bullying which reached significance across three years of follow-ups. Furthermore, anxiety, not looking forward to going to work and constantly feeling tired are some of the psychological effects of workplace bullying of nurses in the Western Cape province of South Africa (Du Toit, 2013). Based on these studies, it seems that workplace bullying severely affect the target more on the emotional and affective domains. This is explored in the study to indicate whether trainee doctors are more likely to report symptoms in the affective and emotional domains as indicated in table 4.

Risk factors on organisational level

Samnani and Singh (2012) found in their systematic review study that there are three major risk factors on organisational level namely, leadership and management style, organisational culture, and organisational policies. These major risk factors will be discussed in this section based on studies conducted by different researchers.

Leadership and management style

Both studies of Gillam (2011), Warren and Carnall (2011) will be discussed in this section regarding medical leadership. Medical leadership and soft skills development are very important to deliver high-quality healthcare; however, the focus still remains on clinical traditional medical training. Unfortunately, this way of teaching sustains a military and hierarchy work environment in the medical field. This results in a workplace bullying culture since power imbalances are

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being facilitated. Therefore, an attempt was made by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement to create a Medical Leadership Competency Framework (Gillam, 2011). The main goal of this framework is to describe the competencies doctors require to enable them in delivering high-quality health services (Gillam, 2011). These competencies include setting direction, demonstrating personal qualities, working with others, managing, and improving services (Gillam, 2011).

Moreover, Warren and Carnall (2011) emphasised that leadership development is important in delivering excellent health services in changing the technological driven world of work. They have suggested that when medical doctors move into strategic roles or lead organisations, they need to have good leadership skills. These authors indicate that the type of leadership skills that doctors require are the following: creating and communicating their vision, setting clear direction, service redesign and healthcare improvement, effective negotiation, awareness of both self and others, working collaboratively and networking. In other words, doctors need to be equipped with good people skills and not solely technical skills. Based on these studies of Warren and Carnall (2011) and Gillam (2011), one can agree that good leadership is important not only for health service delivery but also in preventing workplace bullying. What makes an excellent doctor is not the extensive clinical skills he or she possess, but the good leadership skills he or she has. This is supported by Samsudin et al. (2020b) who found that production and achievement-oriented leadership styles could prevent workplace bullying. This is due to the certainty and purposefulness these types of leadership style might provide to trainee doctors. They have also found that organisational support from superiors could also prevent workplace bullying as it is unlikely for trainee doctors to fear being victimised. Therefore, one can suggest that future research can be conducted to determine the perceived effective leadership style of leaders in a hospital, clinical and/or academic environment.

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Organisational culture

Organisational culture is defined as “how things are being done” in an organisation which distinguishes different organisations from one another (Robbins & Judge, 2015). Therefore, it is important to acknowledge that organisational culture plays an important role in promoting workplace bullying. Additionally, organisational culture creates a climate which refers to guidelines on what is acceptable behaviour which influences employees to share the same perception (Robbins & Judge, 2015). Based on this, one can argue that when negative behaviour such as bullying is tolerated in the workplace, it tends to be institutionalised which contributes to the never-ending vicious cycle. This has also been discussed in the section regarding organisational culture, in terms of individuals accepting bullying behaviours by rationalising it as normal. This can facilitate a workplace bullying culture since it becomes a norm.

What is more, poor mental health and high suicide ideation has been reported among medical students and doctors which raises a concern for the current culture in the medical field (Slavin, 2016; Ward & Outram, 2016). Therefore, the following points have been raised by various researchers in how a toxic medicine culture is formulated: Firstly, there is a notion that medical students must be “toughened” up for the profession. According to Scott et al. (2015), this is done by using the teaching methods of humiliation and degradation which is perceived as a traditional practice in medicine culture. In addition, they have found in their study that 30%-50% of medical students perceive teaching by humiliation as an effective learning tool. In other words, these medical students rationalise mistreatment as an effective learning tool in becoming the “best doctor”. This is also supported by the research study by Colenbrander et al. (2020) who found that trainee doctors believe that one needs to be committed to self-sacrifice, resilience, and deference to tolerate hierarchy, verbal abuse, sexist and racist behaviours during training in order to become a qualified doctor.

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These findings are quite concerning because bullying behaviour is rationalised as a tactic to improve the performance or behaviour of trainee doctors to become qualified medical practitioners which are considered as the norm and/or characteristics of the medical field. As previously discussed, this is also due to the hierarchy structure that exists in the medical field which result in trainee doctors being dependent on seniors for teaching them with the use of humiliation. This way of teaching perpetuates the cycle of abuse because when the trainee becomes a senior doctor, he or she would also mistreat the trainees as he or she was (Scott et al., 2015). Lastly, Ward and Outram (2016) state that this way of teaching creates the expectation that trainee doctors need to strive for perfection and prioritise their work above all other aspects in their life. This would result in no work-life balance which then causes emotional and affective distress as discussed in the section that focuses on the risk factors on the individual level. This is supported by both Colenbrander et al. (2020) and Slavin (2016) who reports that mental health is not taken as seriously in comparison to physical health in the medicine field as well as self-sacrifice, deference and resilience being the key in becoming a doctor. Based on these discussions on the toxic medicine culture, one can suggest for future researchers to use measures to determine what type of culture is currently in the hospital, clinic and/or academic environment and what the engagement levels of trainee doctors are. This research will focus more on whether trainee doctors who identify themselves as a victim and/or witness of bullying, experience a similar toxic culture as discussed in these studies.

Organisational policies

An organisational policy is defined as a clear statement that provides guidelines to employees and employers on expectations of the organisation and what is considered as acceptable behaviour (SHRM, 2020). Based on this definition, one can argue that if an organisation has no anti-bullying policies or no procedures in place to handle negative behaviour, it means no protection for both the employee and the organisation. This could result

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in the acceptance of negative behaviours since there is no clear guidance on what right or wrong behaviour is**.** What is concerning is that this could create an unsafe and unhealthy work environment. This needs to be addressed since it is the employer's duty to ensure a reasonable safe and healthy work environment for the employee during his or her employment period (Boshoff, 2020). Samnani and Singh (2012) states that if clear policies are embedded within the organisational climate, it is highly unlikely for workplace bullying to occur.

What is more, Llewellyn et al. (2019) found that 60% of respondents in their study indicated that they have reported bullying incidents to a senior staff member. However, most respondents found this process either ineffective or harmful since complaints were often dismissed or behaviours blamed on the sensitivity of the complainant, and/or no further action has been taken. What is more, Samsudin et al. (2020b) found that a moderate hierarchical culture could reduce the likelihood of workplace bullying. What they mean is that a structured work environment could allow trainee doctors to work efficiently when there is clear processes and guidelines which could also reduce job strain.

Therefore, this research will explore whether trainee doctors are aware of any policies or grievance procedures in place and whether this has any influence on the prevalence of workplace bullying. Should there be some sort of grievance process, the researcher tends to explore whether trainee doctors in the Western Cape province of South Africa find it to be effective or not.

Outcomes on organisational level

Nielsen and Einarsen (2012) found in their study that workplace bullying has negative consequences for organisations such as higher intentions to leave, low levels of job satisfaction and organisational commitment. Intention to leave should be explored in the medical context since this could result in high costs for hospitals and clinics due to the frequent training and

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replacement of doctors. In addition, one could also investigate whether it is likely for trainee doctors to be unproductive and demotivated should they feel pressured to attend work based on loyalty. Although, Nielsen and Einarsen (2012) found a weak association between exposure to workplace bullying and performance, absenteeism, self-perceptions, and sleep, one can suggest that absenteeism and productivity could still have negative consequences and be explored in the medical context. For example, trainee doctors that attend work despite being exposed to bullying, could be more likely to be unproductive, could struggle to concentrate or could make mistakes which result in high costs for the hospital or clinics. Those that are absent, relates to no productivity taking place and heavier workload might be placed on other trainees. Regarding self-perception and disruption in sleep, this could have a negative impact on the individual level as discussed previously in the section that focuses on risk factors on the individual level.

Moreover, Wild (et al., 2015) indicate that not only does workplace bullying have a negative impact on the victim, but it also poses a threat to patient safety. The reason is that trainee doctors feel incompetent and would hesitate to ask for assistance from superiors when needed. This results in high costs due to litigation cases caused by medical errors, poor-quality patient care, safety, and mortality (Wild et al., 2015).

Risk factors on societal level

The main risk factor on societal level is the type of national culture which determines one's perception on workplace bullying. This is supported by Jacobson et al. (2014), he proposed that workplace bullying is influenced by national culture in, and where the organisation resides. In other words, culture has an influence on whether one perceives bullying as acceptable or not. This is important for the 21st century where globalisation has become an important occurrence and where one interacts with diverse cultures in different countries. This is also important for South Africa since it is well-known as a multicultural country. Also, Jacobson et al. (2014)

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focused on three dimensions of national culture, namely assertiveness, in-group collectivism and power distance which is part of Hofstede's (2011) cultural dimensions as discussed previously in the section that focuses on risk factors on the individual level, specifically culture. This section will focus particularly on in-group collectivism. In-group collectivism is defined as "the degree to which individuals' express pride, loyalty, and cohesiveness in their organisations, families, circle of close friends, or other such small groups" (Jacobson et al., 2014, p. 56-57). Based on this, one can argue that South Africa is a collective (Ubuntu) society which refers to the idea that one needs to have a relationship with the community and be interdependent of others. Jacobson et al. (2014) claim that societies that tend to be high in in-group collectivism, experience less bullying in the workplace. Therefore, the researcher states that should trainee doctors feel part of a collective group, it is highly unlikely for them to experience workplace bullying since they would experience a sense of belonging by being interdependent of each other. However, as previously indicated by Huang et al. (2018), the medicine field is hierarchical which could encourage individualism.

Outcomes on societal level

Research indicates that workplace bullying can have an impact on society in terms of growing medical costs, premature retirement, an increase in need for social services and welfare (Hoel, Sparks, et al., 2001 as cited in Samnani & Singh, 2012). In addition, it will also have an influence on unemployment levels, personal relationships, and legal costs (Vega & Comer, 2005 as cited in Samnani & Singh, 2012). These findings support what has been discussed previously in terms of the impact that workplace bullying has on the individual and organisational level which then result in a snowball impact on society. What this means is that workplace bullying could cause the deterioration of the overall wellbeing and decline in longevity for those working in the medical field. Furthermore, as discussed previously, Wild et al. (2015) indicate that workplace bullying of trainee doctors could result in poor quality patient care,

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threats to patient safety and patient mortality which not only result in an increase in medical and legal costs but could also affect the reputation of the medical field in general. Therefore, one can argue that should the medical field uphold a reputation of fostering a bullying culture, it could result in the unemployment of trainee doctors should they no longer want to pursue their career anymore. This is evident in the video recording of Moosa (2016) where she stated that she no longer wants to practice as a doctor. One can argue that if other trainee doctors feel the same, this could have an enormous impact on society due to the loss of great potential medical doctors and the increase of *brain drain*. Therefore, the intention to leave the profession will be explored in this research study.

Research Methodology

Research design

A research design is defined by Babbie and Mouton (2001) as a plan, being formulated to find something of an occurrence. They claim that the detail in doing so varies according to what one wants to study. In other words, an appropriate plan is needed to answer the research aims of this present study. An exploratory descriptive study was conducted since the occurrence of workplace bullying, specifically among trainee doctors is a relative new topic in the Western Cape province of South Africa and according to the researcher's knowledge, only few research studies have been found. This design did not require too much time and effort for both the researcher and the participants. Hence, the present study used a quantitative *ex-post facto* research design since the researcher only made observations of the results found without any interference (Babbie & Mouton, 2001).

Research paradigm

A research paradigm refers to a frame of reference in how the researcher will make sense of observations and how information will be categorised (Babbie, 2013). This research study used

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an exploratory descriptive study, and a positivistic stance is taken. Positivism is defined as “an epistemological position that advocates the application of the methods of the natural sciences to the study of the social reality” (Bryman, 2012, p.28). What this means is that an objective approach was taken to gain more insight about the topic of workplace bullying towards trainee doctors with the use of self-report questionnaires.

Sampling and sample technique

A sample is described by Bryman (2012) as the selected segment from a population for a research. In other words, this means a representative sample being obtained from a given population. The target population for this research study is 3rd year and above trainee doctors in the Western Cape region of South Africa. This research study used a non-probability convenience sampling technique to choose a sample of subjects/units from this population.

According to Bryman (2012), probability sampling refers to where each participant in the population group will have an equal opportunity to participate in this research through random selection. In contrast, non-probability sampling suggest that some units are more likely to be selected than others and all units in the population do not have an equal opportunity to participate in the research study. Therefore, for the purpose of this research, a non-probability convenience (also known as availability) sampling was used which selected participants that are more readily available to obtain by the researcher (Bryman, 2012). The contact person at the medical faculties from the two universities assisted in distributing the self-report questionnaires. The reason for choosing this sampling technique is due to the restrictions of this research in terms of time, cost, and availability. Also, the aim of this research study is not to generalise the results to the entire population since this would be impossible.

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Data collection procedure

Data was collected with the use of electronic self-report questionnaires. The contact individuals at both the medical faculties of the universities distributed the questionnaires on the researcher's behalf. Questionnaires were created with the use of the SunSurvey which is a platform for surveys conducted specifically for academic research purposes at Stellenbosch University. The reason for using self-report questionnaires is because it is cost-effective, it is quick to administer and is convenient for participants since they can answer the questionnaire at their own time and convenience (Bryman, 2012). However, as Bryman states, the disadvantages of using self-report questionnaires are that additional information cannot be prompted or probed, there is a greater risk for missing data, which has been reported in this study and taken into consideration.

Sample size

As discussed previously, this research is constrained for time and costs. Babbie (2013) suggest that a 70% response rate and more is acceptable to conduct data analysis. However, the response rate for self-report questionnaires can be low which requires action to increase it. This has been done where reminders have been sent to participants by the contact individuals. A total of 194 respondents participated in this study, which was satisfactory for the purpose of this study.

Data analyses procedure

Professor Martin Kidd from the Statistics Department of Stellenbosch University assisted the researcher by analysing the data and provided descriptive statistics to the researcher. Statistica 14 was used for summary statistics and cross tabulations. The mixed model ANOVA was done using the "R" package "lemr". Summary statistics were reported as frequencies and percentages, presented in histograms. Levels of negative acts and degrading and oppressing

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behaviours were reported with means and standard deviations. Mixed model ANOVA was used to test for significant differences in the means.

Ethical considerations

Ethical issues before and/or during the conduct of this research study was considered. One needs to ensure that the study was done in an ethical manner that will not only protect the discipline of Industrial Psychology but ensure that no harm was done to participants. The following was obtained before the research could proceed: ethical clearance and institutional permission as well as permission from the medical faculties at both universities.

As mentioned previously, data was being collected by electronic questionnaires created and distributed with the use of SunSurvey, which is a platform for surveys specifically used for conducting academic research at Stellenbosch University. Therefore, one can be assured that the data collected was anonymous and kept confidential. Questions in section A and section B were developed by the researcher based on the literature review studies. In addition, section C (Negative Acts Questionnaire) and section D (Work Harassment Scale) are standardised Likert-scale questionnaires which has significant high levels of reliability and validity (which is further discussed in the measuring instruments section). Based on this, one can state that the questionnaire was satisfactory and acceptable to use.

The informed consent document was included in the questionnaire that contained information about the purpose of the study and what it intends to measure for participants to make an informed decision whether they wanted to voluntarily participate in the research (as seen in Appendix A). Participants had to give informed consent before they could proceed with the questionnaire. Participants were informed in the consent form that they could withdraw from the study anytime should they no longer want to participate without any negative consequences. Transparency was very important for the researcher and participants were not misled in terms of

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what the research was all about. Privacy and confidentiality were assured to participants since only the researcher, the supervisor and Professor Martin Kidd had access to the information. All necessary protocols were adhered to and constructive feedback and criticism was provided to the researcher to illustrate the significance of the research in an effective manner. The data that was collected, was stored on the researcher's computer with a security password. Additionally, the participants were not asked to reveal their names in the study to ensure anonymity.

Should any participants have recalled unpleasant memories during or after participating in this study and wanted to talk about it, provision has been made where the researcher arranged with an Industrial Psychologist (who is eligible to do trauma counselling) and the supervisor of this study to be on stand-by to provide free counselling and refer individuals to appropriate professionals where needed. The researcher also provided contact details for the counselling services available at both universities for which participants would be liable to pay where deemed necessary. All this information was provided to participants as part of the informed consent. The researcher also approached a registered counsellor in private practice to be available should there have been a need for trauma debriefing and/or counselling for participants. Her contact details, availability and price range for sessions were provided to participants. In addition, the researcher provided contact details for free counselling with the supervisor of this study and provided contact details of other services available for which participants would be liable to pay.

The reason for arranging professional assistance to participants was to encourage them to talk about any recalled unpleasant memories during or after participating in this study. Although, it is important to note that this was a low to medium risk study since the questionnaire mainly intended to explore the prevalence of workplace bullying and could only make the participant aware of being a victim or witness of bullying behaviour in the workplace. The philosophy of this research was that the more participants could talk about their experiences, the quicker they

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could heal and learn how to move forward. Therefore, participation in this study could only have made individuals aware of what workplace bullying is, the types of bullying, how it affected them on a work, physical, emotional, and affective domain and many more. This research could have possibly encouraged trainees to take care of their emotional and psychological well-being by talking about their experiences and finding ways to effectively deal with traumatic events.

Measuring instruments

As seen in Appendix B, a self-report questionnaire was utilised to measure participants standing on specific concepts. The following sections were included in the questionnaire:

Section A: Demographic / Biographic information

Biographical/demographic information such as age, gender, race, perceived hours worked, and overtime was obtained to determine whether there are specific risk groups for workplace bullying.

Section B: Questionnaire related to workplace bullying

The questions in this section were developed by the researcher based on the literature study. The definition of workplace bullying by Kalamdien (2013) was presented to participants to report the following:

- Whether workplace bullying of trainee doctors were prevalent.
- Whether participants have witnessed workplace bullying.
- Characteristics of the perpetrator(s).
- How bullying affects victims and witnesses' on the work, physical, emotional and affective domains.
- Whether anti-bullying policies or grievance procedures were in place.
- Whether participants perceived medical culture as harsh / hierarchical.

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- Whether participants wanted to leave the medical profession.
- Interventions currently in place.
- Suggestions for other interventions.
- Whether participants perceived themselves to be overworked.

In terms of whether participants perceived themselves to be overworked, four questions have been formulated similar to previous measures by Moore and Mulki (as cited in Avery, et al., 2010). Response categories were provided in the form of a Likert scale such as 1=never, 2=seldom, 3=sometimes, 4=often, and 5=very often. A Cronbach Alpha of .79 was found which represents a high internal consistency reliability score (Avery, et al., 2010). Therefore, one can argue that this was satisfactory to use as an indication of perceived work overload.

Section C: Negative Acts Questionnaire (NAQ)

The NAQ is a standardised Likert-scale questionnaire that entails response categories such as 1=never, 2=now, 3=daily, 4=weekly, and 5=monthly. This questionnaire measures how often participants have been exposed to negative acts during a period of six months by indicating this on one of these response categories. This questionnaire consists of 29 items which describes negative behaviours that is associated with workplace bullying (Einarsen & Raknes, 1997). The items contain both direct and indirect behaviours. Einarsen, et al. (2009) found a high internal consistency reliability of the scale from .87 to .93 as measured by Cronbach's alpha. Kakoulakis et al. (2015) also found significant levels of criterion and construct validity of the NAQ. This is also supported by Du Toit (2013) and Kalamdien (2013) who found that the validity of the NAQ has increased. Based on these findings, one can therefore argue that this instrument was psychometrically sound and satisfactory to use in the study.

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Section D: Work Harassment Scale (WHS)

The WHS is a standardised Likert-scale type questionnaire that contains response categories such as 0=never, 1=seldom, 2=occasionally, 3=often, and 4=very often (Bjorkqvist, Osterman & Hjelt-Back, 1994). The questionnaire consists of 24 items and measure the extent that participants were exposed to degrading and oppressing behaviours in the workplace for six months (Kalamdien, 2013). Astrauskaitė et al. (2010) reported an internal consistency reliability ranging between .71 and .92. Additionally, both Du Toit (2013) and Kalamdien (2013) revealed acceptable validity of this instrument. Therefore, one can argue that this instrument was psychometrically sound and satisfactory to use in the study.

Presentation of research results

The prevalence of workplace bullying of trainee doctors in the Western Cape

Prevalence was determined by investigating the biographical demographics of this study and the total of respondents who indicated that they perceive themselves as a victim or witness of workplace bullying or being the bully or perpetrator themselves. However, the focus of the study was on the victims and witnesses' perception. Therefore, based on their perception, the researcher investigated the following: how often and long respondents experience workplace bullying within the last six months, what the most prevalent reported gender and position of the perpetrator is, whether workplace bullying incidents are being reported, whether those that self-identified themselves as victims and/or witnesses have thought about leaving the medical profession, whether the medical culture are perceived as harsh and hierarchical and whether there are any workplace bullying policies and/or interventions in place.

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Biographical demographics

The number of respondents that fully completed the questionnaire in the present study was 194. Respondents reported the following biographical information:

- As seen in figure 1, the sample consisted mostly of female respondents (73% / n=141), while only 25% (n=49) were males, 1% (n=2) preferred not to answer and 1% (n=1) indicated as other.

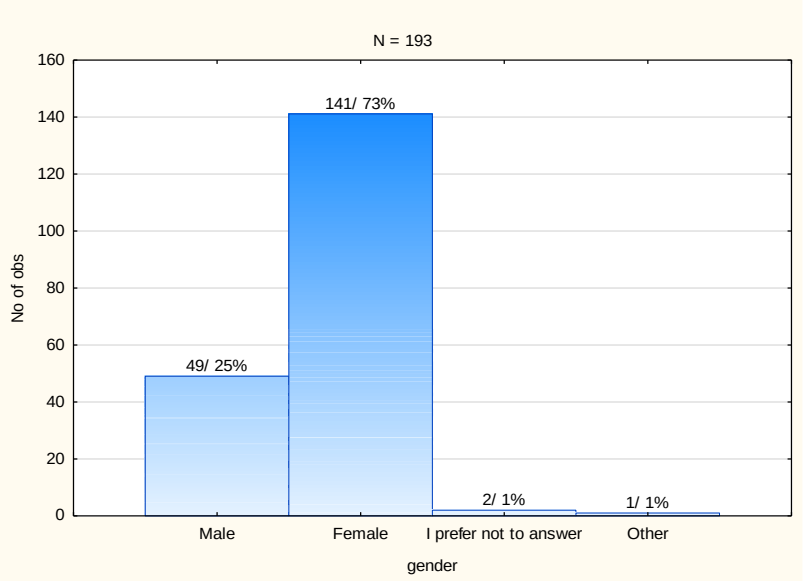

Figure 1: Gender of the sample group

- As seen in figure 2, the majority reported age group is 20 and 30 years of age (98% / n=190), while the other were 1% (n=1) in the 31-40 age group and 1% (n=2) in the 41-50 age group.

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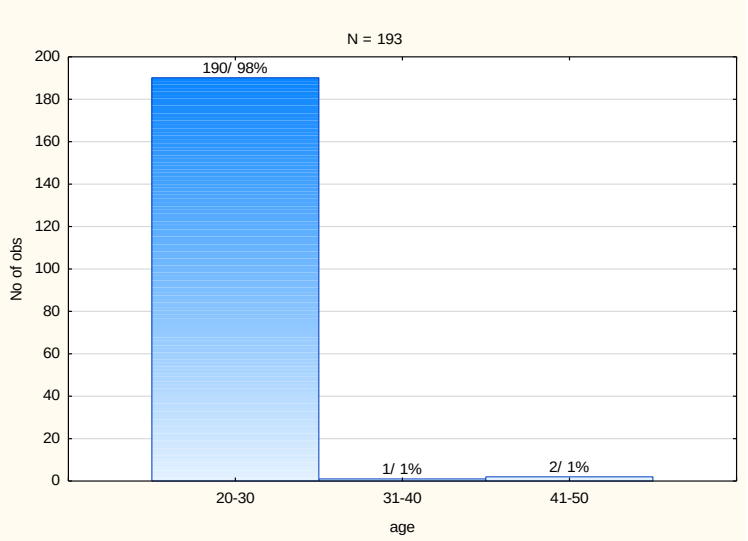

Figure 2: Age group of sample

- As seen in figure 3, respondents reported to be mostly 5th year and above (56% / n=108), while only 31% (n=60) were 4th year, 11% (n=22) were 3rd year, 1% (n=2) preferred not to answer and 1% (n=1) indicated as other.

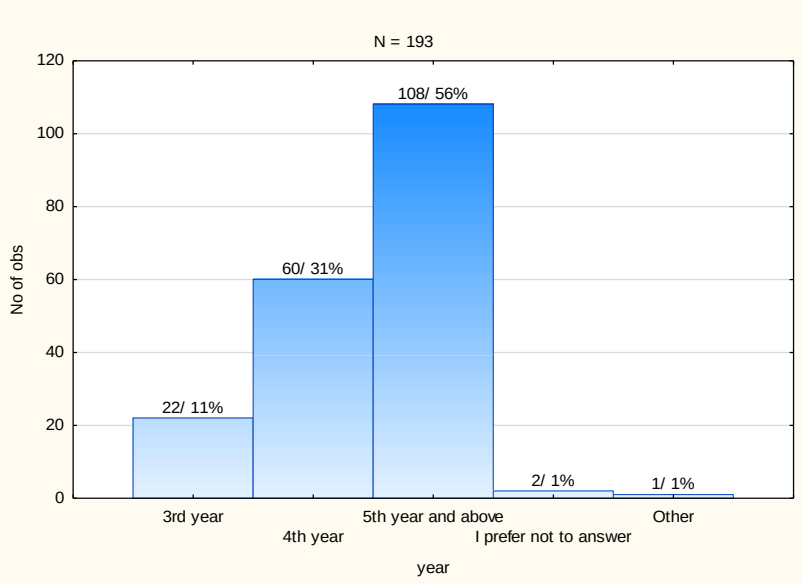

Figure 3: Year of study of sample

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- As seen in figure 4, the reported race demographics were predominately White 38% (n=74), African 27% (n=53), Coloured 17% (n=33), Indian 12% (n=24), other 3% (n=6) and 2% (n=3) preferred not to answer.

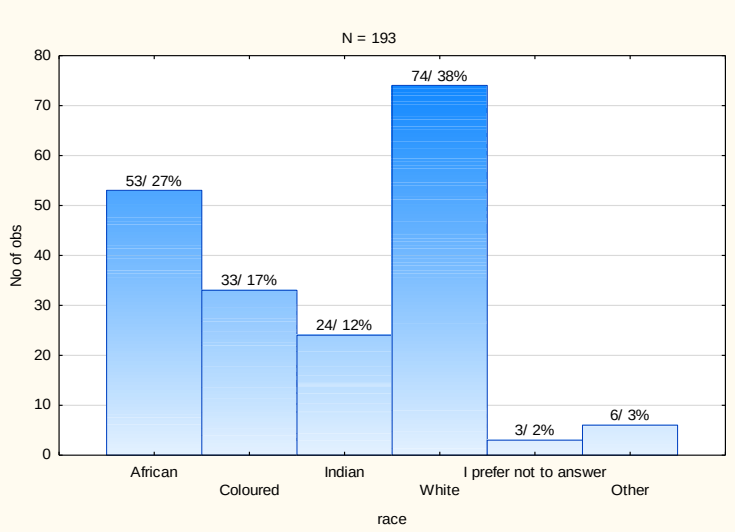

Figure 4: Race group of sample

Perception of different race groups in either being the victim or witness of workplace bullying

The following results have been reported:

- As seen in figure 5, most respondents reported sometimes being the victim (as indicated on the x-axis as “2”): African (42%), Coloured (61%), Indian (58%) and White (39%). Another important observation is that all different race respondents closely indicated never being the victim (as indicated on the x-axis as “3”): African (40%), Coloured (33%), Indian (38%) and White (58%). Smaller percentages have been found for those that indicated always being the victim (as indicated on the x-axis as “1”): African (17%), Coloured (6%), Indian (4%) and White (3%).

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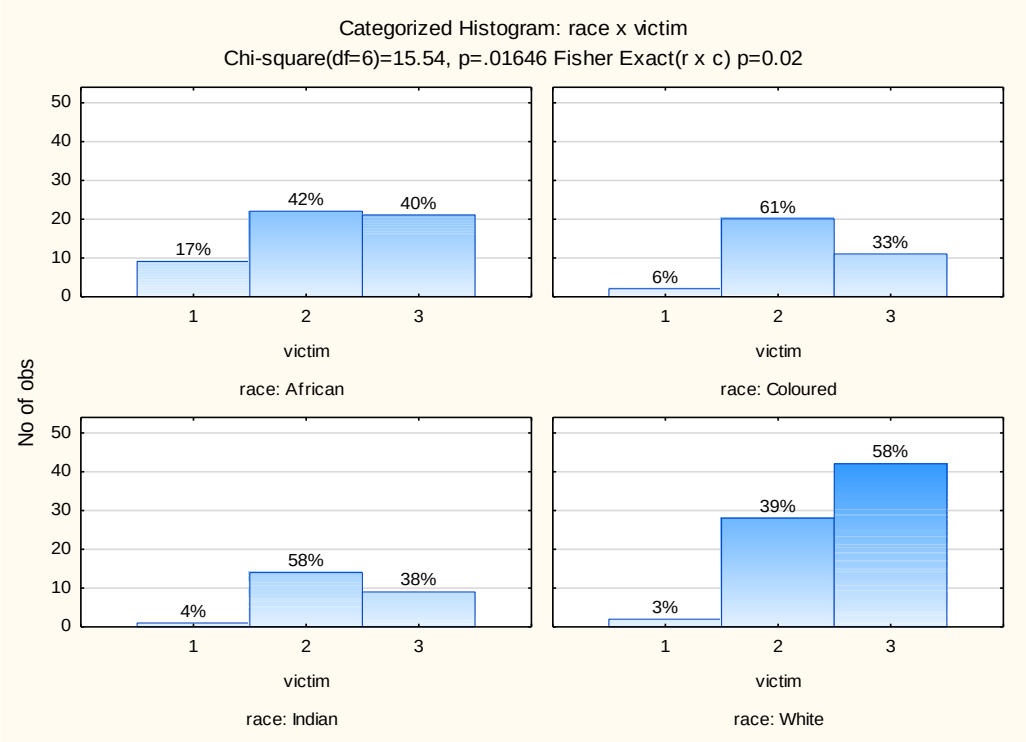

Figure 5: Perception of being a victim

- As seen in figure 6, most respondents reported sometimes witnessing workplace bullying (as indicated on the x-axis as “2”): African (50%), Coloured (55%), Indian (57%) and White (59%). Another important observation is that all different race respondents closely indicate to always witnessing bullying behaviour (as indicated on the x-axis as “1”): African (35%), Coloured (30%), Indian (30%) and White (23%). Smaller percentages have been found for those that indicated to never witness bullying behaviour (as indicated on the x-axis as “3”): African (15%), Coloured (15%), Indian (13%) and White (18%).

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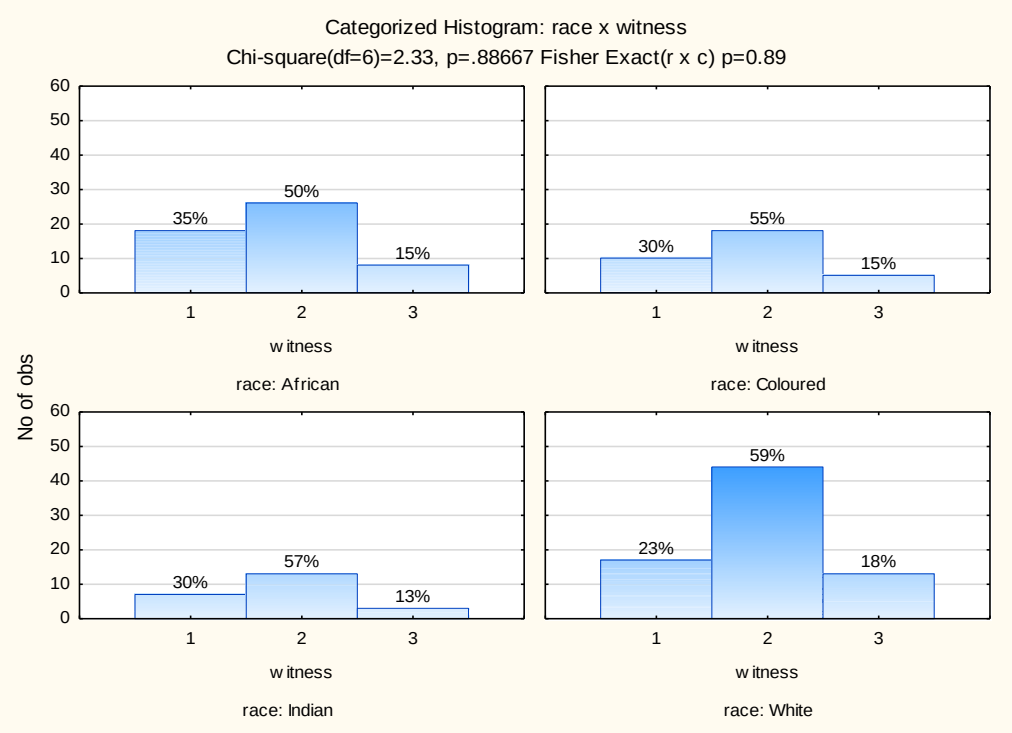

Figure 6: Perception of being a witness

How often victims experienced workplace bullying within the last six months

A case of 105 respondents answered this question (those that identified themselves as victims), as seen in Figure 7. Respondents reported 48% (n=50) being bullied monthly, 21% (n=22) indicate to be bullied weekly, 18% (n=19) indicated in never being bullied, whereas 10% (n=11) preferred not to answer and 3% (n=3) experience being bullied daily.

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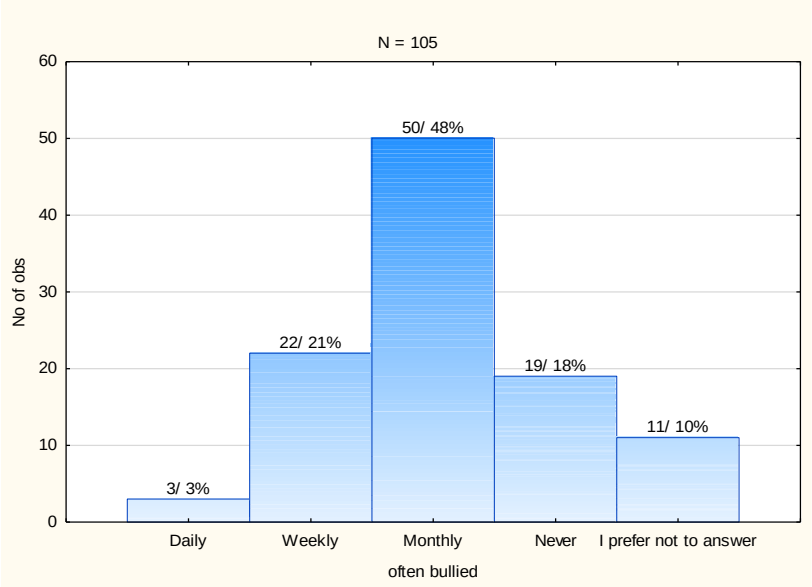

Figure 7: Frequency of being bullied

How often witnesses witnessed workplace bullying within the last six months

A case of 162 respondents (those that identified themselves as witnesses) have indicated how often they witnessed bullying within the last six months, as seen in Figure 8. About 51% (n=82) witnessed workplace bullying behaviours monthly, 28% (n=46) witnessed workplace bullying behaviours weekly, 10% (n=17) witnessed workplace bullying behaviours daily, whereas 6% (n=9) preferred not to answer and 5% (n=8) never witnessed workplace bullying.

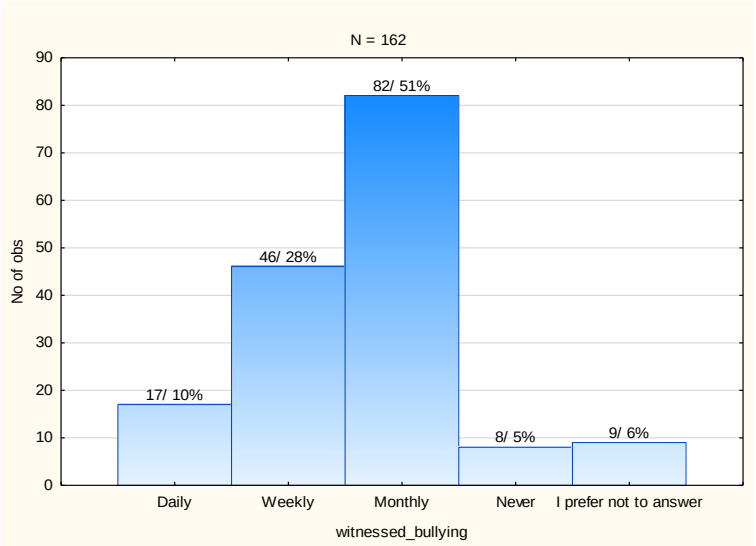

Figure 8: Frequency of witnessing bullying

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How long victims experience being bullied

As seen in Figure 9, a case of 105 respondents (those that indicated themselves as victims) have indicated how long they have been bullied. Respondents reported 35% (n=37) to be bullied for more than one year, 28% (n=29) indicated to be bullied within the last six months, 13% (n=14) never experienced being bullied, 11% (n=12) preferred not to answer, 6% (n=6) have been bullied for one year (12 months) and 3% (n=3) have been bullied from six to 10 months and 4% (n=4) have been bullied for approximately 6 months.

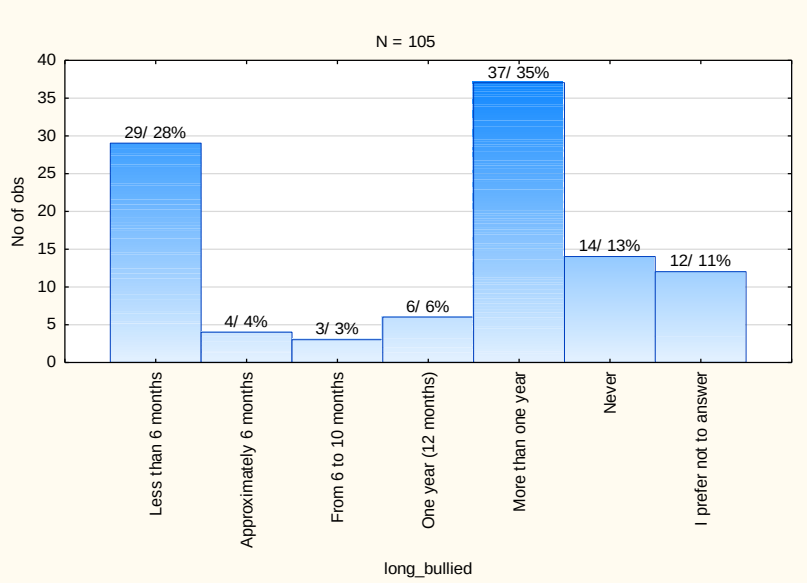

Figure 9: The duration of victims being bullied

Reported gender and position of perpetrator

Results indicate that 101 respondents reported the gender of the perpetrator (as seen in Figure 10) and 105 respondents reported the position of the perpetrator (as seen in Figure 11). These respondents perceive themselves as either a victim and/or witness. Respondents reported 43% (n=43) to be males and 35% (n=35) were indicated as females. Other reported 16% (n=16) and 7% (n=7) preferred not to answer. As seen in Figure 11, the most prevalent

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position of the perpetrator is a supervisor/manager (69%) which is followed by colleagues (35%), patients (24%) and other (7%).

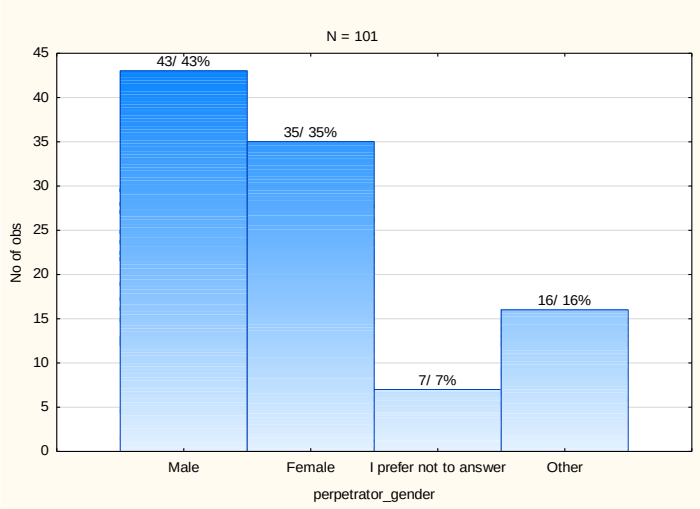

Figure 10: Reported gender of perpetrator

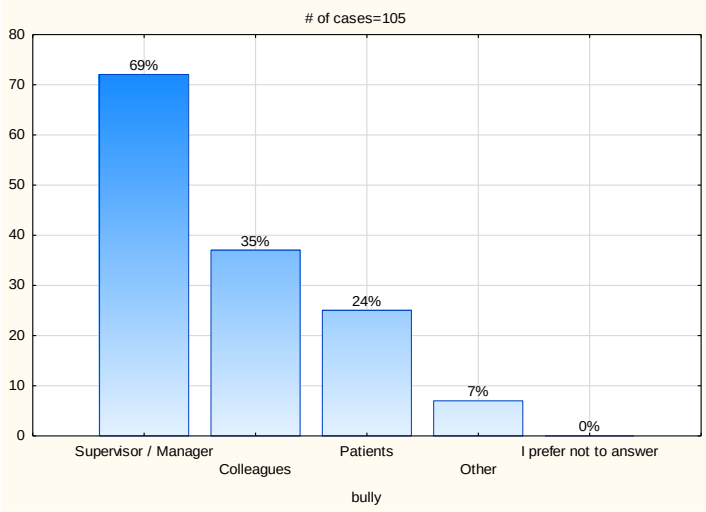

Figure 11: Reported position of perpetrator

Reporting of workplace bullying incidents

A total of 162 respondents indicated whether bullying behaviour is reported, as seen in Figure 12. These respondents identified themselves as a victim and/or witness. Respondents indicate that 84% (n=136) did not report bullying incidents. Only 9% (n=14) indicate that they do report bullying incidents and 7% (n=12) prefer not to answer.

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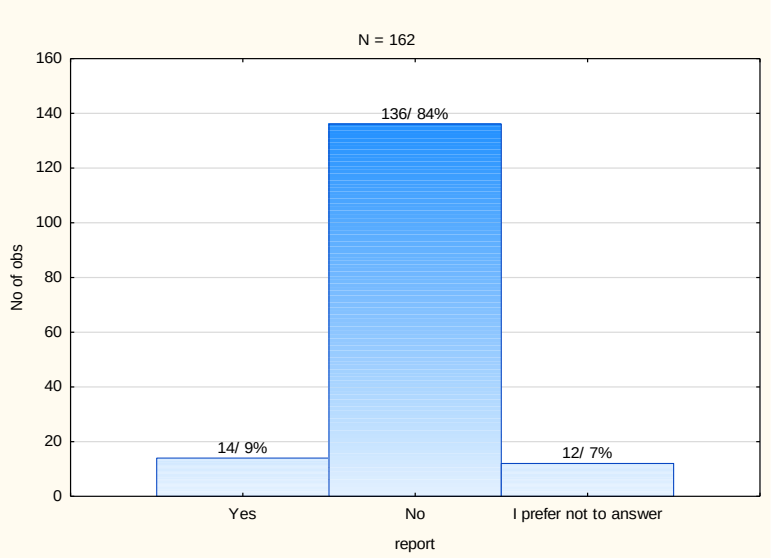

Figure 12: Reporting of workplace bullying incidents

Intention to leave the medical profession

As seen in Figure 13, a total of 194 respondents (identified as victim and/or witness) indicated whether they have thought about leaving the medical profession. Respondents reported that 42% (n=82) do not want to leave the profession. However, 31% (n=60) indicate that they have thought about leaving, whereas 26% (n=51) have sometimes thought about it and 1% preferred not to answer.

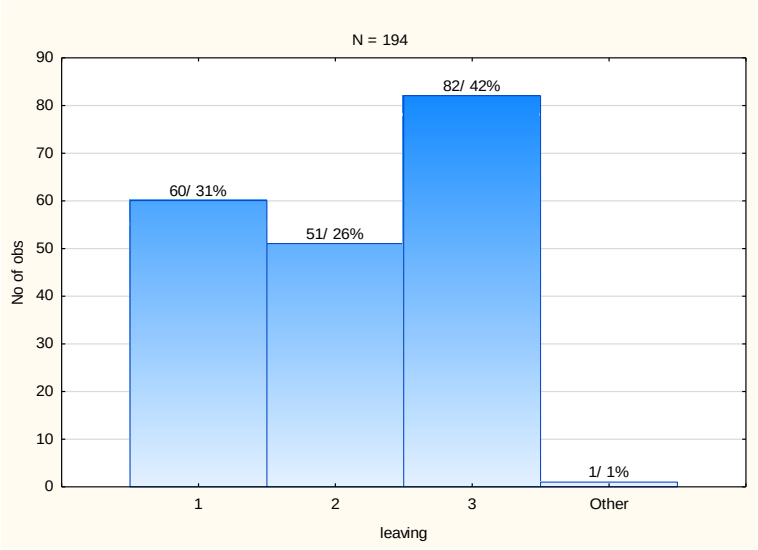

Figure 13: Intention to leave the medical profession

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Perceived harsh or hierarchical medical culture by victims and witnesses

As seen in Figure 14, 194 respondents reported whether they perceive the medical culture as harsh or hierarchical. Respondents reported 61% (n=118) that they always perceive the culture as harsh or hierarchical and 39% (n=75) reported it to be harsh or hierarchical sometimes. Only 1% (n=1) indicate that they do not perceive it in that manner.

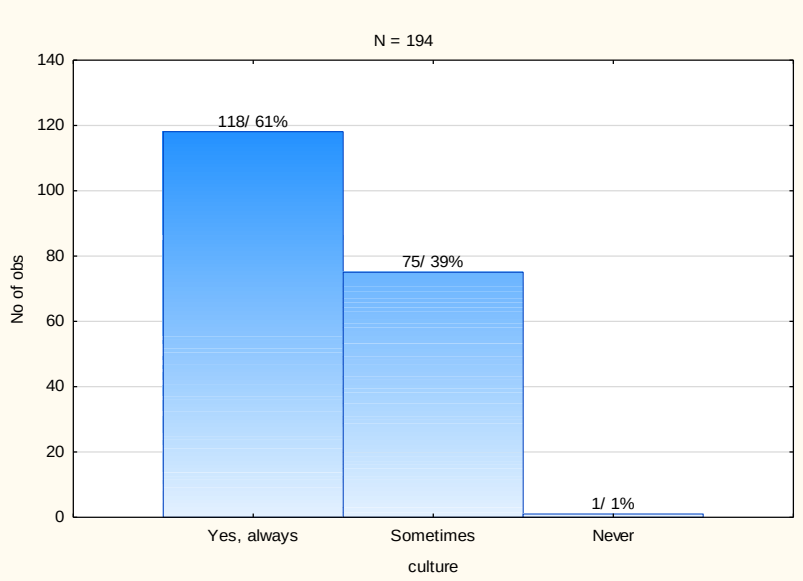

Figure 14: Perceived culture by sample

Workplace bullying policies and interventions

All respondents were asked whether they are aware of any workplace bullying policies and implemented interventions in the hospital/clinic/faculty where they found themselves. As seen in Figure 15, results indicate that 194 respondents reported whether they are aware of workplace bullying policies. Respondents reported 65% (n=126) that there could be but are unsure, 18% (n=35) reported that there are no policies, 16% (n=31) indicate that there are policies in place, whereas 1% (n=2) prefer not to answer. As seen in Figure 16, a case of 213 participants indicated the following five most implemented interventions as the following: stress management workshops (53%), feedback sessions (47%), mentoring and coaching (46%), patient safety culture (27%) and leadership development programs (26%).

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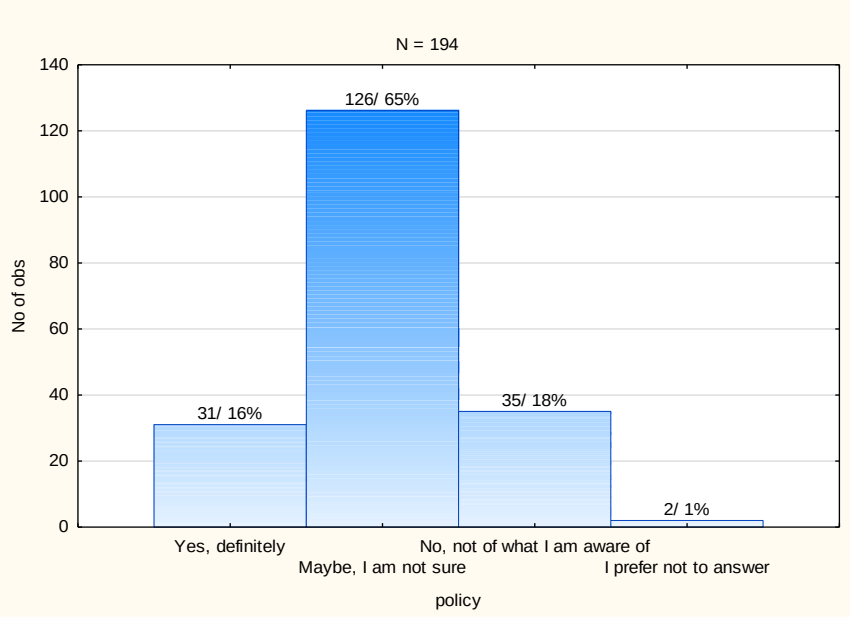

Figure 15: Workplace policies or implemented interventions

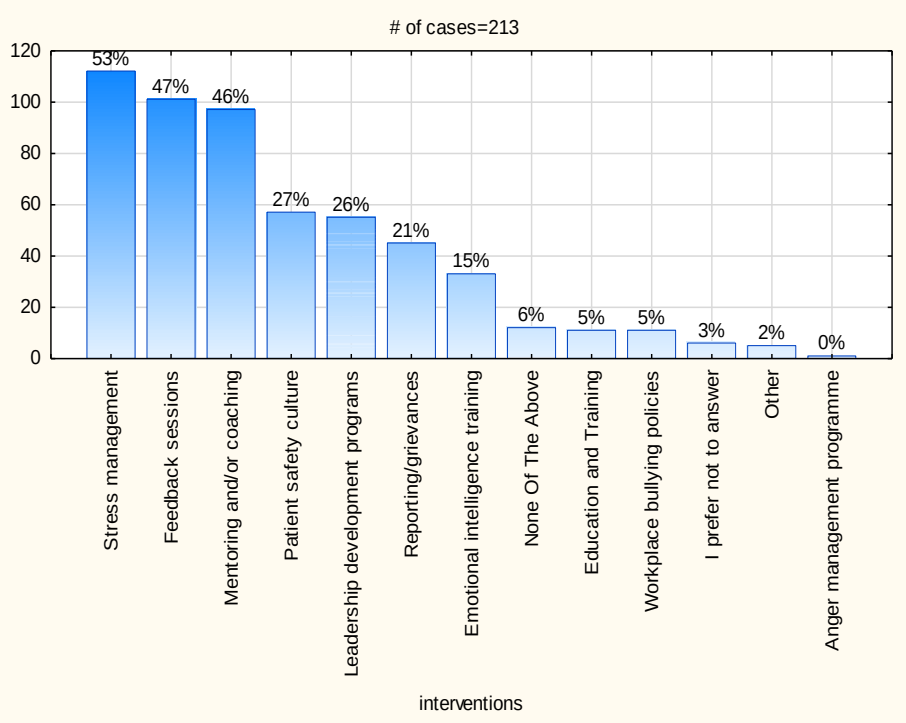

Figure 16: Histogram of current implemented interventions

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Effect of work bullying on the work, physical, emotional and affective domains of victims

This research question was determined by investigating the symptoms that victims and witnesses experience. The five most prevalent symptoms reported by 181 participants (as seen in Figure 17) are the following: feeling exhausted (74%), sleep disruptions (58%), feeling constantly anxious or nervous (57%), experiencing high levels of stress (56%) and decrease in self-confidence (55%). As seen in Figure 17, one should also take note of the other symptoms that participants are experiencing.

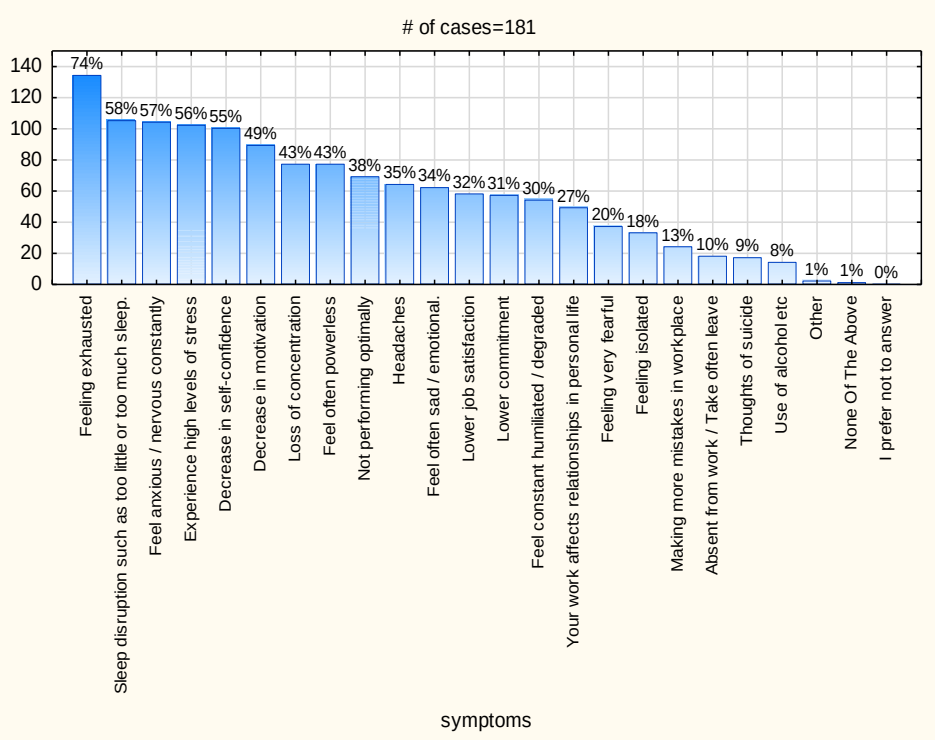

Figure 17: Histogram of experienced symptoms of victims and witnesses

Participants' perception of being overworked

This research question was determined based on trainee doctors work experience in clinical rotations or time spent in the wards of hospitals or clinics. This was investigated based on the following: Firstly, the perception of trainee doctors of whether they think that they are expected to work longer hours than required. Secondly, those that have indicated that they are required

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to work overtime hours, whether they believe it to be reasonable. Lastly, trainee doctors' perceptions of whether they are required to do excessive amounts of work, if they feel overwhelmed by the workload, whether they must do multiple tasks at once, and whether they experience any interruptions that could cause delays in making it difficult for them to complete tasks, were investigated. The following results are reported:

- As seen in Figure 18, a total of 193 respondents indicated that 54% (n=104) sometimes believe that they are working longer hours than required, 32% (n=62) indicated this is not the case and 12% (n=24) perceive that this is always the case, whereas 2% (n=3) indicated as other.

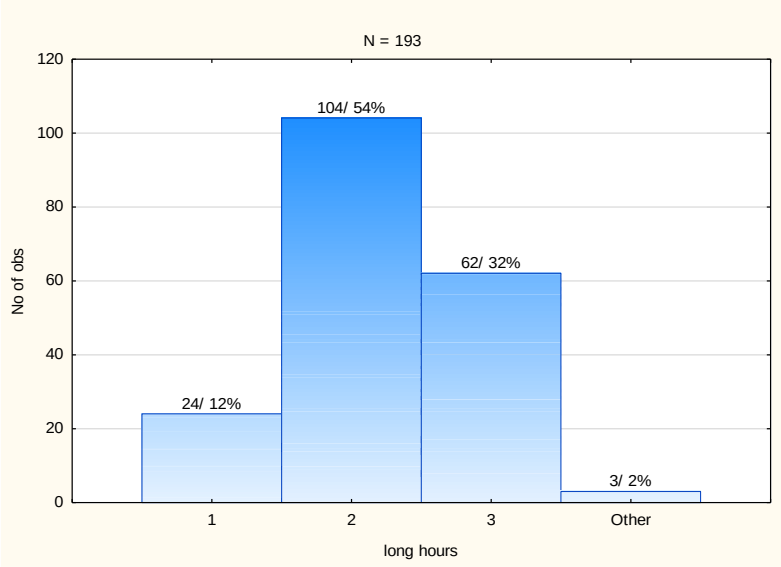

Figure 18: Perception of sample in working long hours

- As seen in Figure 19, a total of 193 respondents have indicated that 42% (n=81) are sometimes expected to work overtime hours, 34% (n=66) indicated that they are mostly expected to work overtime and 22% (n=42) indicated that they are not expected to work overtime, whereas 2% (n=4) indicated as other.

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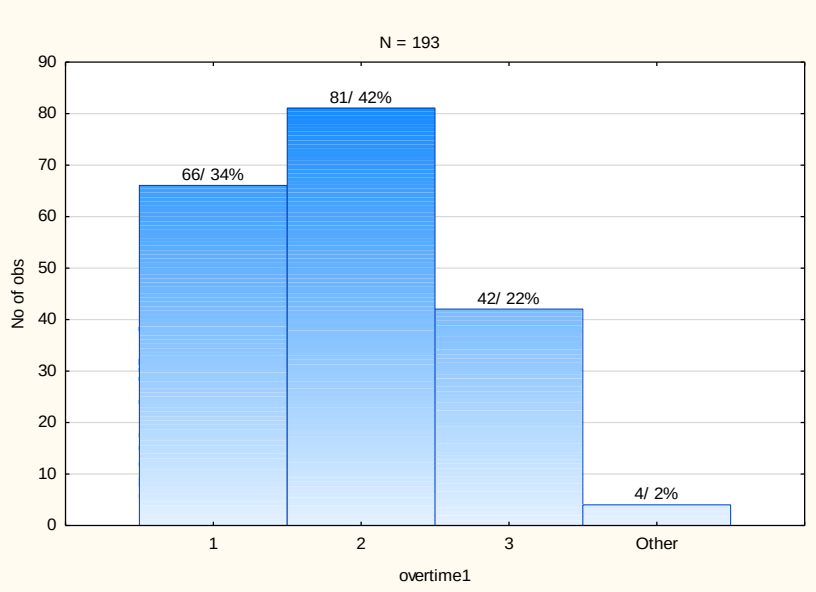

Figure 19: Perception of sample working overtime

- A total of 151 respondents indicated whether they perceive it as reasonable to work overtime (as seen in Figure 20), where 56% (n=85) indicated that it is sometimes reasonable, 30% (n=45) indicated that it is always reasonable, 13% (n=20) do not feel it is reasonable, and 1% (n=1) indicated as other.

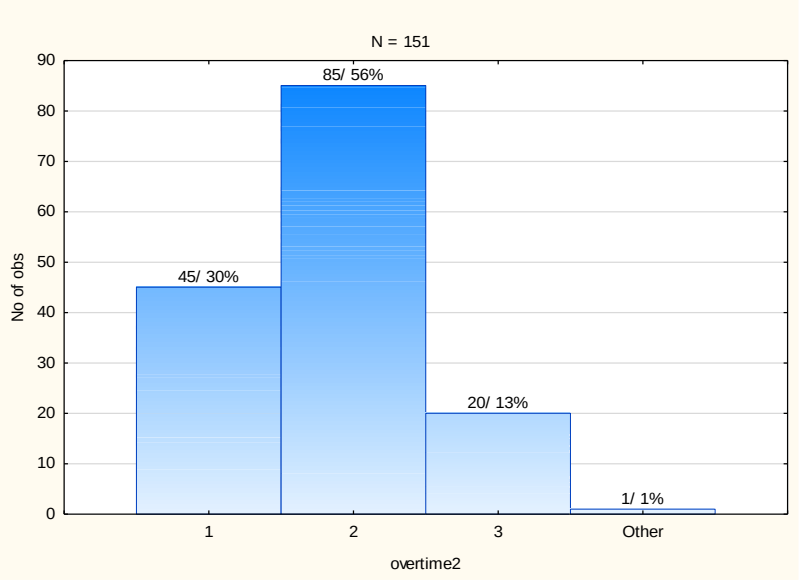

Figure 20: Perception on whether working overtime is reasonable

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Experienced negative acts and degrading and oppressing behaviours

As seen in Appendix C and Figure 21, the NAQ reported the frequency of negative direct and indirect negative behaviours during the past six months. In addition, the WHS reported the frequency of degrading or oppressing activities during the last six months, which can be seen in Appendix C and figure 22. Both these measures indicated the different types of bullying behaviour being experienced by victims and witnesses.

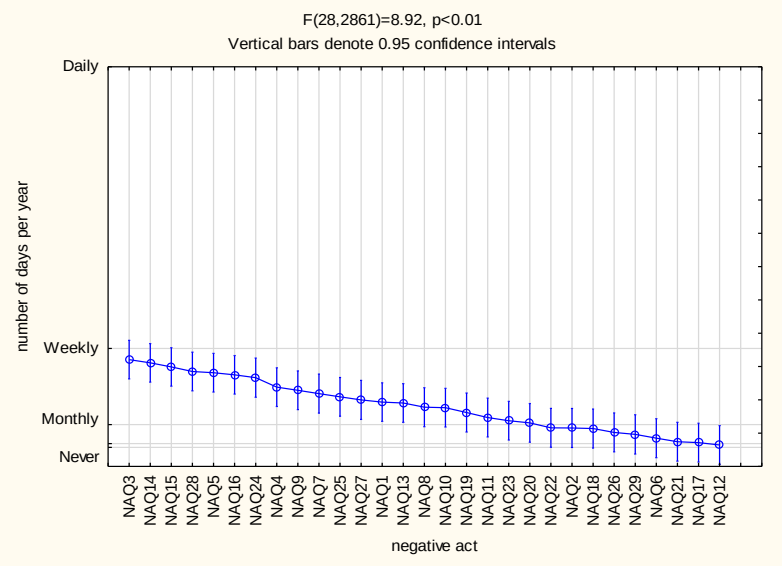

Figure 21: Frequency of negative direct and indirect negative behaviours during the past six months

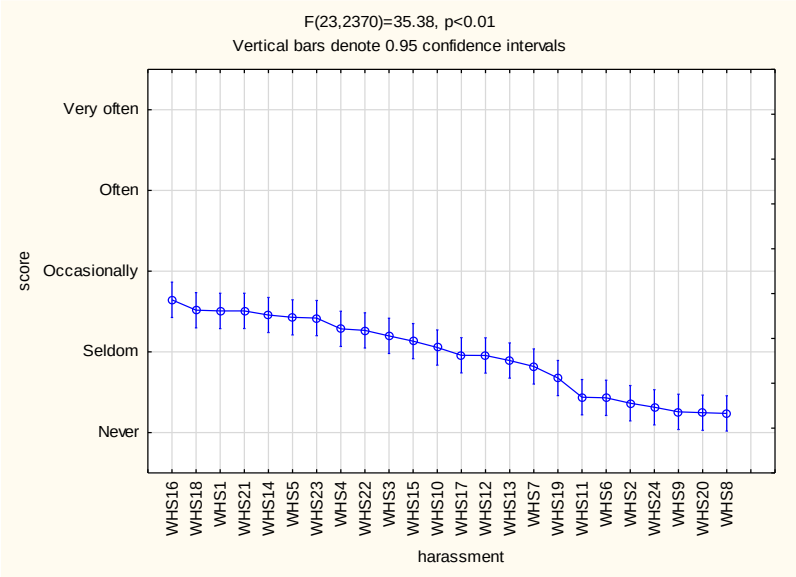

Figure 22: Frequency of degrading or oppressing activities during the last six months

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Discussion of research results

This section discusses the research results based on the research objectives, as well as the literature review.

Explore the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa.

The main aim of this study was to determine the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. This has been determined by exploring the following: the biographical demographics of the sample group, the perception of different race groups in either being the victim or witness of workplace bullying, the frequency and duration of workplace bullying acts, the reported gender and position of perpetrator and the perceived culture of the medical field, workplace bullying policies and interventions.

Biographical demographics

One needs to take the biographical demographical details of the sample group into consideration to identify the most likely risk groups, which has been identified as the following:

- Most of the sample group consisted of females
- The majority reported age group is 20 and 30 years of age
- Most respondents reported to be in 5th year and above study group
- The sample is predominantly in the white race category

The reported gender group (female) and age group (20 and 30 years of age) is consistent with previous research findings (Aykut et al., 2016, Chadaga et al., 2016; Colenbrander et al., 2020; Fakroodeen, 2020; Fnais et al, 2013; Hills et al., 2012, Ling et al., 2016 & Llewellyn et al., 2019). In addition, most respondents reported being in their 5th and above study year and

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identified themselves as white. This would be further discussed in the next section, in terms of different race groups' perception of their position in the occurrence of workplace bullying.

Perception of different race groups in either being the victim or witness of workplace bullying

The researcher investigated different race groups' perceptions of whether they perceive themselves to be the victim or witness of workplace bullying. The reason for investigating this is to identify which race groups are more at risk in experiencing or witnessing bullying behaviour to understand which individuals are more prone or vulnerable to the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa.

As seen in the research results, most respondents in all the different race groups reported to sometimes experience being a victim as well as never being the victim. A smaller percentage of the overall race groups indicate to always being the victim. What is more, most respondents in all race groups reported sometimes witnessing bullying behaviour as well as always witnessing bullying behaviour. Smaller percentages for all race groups have been found for those that indicated to never witness bullying behaviour. What is interesting about these findings is that it seems that individuals are more comfortable admitting being witnesses, rather than victims of bullying. These findings emphasise the sensitivity of this study since it could mean that perhaps some were unaware or afraid of identifying themselves as a victim since negative acts as well as degrading and oppressing behaviours have been reported in the NAQ and WHS (which is further discussed at the end of this section). One can argue that respondents might be hesitant to answer questions that would directly ask whether they are being bullied. The NAQ and WHS questionnaires contained indirect questions and it seems that respondents felt more comfortable in admitting in this manner that they are indeed being bullied (see appendix B for examples of questions). Respondents might also feel safer in admitting that they have just witnessed it.

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Again, this highlights the sensitivity of this study and how afraid or hesitant individuals might be to admit their exposure to workplace bullying.

Furthermore, it has also been observed in the research results that the white race group reported mostly not being a victim or witness of bullying. These findings are consistent with previous research conducted by Chadaga et al. (2016) and Fakroodeen, (2020) that found non-white trainee doctors were more likely to report workplace bullying than white trainee doctors. Therefore, this needs further investigation since it is important to encourage diversity and fairness in South African workplaces today, due to the country's history of marginalising groups during Apartheid.

Frequency and duration of workplace bullying acts

In terms of frequency of bullying acts, research found in the literature review indicate that there is no agreed upon criterion found among researchers. For this research, the definition of Kalamdien (2013) was used to explain workplace bullying where he refers to workplace bullying as situations where one or more victims experience persistent and repetitive harmful negative or hostile acts by one or a group of individuals in the workplace over a period of at least six months. He also states that once-off isolated incidents or conflicts that arise between two equal powerful individuals are excluded. Research results indicate those who identified themselves as a victim, reported that bullying acts occur mostly on a monthly basis in the last six months (48%) as well as on a weekly basis (21%). This finding is consistent with those who identified themselves as a witness since the majority also witnessed bullying acts on a monthly basis (51%) as well as on a weekly basis (28%).

Regarding the duration of bullying acts, research results indicate that the majority who identified themselves as victims, were being bullied for more than one year (35%) and within the last six months (28%). This could be concerning since this indicates that workplace bullying might be a cause of Post-Traumatic Stress Disorder (PTSD). This possibility is supported by

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Askew et al. (2012), Fakroodeen, (2020) and Nielsen and Einarsen (2012), who found that workplace bullying is strongly related to symptoms of post-traumatic stress. Therefore, counselling as an intervention would be recommended in this case. Also, as discussed previously, these findings highlight the sensitivity of the study since a few did report never experiencing or witnessing bullying, nor did they indicate the duration of being bullied which could indicate how afraid or hesitant individuals might be to admit their exposure to workplace bullying when being directly questioned about it.

Reported gender and position of perpetrator

What is more, as discussed previously, many researchers found that the medical field tends to be male dominated where female trainees are more likely to be victims (Aykut et al., 2016, Chadaga et al., 2016; Colenbrander et al., 2020; Fakroodeen, 2020; Fnais et al, 2013; Hills et al., 2012, Ling et al., 2016, Llewellyn et al., 2019). This corresponds with what has been found in this research study, as most of the sample were females (73%) and respondents who identified themselves as either a victim and/or witness, reported that the perpetrator is more likely to be male (43%) in a supervisor/manager position (69%). Furthermore, in terms of the perpetrator being identified as a manager or supervisor, this finding supports research conducted by Huang et al. (2018) who found that in a hierarchical environment, individuals in higher positions are more powerful and respected in comparison with those in lower ranks. Therefore, it is highly likely that senior superiors could abuse their authoritative power since junior trainee doctors are dependent on them for career advancement or to be signed off to become a professional medical doctor.

Perceived culture of the medical field, workplace bullying policies and interventions

This section will discuss the research results found for the following: reporting of workplace bullying acts, anti-bullying policies, current interventions implemented, trainee doctors' perception of the medical field being harsh or hierarchical and whether trainees have thought

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about leaving the medical profession. This will provide an indication on what the current perceived culture of the medical field is. As discussed in the literature review, individuals bring their own cultural background to any workplace (Imran, et al., 2010 & Jacobson et al., 2014 &). What this means is that different individuals have different interpretations and perceptions of workplace bullying. Therefore, this needs to be taken into consideration when interpreting the research results.

Research results indicate that most respondents are less likely to report workplace bullying acts (84%). What is more, the research results also indicate that most respondents 65% (n=126) are unsure whether there are any policies in place whereas 18% reported that there are no policies. One can argue that should there be no anti-bullying policies or procedures in place or awareness of any similar policies or procedures to handle negative behaviour, means no protection for both the employee and the organisation. This is supported by Boshoff (2020), who indicate that it is the employer's duty to ensure a reasonable safe and healthy work environment for the employee during his or her employment period. In other words, this could result in the acceptance of negative behaviours and create an unsafe and unhealthy work environment since there is no clear guidance on what the right or wrong behaviour is. Should there be any policies in place; this needs to be revised or policies needs to be drafted should there be none in place. Trainee doctors should then be made aware of the policies by training or communication measures.

Furthermore, the five most reported prevalent interventions (stress management workshops feedback sessions, mentoring and coaching, patient safety culture and leadership development programs) that is currently implemented seem to be common in the medical field. This finding supports research conducted by Leisy and Ahmad (2016) since the same interventions have been found consistently. Based on this, one can suggest that instead of implementing new interventions; one can rather recommend implementing an evaluation assessment to monitor

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the current interventions and measure whether the interventions bring about change and investigate where it can be improved. In other words, one needs to evaluate the process and the impact that it currently has. The researcher suggests that an education awareness training on the occurrence of workplace bullying could be implemented by informing trainee doctors as well as managers/supervisors what this is, what the policies and guidelines are, what behaviour is acceptable and how to report any incidents.

In addition, research results indicate that most respondents (61%) reported that they perceive the medical field to be harsh and hierarchical. What is more, it has been found that it is unlikely for most respondents to leave the profession (42%), although some respondents (31%) indicate that they have at times thought about leaving the profession. Despite this finding which indicates that it is unlikely for trainees to leave the profession, there are still risks involved on the organisational level should bullying behaviour be tolerated. This is supported by Nielsen and Einarsen (2012) who found in their study that workplace bullying has negative consequences for organisations such as higher intentions to leave, low levels of job satisfaction and organisational commitment. Other reasons for trainees to perhaps perceive the medical field as hierarchical and harsh is discussed in the section which focus on perceived negative acts, degrading and oppressing behaviours in the workplace. Therefore, one can argue that there is a need to change the current workplace culture to not only focus on quality patient care but also on treating trainee doctors in a more humane manner.

Investigate how bullying affect victims on the work, physical, emotional, and affective domains

As discussed in the literature review, Bartlett and Bartlett (2011) found that workplace bullying tends to affect trainee doctors predominantly on the emotional and affective domains. In addition, Nielsen and Einarsen (2012) found no association between victims' exposure to

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bullying and sleep difficulties as well as core self-evaluations. These findings are not consistent with what has been found in this study. The research results indicate that the most prevalent symptoms seem to reflect in the affective and work domains and there were indication of sleep difficulties and lack in self-confidence for those being exposed to workplace bullying. In addition, a small percentage has been found for those reported to have suicidal thoughts and using alcohol. This is consistent with research that found trainee doctors to be at high risk for depression and suicide ideation which can be caused or worsened by workplace bullying (Fakroodeen, 2020; Loerbroks et al., 2015; Rotenstein et al., 2016; Slavin, 2016; Ward & Outram, 2016). Although a low indication has been found on suicide thoughts and use of alcohol in this study, one should take still this in a serious light as this could worsen in time. Also, self-efficacy training could be recommended to increase trainee doctors' confidence in their own abilities as this is necessary to become a competent doctor.

Investigate whether participants perceive themselves to be overworked.

Based on results found, participants reported that they are sometimes required to work longer hours than needed, sometimes they are required to work overtime and believe that this is at times reasonable. As discussed in the literature review, Hussain and Rahim (2014) found more than 80% of participants have indicated that they perceive their workload and their current working schedule affecting them severely. In addition, respondents in this study reported feeling exhausted, having sleep disruptions, constantly feeling anxious or nervous and experiencing high levels of stress. This could be due to the long hours and overtime that trainees must work. However, since this seems to be considered as reasonable among respondents, working long hours and overtime may seem normal for trainee doctors as this could be part of the culture. This view is supported by Colenbrander et al. (2020) and Scott et al. (2015) as discussed in the literature review, since bullying behaviour is rationalised as a tactic to improve the performance or behaviour of trainee doctors. Therefore, working long hours and overtime could be seen as

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"part of the training". This should be further investigated. Also, one could also evaluate the stress management workshops that are currently implemented to assist trainees in maintaining work-life balance.

Explore what the most frequent experienced negative acts degrading, and oppressing behaviours are.

A variety of negative acts and degrading and oppressing behaviours have been reported by respondents. However, this seems to be in contrast with the other questions that focused on the frequency of victims and witnesses to experience bullying behaviour in the last six months, as found in the research results. Victims and witnesses reported that bullying acts occur monthly, which differ with the NAQ and WHS results. These results demonstrate that negative acts were being reported on a daily and weekly basis, whereas degrading and oppressing acts were reported to occur seldom. One could rather rely on the outcome of the NAQ and WHS as these are sound psychometric questionnaires, as discussed in the research methodology section. The other similar questions were developed by the researcher based on the literature review. One can argue that these findings are consistent with previous research who found that one needs to be "toughened" up for the profession by using the teaching methods of humiliation and degradation which is perceived as an effective learning tool in becoming the "best doctor" (Colenbrander et al., 2020 & Scott et al., 2015). One can agree that this finding is quite concerning because bullying behaviour is rationalised as part of becoming a qualified professional doctor which perpetuates the vicious cycle and toxic culture.

Recommendations

Possible anti-bullying interventions is investigated to tackle the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. The following suggestions have been made by Leisy and Ahmad (2016): Firstly, education and training programmes for trainees

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and management can be implemented on what workplace bullying is, the consequences of this behaviour, stress management, coping strategies, mentoring, and coaching as well as leadership development programmes. Trainee doctors should also be allowed to provide feedback on these programmes. Secondly, trainees must be informed about the reporting process should they experience bullying behaviour and be assured of anonymity and confidentiality in this process. Thirdly, a workplace culture needs to be created that focuses on the importance of patient safety, team-based care, well-being of staff members and the implementation of zero-tolerance policies on workplace bullying and a supportive learning environment must be created. Other preventive strategies have been suggested by participants in Du Toit's (2013) research such are: a policy on how to interact with staff; complying with the language policy; support groups and training with a specific focus on anger management; emotional intelligence, and coping skills. Based on these suggestions, the researcher argues that the implementation of these suggestions could possibly reduce the prevalence of workplace bullying and can be used to create a working culture free of bullying. The participants in the research are asked whether any of these suggestions are currently implemented in the hospital and what they suggest is necessary to create a safe working environment free of workplace bullying.

The main idea of this section is to suggest the creation of an anti-bullying workplace culture with the use of primary anti-bullying interventions as suggested by Leisy and Ahmad (2016) and Du Toit (2013). Ward and Outram. (2016) stated that there is a need to change the toxic culture in medicine by creating a nurturing and supportive approach towards teaching and facilitating the wellbeing of staff. As discussed in the section that focuses on risk factors on the organisational level, organisational culture describes "how things are being done" which creates a specific work atmosphere. In other words, if bullying is being overlooked, it results in a decrease of a psychosocial safety climate (Dollard et al., 2017). It is therefore imperative to

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incorporate effective anti-bullying interventions to create a psychosocial safety climate. Dollard et al. (2017) suggests that one can create an organisation free of bullying by implementing bullying procedures, work stressor reduction strategies through work redesign, and conflict resolution. Based on these findings, the researcher argues that hospitals, clinics, and academic environments need to create more awareness by implementing primary interventions to emphasise the need in creating an anti-bullying culture in the workplace as suggested by Leisy and Ahmad (2016) and Dollard et al. (2017). This is also supported by the study of Chipps et al. (2013) where they have found a difference in the prevalence of workplace bullying between two hospitals since the one hospital developed a programme to eliminate bullying behaviour in the OR. This has highlighted the importance of implementing an educational programme to create awareness of workplace bullying.

Therefore, based on these previous research findings and the results of this study, the following recommendations can be made: Firstly, the current implemented interventions as well as the induction and onboarding processes should be evaluated. The reason being is that a need for awareness and education of workplace bullying has been identified. Medical students should also be prepared in terms of what the expectations are for becoming a qualified doctor and provide clear guidelines on the career path ahead. Therefore, Human Resources should be involved during onboarding and induction processes to inform first year medical students on their lawful rights in terms of working conditions, grievance procedures and how to report incidents. A clear disciplinary code should be created and be provided to first year students to inform them of what constitutes negative workplace behaviours, such as bullying and harassment which should not be tolerated. The impact of current interventions also needs to be evaluated to ensure return on investment to reduce the occurrence of bullying behaviour. One also needs to investigate whether trainee doctors are being made aware of counselling services that universities offer, should they have a need to talk to someone.

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Secondly, research results indicate that most respondents are less likely to report workplace bullying behaviour and most respondents are unsure whether there are any policies in place. This reflects the lack in a culture of psychological safety in the medical field where trainee doctors might be afraid to be victimised when reporting an incident. This was also evident in the findings where respondents seem to be reluctant in admitting their exposure to workplace bullying when direct questions are posed but seem more comfortable in disclosing in an indirect manner in the NAQ and WHS questionnaire. Therefore, there is a need to create a psychologically safe culture where trainee doctors feel safe to ask for help, admit mistakes, and have a platform to raise their voice and be treated in a humane manner. Also, should there be any policies in place, these need to be revised; where none is in place, these need to be drafted. Trainee doctors should then be made aware of these policies.

Thirdly, a need has been identified for self-efficacy training since one would set aspiring doctors up for failure if they do not have confidence in their own abilities which can increase psychological distress of trainee doctors. This would most likely result in burnout, high levels of stress and anxiety as well as trainee doctors no longer wanting to pursue the profession. Diversity and sensitivity training is also recommended. Despite the study consisting mostly of white participants, it has been noted that historically marginalised race groups (African, Indian, and Coloured) are more prone to experience and witnessing bullying behaviour. Therefore, there is a need to create awareness of one's own beliefs, values and background which could cause prejudice and bias; as well as those of other individuals. This type of training can improve interaction, communication, management and leadership skills of trainee and senior doctors to work more efficiently together.

Fourthly, the Doctor as Change Agent (DrACA) module, currently being presented at Stellenbosch University's medical faculty for undergraduate medical students, can be recommended for all universities to be part of their curriculum. The Department of Industrial

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Psychology at Stellenbosch is working in collaboration with the medical faculty in presenting the module with the purpose of equipping aspiring doctors with soft skills which are needed for their profession, such as person-centred care, emotional intelligence, self-care, collaborative leadership, and health advocacy. These competencies are necessary for aspiring doctors to become an effective change agent in communities. Often medical students are only trained in clinical practices and lack soft skills development which are very important to deliver high-quality healthcare. Therefore, one can recommend that a similar module be developed for all medical faculties at South African universities. This module could also include the above recommendations being made such as the following: The Human Resources aspect such as working conditions, grievance procedures, how to report incidents and a disciplinary code, policies, as well as psychological safety, self-efficacy and diversity and sensitivity training.

Lastly, Samsudin et al. (2020a) conducted a study to examine the relationships of negative affect, personality and self-esteem of workplace bullying among trainee doctors in Malaysia. These researchers found evidence for the relationships between negative affect, neuroticism, and workplace bullying. For example, they found that individuals high in neuroticism are more likely to perceive assertive behaviours or criticism by others as abusive. What this research suggests is that anti-bullying interventions should take into consideration that individuals with particular personality traits are more likely to be predisposed towards workplace bullying than others. Therefore, anti-bullying interventions should have an interpersonal focus which includes primary interventions such as cognitive training, secondary interventions such as resource enhancement building and conflict management skills training, and tertiary interventions such as counselling. The researcher agrees with these authors and would recommend that these types of interventions should be taken into consideration to implement. It would have been ideal to include personality type assessments for this research to investigate whether there are specific traits associated with those that identified themselves as either a victim and/or witness of

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workplace bullying. Unfortunately, due to time and costs constraint, this was not possible, and it is recommended for future researchers to investigate.

Contribution to the body of knowledge of workplace bullying of trainee doctors in the Western Cape, South Africa.

The study intended to inspire future researchers to elaborate or make further contributions based on the findings of this study. One can recommend that longitudinal and qualitative studies be conducted. Although longitudinal studies can take place over a period of weeks, months, years or even decades; it can be valuable in terms of providing great insight into the prevalence of workplace bullying of trainee doctors during a specific period. In this case, one can recommend that a group of trainee doctors be studied from first year until they have graduated with their medical degree. This could provide insight in what causes workplace bullying by studying various relationships of different variables and observe any changes that might occur. Qualitative studies could also provide more in-depth information about workplace bullying than what a structured close-ended questionnaire could provide. This type of study would allow researchers to probe and obtain more information based on respondents' experiences, thoughts, opinions, and feelings. This could provide more insight on the causes of workplace bullying and contribute to finding solutions or developing concepts or theories which can then be further explored with quantitative studies. However, the sensitivity of this study should be always kept in consideration as respondents may be reluctant to voluntarily participate in longitudinal and qualitative studies which could pose challenges for future researchers.

Strengths and limitations

The main strength of this study is that this research study, as well as the study by Fakroodeen (2020), is one of the two most recent studies to be conducted on workplace bullying of trainee doctors to the researcher's knowledge, specifically in the Western Cape province of

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South Africa. Although a high incidence of workplace bullying has not been reported in this study, research results still indicate that workplace bullying of trainee doctors does occur. Therefore, this research has great value for medical faculties at South African universities to be aware of this problem area and consider recommendations made in this study. This research also contributed to the body of knowledge and could inspire future researchers to elaborate and further this study such as investigating the type of bullying that perpetrators tend to use often as well as the effect it has on victims and witnesses. For this reason, one can recommend the use of longitudinal and qualitative studies. This would benefit both researchers, Human Resource practitioners and Industrial Psychologists in South Africa to gain more insight into this topic and how to rationally manage it.

The main limitation of this study is that it does not provide conclusive evidence. The study did not determine the reasons and/or evidence for the occurrence of the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. Other limitations include the following: A questionnaire was developed by the researcher (as seen in Appendix B) based on a specific definition of workplace bullying by Kalamdien (2013). It would have been ideal to integrate all different definitions of workplace bullying (as discussed in the literature review). However, due to time and cost constraints, this would be impossible. Also, the reason for the researcher to develop her own questionnaire is because there is no existing questionnaire, to the researcher's knowledge, that specifically measure only the variable of workplace bullying. Other researchers, such as Du Toit (2013) and Kalamdien (2013) also developed their own questionnaire for their research studies based on their specific workplace bullying topic. There is no "one correct" definition of workplace bullying since this term is subjective and there are different perspectives on workplace bullying, depending on the topic of a research study. Therefore, the researcher incorporated the NAQ and WHS questionnaires that measure negative, degrading, and oppressing behaviours associated with workplace bullying. The reason

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for incorporating these questionnaires is because it gives an overall indication on the type of behaviours associated with workplace bullying indicated by respondents as well as the frequency and duration thereof. Also, these questionnaires are reliable as confirmed by Astrauskaitė, et al. (2010), Du Toit (2013), Einarsen, Raknes (1997), Einarsen et al. (2009), Kakoulakis et al. (2015) and Kalamdien (2013),

The data collected was based on victims and witnesses' perceptions, which makes it subjective and descriptive. Correlational quantitative studies could be recommended to minimise subjectivity. Missing data has also been reported, which could have a significant effect on the conclusions drawn from the results in this study. The majority respondents in this study were found to be in the white race group. It would have been ideal to obtain a more diverse distribution of all race groups. Lastly, the study was conducted in the Western Cape region, only at two universities which means that results are not generalisable to the whole of South Africa.

Conclusion

As discussed in the introductory section, the main aim of this study is to explore the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. The results found is based on the subjective perspectives of trainee doctors who identify themselves as victims and/or witnesses of workplace bullying and how they reported to be affected by this. This study intended to provide insight on the prevalence of workplace bullying of trainee doctors in the Western Cape, which it successfully did by exploring the biographical demographics of risk groups that are more prone in being exposed to workplace bullying in terms of age, gender, year of study and race groups, the perceived frequency and duration of bullying behaviour, the perceived gender and position of perpetrator, the perceived culture of the medical profession, the impact of bullying on individuals and what type of bullying behaviours are perceived to be more prevalent. Based on the results of the study, the prevalence of workplace bullying of trainee doctors in the Western Cape has been found.

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In conclusion, this study contributed to creating awareness of the prevalence of workplace bullying of trainee doctors in the Western Cape in South Africa. To the researcher's knowledge, this research study, as well as the most recent study by Fakroodeen (2020), is one of the two first research studies to be conducted on workplace bullying of trainee doctors, specifically in the Western Cape province of South Africa. Therefore, this study contributed to the body of knowledge of workplace bullying of trainee doctors in South Africa. Recommendations to medical faculties and hospital management has been discussed. Strengths and limitations of this study should also be taken into consideration when utilising the results of this study.

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ETHICAL CLEARANCE LETTERS

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UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room G50-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

09 January 2020

HREC REF:600/2019

Mrs M de Wet
Department of Industrial Psychology
Stellenbosch University
Stellenbosch

Dear Mrs de Wet

PROJECT TITLE: THE PREVALENCE OF WORKPLACE BULLYING OF TRAINEE DOCTORS IN THE WESTERN CAPE, SOUTH AFRICA: AN EXPLORATORY DESCRIPTIVE STUDY (MASTER'S DEGREE - MISS A BREMERT)

Thank you for your response, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 January 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Ms Andrea Bremert will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

HREC 600/2019sa

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Institutional Review Board (IRB) number: IRB00001938
NHREC-registration number: REC-210208-007

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

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UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

26 November 2019

Project number: 10432

Project Title: The Prevalence of Workplace Bullying of Trainee Doctors in the Western Cape, South Africa: An Exploratory Descriptive Study

Dear Miss Andrea Bremert

Your response to stipulations submitted on 6 November 2019 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
26 September 2019	25 September 2020

GENERAL COMMENTS:

The researcher is reminded to submit proof of UCT permission before data collection proceeds at UCT. [ACTION REQUIRED]

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (10432) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Letter of support_counselling	Confirmation of availability for counselling - Andrea Bremert(1)	22/03/2019	1
Research Protocol/Proposal	FINAL Research Prop 6 Aug 2019	06/08/2019	1
Informed Consent Form	Consent template_electronic survey-1	06/08/2019	1
Default	DESC_REC Humanities- Bremert_Confirmation of availability for counselling - Andrea Bremert(1)	07/08/2019	1
Proof of permission	Screenshot_2019-08-07 Gmail - IRPSD-1502 The Prevalence of Workplace Bullying of Trainee Doctors in the Western Cape, South[...]	07/08/2019	1
Default	UCT Application form	07/08/2019	1
Default	CURRICULUM VITAEMARIETHA DE WET	07/08/2019	1
Default	Institutional Permission_Standard Agreement 1502(1)	01/11/2019	1

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Data collection tool	Questionnaire	01/11/2019 2
Default	Stellenbosch RESPONSE LETTER	01/11/2019 1

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

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APPENDIX A:

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CONSENT TO PARTICIPATE IN RESEARCH

Dear Prospective Participant,

My name is Andrea Bremert, a student at the Department of Industrial Psychology of Stellenbosch University and I would like to invite you to take part in a survey, the results of which will contribute to a research project in order to complete my Masters degree in Industrial Psychology.

Please take some time to read the information presented here, which will explain the details of this project. Your participation is entirely voluntary, and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

PURPOSE OF THIS STUDY

The purpose of this study is to explore the prevalence of workplace bullying of trainee doctors in the Western Cape, South Africa. The workplace is related to students' medical training (i.e. clinical rotations / any time spent in the wards of hospitals or clinics etc.). The focus is on the subjective perspectives of trainee doctors who identify themselves as victims and/or witnesses of workplace bullying and how they perceive to be affected by this.

LAYOUT OF QUESTIONNAIRE

The questionnaire will take approximately 15-20 minutes to complete since it is mostly multiple-choice questions and consists of four sections.

Section A contains questions based on demographics.

Section B contains workplace bullying-related questions.

Section C contains questions based on how often you have been exposed to negative acts during a period of six months.

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Section D contains questions based on being exposed to degrading and oppressing behaviours in the workplace for six months.

PAYMENT FOR PARTICIPATION

Participation is voluntary and no financial payment will be made to you. You can voluntarily enter in a lucky draw for a R1000 Canal Walk voucher after participating in this study, however this is not obligated and entirely voluntary. The lucky draw will be revealed at the end of the questionnaire. Should you want to be entered in this lucky draw, you will be required to provide your cell phone number for the researcher to contact you. The lucky draw would take place approximately 4 weeks after the completion of this questionnaire.

RIGHTS OF RESEARCH PARTICIPANTS:

You have the right to decline answering any questions and you can exit the survey at any time without giving a reason. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Mrs. M [ ] at the Division for Research Development. To save a copy of this text, you can use the download option.

CONFIDENTIALITY

Any information that is shared during this study will be protected. Privacy and confidentiality will be ensured since only the researcher, the supervisor and Professor Martin Kidd from the Department of Statistics at Stellenbosch University will have access to this information. This will ensure that all the necessary protocols are adhered to and constructive feedback and criticism is provided to the researcher to illustrate the significance of the research. The research will be stored electronically on the researcher's laptop and the researcher and supervisor will have ownership of the data. The

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data that is collected, will be stored on the researcher's computer with a security password. Participants will not be asked to reveal their name or student number in the study to ensure anonymity.

Also, no identifiable particulars are required for this study; therefore, you cannot be linked to your questionnaire or response. This will ensure that you cannot be identified for the final research report to maintain confidentiality and anonymity. Should you withdraw from the study, you can just exit your questionnaire and it will be discarded and there will be no linkage to this.

POTENTIAL BENEFITS TO PARTICIPANTS, FACULTY AND SOCIETY

Participation in this research could make you aware of being a victim or witness of bullying behaviour in the workplace by recognising the types of bullying, how it affects you on a work, physical, emotional and affective domain and many more. This could encourage you to seek support and help. The more you can talk about your experience, the quicker you can heal and learn how to move forward. Therefore, this research can encourage you to take care of your emotional and psychological well-being.

Participation in this research can also indirectly benefit you since recommendations can be made to Human Resources and the Head of Department of the medical faculties on how to rationally and purposefully monitor and manage bullying of trainee doctors. This could result in a workplace culture that is free of bullying and could enhance an effective learning and training environment for all trainee doctors. This will result in minimising the shortage of medical staff in the South African society due to trainee doctors leaving the profession of which workplace bullying plays a factor.

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RISK OF STUDY

This is a low to medium risk study since it only intends to investigate the prevalence of workplace bullying. It is important to note the questions may only bring back memories of personal bad experience.

URGENT COUNSELING REQUIRED

Should you have the need to talk to someone, you can contact Marietha de Wet, an Industrial Psychologist (who is eligible to do trauma counseling) and the supervisor of this study who will be on stand-by to provide free counseling and she can refer you to appropriate professionals where needed. She can be contacted directly at

COUNSELING SERVICES FOR UNIVERSITY A STUDENTS

Participants from this university can contact the Centre for Student Counseling and Development (CSCD) which offer limited free and confidential counseling. You can contact them directly at 021 xxx or email xxx to use their services; however, they have a waiting list. This means it is likely that you will be placed on a waiting list. If you are in crisis, you can request an urgent appointment and one of the psychologists will have a brief screening conversation with you to assess the situation and determine the way forward. You can also contact a trauma counselor free of charge between 4pm and 8 am via ER 24 at xxx. If there is a crisis, the 24-hour Crisis line is also available for students at xxx. You will be responsible for payment of using this telephone line.

COUNSELING SERVICES FOR UNIVERSITY B STUDENTS

Participants from this university can contact the Student Wellness Service at xxx. They offer counseling service which may include assessment, brief counseling and/or referral. You can contact them directly at xxx and/or use their online booking service. However, limited services are

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available from April until after the June examination and again from September / October until after the end of year examination due to high demand. This means that is likely for you to be placed on a waiting list. If you should use their services, their fees range between R20 and R150 (negotiable) per session except if you receive financial support from the university. You will be responsible for paying these fees at your own cost. You can also contact the toll-free number for SADAG Student Careline when you are in distress at xxx or SMS xxx for a call-me-back. They offer 24/7 telephonic counseling, advice, referral facilities and general support.

PRIVATE COUNSELING SERVICES

You can also approach Mimi Hewett, a registered counselor in private practice should you have a need for trauma debriefing and/or counseling. You can contact her at 0842055723. Her office hours are from 08h00-12h00 on weekdays, and she is possibly available one evening per week, (Tuesdays), 19h00-20h00 and one Saturday per month from 08h00-12h00. She is also open to the idea of Skype (long distance) counseling. Her fees are R500 for 1-hour session and R750 for 90 minutes. You will responsible for the payment of these fees should you want to make use of her services.

IDENTIFICATION OF INVESTIGATORS

Should you have any questions or concerns about the research, please feel free to contact the researcher or supervisor at the following numbers.

You can download the consent form *here* if you would like to keep it.

Researcher: Andrea Bremert

Cell no:

E-mail:

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Supervisor: Marietha de Wet

Work:

Cell no:

E-mail:

Your honest participation will be very valuable to gain more insight about the prevalence of workplace bullying of trainee doctors in the Western Cape which requires instantaneous attention in South Africa.

Please try to answer all questions - there is no right or wrong answer.

Thank you for your participation - it is highly valued and appreciated!! :)

1.1. I agree to take part in this survey.

☐ Yes

No

1.2. I agree that I am a third-year or above medical student that is currently busy with clinical modules / consolidation (doing practical work at hospitals/clinics) and/or busy with my internship

☐ Yes

No

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1.3. I confirm that I am 18 years or older and that I have read and understood the information provided for the current study. By clicking “NEXT”, I understand that this will serve as providing my consent to participate.

☐ Yes

No

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APPENDIX B

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SECTION A: Demographic / Biographical Information

Your honest participation will be very valuable to gain more insight about the prevalence of workplace bullying of trainee doctors in the Western Cape which requires instantaneous attention in South Africa. However, your participation is entirely voluntary, and you are free to decline to participate at any time. If you do not want to answer a particular question, you can just select the option "I prefer not to answer" or "n/a".

If you wish to no longer participate, you can just exit the survey. This will not affect you negatively in any way whatsoever.

2.1. What is your gender?

- Male
- Female
- I prefer not to answer
- Other: Please specify

2.2. What is your age?

- 20-30
- 31-40
- 41-50
- I prefer not to answer
- Other: Please specify

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2.3. What is your year of study?

- 3rd year
- 4th year
- 5th year and above
- I prefer not to answer
- Other: Please specify

2.4. We are proud of our rainbow nation! We would like to create awareness and gain insight in terms of what type of groups are more at risk to experience workplace bullying in the Western Cape province of South Africa. For that reason, we want to know, are you:

- African
- Coloured
- Indian
- White
- I prefer not to answer
- Other: Please specify

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2.5. Do you think that you work too long hours than actually expected during your practical medical training in clinical rotations / any time spent in the wards of hospitals or clinics?

- Yes
- Sometimes
- No
- n/a

2.6. Are you expected to work overtime during your practical medical training in clinical rotations / any time spent in the wards of hospitals or clinic?

- Yes
- Sometimes
- No
- n/a

2.7. Do you think that the hours you have to work overtime during your practical medical training in clinical rotations / any time spent in the wards of hospitals or clinic is reasonable?

- Yes
- Sometimes
- No
- n/a

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SECTION B: Workplace Bullying Related Questions

Your honest participation will be very valuable to gain more insight about the prevalence of workplace bullying of trainee doctors in the Western Cape which requires instantaneous attention in South Africa. However, your participation is entirely voluntary, and you are free to decline to participate at any time. If you do not want to answer a particular question, you can just select the option "I prefer not to answer" or "N/A".

If you wish to no longer participate, you can just exit the survey. This will not affect you negatively in any way whatsoever.

Please answer the following questions based on your workplace experience in medical training during clinical rotations / any time spent in the wards of hospitals or clinic.

This section will provide a definition on what workplace bullying is. It will be required of you to answer the questions based on this definition.

Workplace bullying is defined by Kalamdien (2013) as the following:

He refers it to situations where one or more victims experience persistent and repetitive harmful negative or hostile acts by one or a group of individuals in the workplace over a period of at least six months. Once-off isolated incidents or conflict that arise between two equal powerful individuals are excluded. He states that the victim feels helpless and defenseless and the intention of the perpetrator is considered insignificant.

Based on the above definitions, please answer the following questions:

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3.1. Do you consider yourself to be a victim of bullying?

- Yes
- Sometimes
- No
- n/a

3.2. Do you consider yourself as a bully?

- Yes
- Sometimes
- No
- n/a

3.3. Have you witnessed any bullying behaviour in the workplace?

- Yes
- Sometimes
- No
- n/a

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4.1. How often have you been bullied during the last six months?

- Daily
- Weekly
- Monthly
- Never
- I prefer not to answer

4.2. How often have you witnessed bullying behaviour during the last six months?

- Daily
- Weekly
- Monthly
- Never
- I prefer not to answer

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4.3. How long would you say that you have been bullied?

- ○ Less than 6 months
- ○ Approximately 6 months
- ○ From 6-10 months
- ○ One year (12 months)
- ○ More than one year
- ○ Never
- ○ I prefer not to answer

5.1. By who were you or others bullied in the workplace? (You can tick more than one)

- ☐ Supervisor / Manager
- ☐ Colleagues
- ☐ Patients
- ☐ I prefer not to answer
- ☐ Other: Please specify

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5.2. What is the gender of the perpetrator?

- ○ Male
- ○ Female
- ○ I prefer not to answer
- ○ Other:_____

5.3. Do you experience any of the following symptoms or behaviour at work? (You can tick more than one)

Absent from work / Take often leave		Have any chronic diseases		Decrease in motivation		Feeling very fearful	
Feeling exhausted		Headaches		Feel often powerless		Feel constant humiliated / degraded	
Lower commitment		Use of alcohol, smoking or other drugs excessively.		Feel often sad / emotional.		Not performing optimally	
Loss of concentration		Sleep disruption such as too little or too much sleep.		Decrease in self-confidence		Feeling isolated	

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Making more mistakes in workplace		Thought of suicide.		Experience high levels of stress			
Lower job satisfaction		Feel anxious / nervous constantly.		Your work affects relationship in personal life.			

5.4. If you are being bullied, did you report the incident to someone?

- Yes
- No
- I prefer not to answer

5.5. Have you ever thought of leaving the medical profession?

- Yes
- Sometimes
- No
- n/a

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6.1. Does the hospital/faculty have any anti-bullying policies or grievance procedures to address bullying?

- Yes, definitely
- Maybe, I am not sure
- No, not that I am aware of
- I prefer not to answer

6.2. Would you describe the medicine culture in general as harsh and/or hierarchical?

- Yes, always
- Sometimes
- Never
- I prefer not to answer

6.3. Which of these interventions are currently implemented at your work? (You can choose more than one)

Education & Training programmes on what bullying is and the consequences of this behaviour.		Workplace bullying policies	
Stress management and/or coping strategies programme		Anger management programme	
Mentoring and/or coaching		Emotional intelligence training	

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Leadership development programs		Reporting process / grievance procedures if experiencing bullying.	
Feedback sessions on any programmes		Culture that focuses on the importance of patient safety	
Other; please specify		None of the above	

6.4. Do you have suggestions for other interventions? If yes, please list them otherwise you can skip this question

_____

_____

_____

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SECTION C: Negative Acts Questionnaire

Your honest participation will be very valuable to gain more insight about the prevalence of workplace bullying of trainee doctors in the Western Cape which requires instantaneous attention in South Africa. However, your participation is entirely voluntary, and you are free to decline to participate at any time. If you do not want to answer a particular question, you can just select the option "I prefer not to answer".

If you wish to no longer participate, you can just exit the survey. This will not affect you negatively in any way whatsoever.

Please answer the following questions based on your workplace experience in medical training during clinical rotations / any time spent in the wards of hospitals or clinics.

The following direct and indirect behaviours, often observed and regarded as negative behaviour in the workplace, are associated with workplace bullying. During the past six months, how often have you been subjected to and/or experienced the following negative acts at work?

(Einarsen, Hoel & Notelaers, 2009; Einarsen & Raknes, 1997; Einarsen, Raknes, Matthiesen & Hellesoy, 1994)

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	Never	Now and then	Daily	Weekly	Monthly	I prefer not to answer
Someone witholding information which affects your performance.						
Unwanted sexual atttention.						
Being humilated or rediculed in connection with your work.						
How often are you being ordered to do work beyond your level of competence?						
Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks.						
Spreading of gossip or rumours about you.						
Being ignored, excluded or being 'sent to coventry'.						
Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life.						

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Being shouted at or being the target of spontaneous anger (or rage).						
Intimidating behaviour such as finger pointing, invasion of personal space, shoving, blocking/barring the way.						
Hints or signals from others that you must quit your job.						
Threats of violence or physical abuse.						

Repeated reminders of your errors or mistakes.						
Being ignored or facing a hostile reaction when you approach.						
Persistent criticism or your work and effort.						
Having your opinions or views ignored.						
Insulting messages, telephone calls or emails.						

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Practical jokes carried out by people with whom you do not get on.						
Systematically being required to carry out tasks which clearly fall outside your job description, e.g. private errands						
Being given tasks with unreasonable or impossible targets or deadlines.						
Having allegations made against you.						
Excessive monitoring of your work.						
Offensive remarks or behaviour with reference to your race or ethnicity.						
Pressure not to claim something to which you are entitled to by right (e.g. sick leave, holiday entitlement and travel expenses)						
Being the subject of excessive teasing and sarcasm.						

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Threats of making your ife difficult, e.g. overtime, nightwork, unpopular tasks.						
Attempts to find fault with your work.						
Being exposed to an unmanageable workload.						
Being moved or transferred against your will.						

SECTION D: Work Harassment Scale

Your honest participation will be very valuable to gain more insight about the prevalence of workplace bullying of trainee doctors in the Western Cape which requires instantaneous attention in South Africa. However, your participation is entirely voluntary, and you are free to decline to participate at any time. If you do not want to answer a particular question, you can just select the option "I prefer not to answer".

If you wish to no longer participate, you can just exit the survey. This will not affect you negatively in any way whatsoever.

Please answer the following questions based on your workplace experience in medical training during clinical rotations / any time spent in the wards of hospitals or clinics. How often have you been exposed to degrading or oppressing activities by superiors, colleagues, subordinates or customers at work during the last six months? The activities clearly must have been experienced as a means of bullying/harassment, not as normal communication, or as exceptional occasions (Bjorkqvist, Osterman & Hjelt-Back, 1994)

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	Never	Seldom	Occasionally	Often	Very often	I prefer not to answer
Unduly reduced opportunities to express yourself?	○	○	○	○	○	○
Lies about you told to others?	○	○	○	○	○	○
Being unduly disrupted?	○	○	○	○	○	○
Being shouted at loudly?	○	○	○	○	○	○
Being unduly criticised?	○	○	○	○	○	○
Insulting comments about your private life?	○	○	○	○	○	○
Being isolated?	○	○	○	○	○	○
Having sensitive details about your private life revealed?	○	○	○	○	○	○
Direct threats?	○	○	○	○	○	○
Insinuative glances and/or negative gestures?	○	○	○	○	○	○
Accusations?	○	○	○	○	○	○
Being sneered at?	○	○	○	○	○	○
Refusal to speak with you?	○	○	○	○	○	○
Belittling of your opinions?	○	○	○	○	○	○
Refusal to hear you?	○	○	○	○	○	○
Being treated as non-existent?	○	○	○	○	○	○

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Words aimed at hurting you?						
How often are you being given meaningless tasks?						
How often are you being given insulting tasks?						
Having malicious rumours spread behind your back?						
Being ridiculed in front of others?						
Having your work judged in an incorrect and insulting manner?						

Having your sense of judgement questioned?						
Accusations of being mentally disturbed						

8.1. Do you want to participate in the Lucky draw?

- Yes
- No

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APPENDIX C

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Most frequent experienced negative acts and degrading and oppressing behaviours

1	NAQ3	Being humiliated or ridiculed in connection with their work
2	NAQ 14	Being ignored or facing a hostile reaction when approach to others
3	NAQ15	Persistent criticism on work and effort
4	NAQ28	Being exposed to unmanageable workload
5	NAQ5	Having key areas of responsibility removed or replaced with more trivial tasks
6	NAQ16	Opinions or views being ignored
7	NAQ24	Pressure not to claim something to which you are entitled to by right (e.g. sick leave, holiday entitlement and travel expenses)
8	NAQ4	Being ordered to do work beyond their level of competence
9	NAQ9	Being shouted at or being the target of spontaneous anger
10	NAQ7	Being ignored, excluded or being 'sent to coventry'
11	NAQ25	Being the subject of excessive teasing and sarcasm
12	NAQ27	Attempts to find fault with work
13	NAQ1	Someone withholding information which affects performance
14	NAQ13	Repeated reminders of your errors and mistakes (NAQ13)
15	NAQ8	Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life
16	NAQ10	Intimidating behaviour such as finger pointing, invasion of personal space, shoving, blocking/barring the way.
17	NAQ19	Systematically being required to carry out tasks which clearly fall outside your job description, e.g. private errands
18	NAQ11	Hints or signals from others that you must quit your job

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19	NAQ23	Offensive remarks or behaviour with reference to your race or ethnicity
20	NAQ20	Being given tasks with unreasonable or impossible targets or deadlines
1	WHS16	Being treated as non-existent
2	WHS18	Being given meaningless tasks
3	WHS1	Unduly reduced opportunities to express themselves
4	WHS21	Being ridiculed in front of others
5	WHS14	Belittling of opinions
6	WHS5	Being unduly criticised
7	WHS23	Sense of judgement being questioned
8	WHS4	Being shouted at loudly
9	WHS22	Work being judged in an incorrect and insulting manner
10	WHS3	Being unduly disrupted
11	WHS15	Refusal to listen
12	WHS10	Insinuated glances and/or negative gestures