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Workplace Bullying Among Senior Medical Staff in Africa: Prevalence, Impact, and Contributing Factors

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ABSTRACT



Objective: This cross-sectional quantitative study aimed to establish the prevalence, antecedents, and outcomes of workplace bullying among senior medical staff in Africa. It will look at how workplace demands, peer and managerial support and bullying affects personal and professional outcomes.

Methods: We used a mixed methods approach with quantitative surveys and qualitative interviews in several African healthcare settings. The prevalence of bullying was measured using the Negative Acts Questionnaire (NAQ-r), and the level of workplace demands and support for individuals was assessed using the Health and Safety Executive Management Standards Analysis Tool.

Findings: The new study found that 38% of senior doctors reported experiencing bullying on a weekly basis and even higher rates in emergency medicine and related specialties. Bullying was significantly associated with high workplace demands and low peer and managerial support. So far-reaching were the ramifications of his bullying that they undermined both individual welfare and organizational efficacy. In other words, 69.6% of responses did not indicate bullying because of alleged reasons of barriers for reporting like fear of retaliation, and lack of trust in management whatsoever.

Novelty: This study offers unprecedented insights into a hitherto neglected area workplace bullying in African healthcare. It showcases novel contributing aspects, including workload and support systems, while shedding light on the barriers to reporting, providing a new lens of contention in African contexts.

Research Implications: Its findings highlight the importance of schools' implementing interventions to reduce workplace bullying, including promoting supportive infrastructures, managing demands and stressors in the workplace, and creating environments for safe reporting, to protect the well-being of Africa's senior medical professionals.

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1. Introduction

Globally, workplace bullying is increasingly recognised as a growing concern for health systems and a barrier to workforce effectiveness. Africa presents a unique set of challenges to its healthcare sector, including high workload demands, resource constraints and hierarchical structures that can create an environment in which bullying can thrive (Mijovic et al., 2016; Muthuri et al., 2020). Bullying between senior and junior members of medical teams is strongly associated with higher stress, lower job satisfaction, and poorer patient care (Dubale et al., 2019; Walker & Gilson, 2004). Senior doctors, who are often in leadership positions and expected to carry heavy workloads, are particularly at risk of both experiencing and perpetuating bullying behaviours (Hawkins et al., 2019; Munro & Phillips, 2023). Despite the need to understand these phenomena in the context of Africa's unique healthcare systems, little is known about the prevalence and impact of bullying among the continent's senior medical workforce (D'Cruz et al., 2021; Dafny et al., 2023).

Workplace bullying in medicine is a serious problem and has important consequences for individuals and the health system. Such bullying behaviours can include shaming, ostracising and undermining others, and are typically associated with power dynamics, workplace stressors and inadequate management support (Arena et al., 2021; Campbell et al., 2010; Roberts et al., 2020). In many African health systems, the hierarchy is very steep, which means that senior staff may be contributors to, or helpless bystanders to, the harm caused by bullies. Furthermore, the stigma of medical bullying



and inadequate reporting methods may further discourage victims from seeking help (Earnshaw et al., 2018; LaGuardia & Oelke, 2021; Puhl & King, 2013). As a result, the true extent of the problem is obscured, making it difficult to implement positive interventions - ultimately affecting patient care and professional well-being (Bamforth et al., 2023; Embuldeniya et al., 2013; Lacy & Chan, 2018).

Perceptions of workplace bullying are best explored through different streams of theory. Particularly relevant is the Job Demands-Resources (JD-R) model, which suggests that high job demands and low resources can lead to stress and burnout, but also interpersonal conflicts such as bullying (Law et al., 2011; Vander Elst et al., 2016). A similarly stressful nature of the workplace is found in senior medical work among African doctors, with little separation and a lack of support and management from colleagues and managers leading to an environment conducive to bullying (Ariza-Montes et al., 2021; Safari et al., 2022). Abusive behaviours such as bullying disrupt this theory and subsequently create toxic workplaces and wounds that affect professional relationships (Felblinger, 2008; Mammen et al., 2023; Sharma, 2018). Understanding the contextual factors of bullying in health care settings can be crucial, and the theory of planned behaviour and organisational deviance are useful in addressing the systemic and individual aspects of bullying in health care systems (LaGuardia & Oelke, 2021; Özer & Escartín, 2023).

In African healthcare settings, the need to address workplace bullying is both urgent and timely, as the negative impact on staff and patient care is increasingly recognised. Previous studies have provided conflicting evidence on the causes of bullying, with some highlighting high workload demands as an influencing factor (Laschinger & Grau (2012), Trépanier et al. (2016), Van den Brande et al. (2016), and others focusing on cultural and organisational factors (Nielsen & Einarsen, 2018; Sheppard et al., 2022). Furthermore, some studies emphasised the importance of managerial support in mitigating bullying (Ariza et al. (2021), Koh (2016), Said & Tanova (2021), while others showed that peer support was equally effective in preventing bullying in the first place (Gaffney et al., 2019; Garandeanu et al., 2014; Lee et al., 2022). These conflicting findings have highlighted the need for more research in the African context, with different aspects influencing the impact of bullying (Maunder & Crafter, 2018; Power et al., 2013). This study is novel in that it focuses on the African healthcare workforce, where such comprehensive studies are rare, and examines both the prevalence and systemic factors of bullying.

This study aims to fill this gap by investigating the prevalence, consequences and determinants of workplace bullying among senior medical professionals in Africa. In particular, it will assess the relationship between job demands and the prevalence of bullying, the relationship between peer and manager support and the prevalence of bullying, and differences in the prevalence of bullying between medical specialties. It will also assess the impact of workplace bullying on the individual and others in their professional and personal lives, and consider the barriers to reporting bullying and their possible impact. These objectives have the potential to provide insights into both the nature of workplace bullying in the African health sector and what can be done to improve the working environment for health professionals, with a positive impact on patient care. This will help to address some of the key issues for improving healthcare in Africa, as well as informing policy that can help to reduce bullying in the medical workplace.

2. Theoretical Framework and Hypotheses Development

2.1 Theoretical Background

Several psychological and organizational theories frame the theoretical perspective of workplace bullying specific to senior professionals in the medical sector in Africa. A pertinent theory in this case is the Job Demands-Resources (JD-R) model, which proposes that job demands are associated with burnout and interpersonal conflict one such area is bullying (Bakker et al., 2016; Nkrumah et al., 2021; Sanjeeva Kumar, 2024). Excessive workload-related pressures and insufficient supervision can increase the incidence of bullying behaviors when it comes to aged medical professionals. The other theory is Social Exchange Theory, which indicates that workplace relationships of reciprocity and mutual respect can diminish when faced with unfair treatment such as bullying (Cropanzano & Mitchell, 2019). Perverted in this way, bullying tends to violate the very social dynamics described above, producing poor emotions for the sniper and bad consequences for the target. Signed up, Power and Control Theory can help pair up with the bullying theory in explaining how hierarchical structures within healthcare settings can foster power imbalances that underlie bullying behaviors. SHARE ON: Head to head reports senior clinicians abusing their power to condone or perpetrate bullying, whilst they junior medical colleagues feel powerless to report or speak out against bullying. Lastly, Organizational Culture Theory posits that the culture within an organization, such as the extent to which bullying behavior is tolerated, can inform the normative framework that underpins both the occurrence and nature of bullying. Conclusion These are theoretical views that provide a provisional summary of the individual and systemic conditions that not only elucidate the causes of bullying in the medical workforce but also highlight the scenarios that need to be tackled to eradicate bullying in practice.

2.2 Workplace Demands and Bullying

Bullying of more senior medical professionals is endemic in the workplace and these pressures will have played a significant role. Long working hours, emergencies, and high-pressure situations are some of the high workload demands that are associated with heightened stress and interpersonal conflicts (Vermeir et al., 2020). When medical professionals become overwhelmed by excessive demands, they are more susceptible to bullying or being bullied as a result of stress, burnout, and frustration (Bañez-Coronel et al., 2018; Wong, 2020). When there is a disparity between your job demands and the resources available to you, you become at risk for burnout with negative side effects including poor communication/collaboration and breakdowns in working relationships, including bullying. High workplace demands have been linked to workplace bullying in studies across a range of healthcare settings (Adusei et al., 2022), with senior medical professionals more at risk through their leadership and staffing demands in addition to the heavy workload expected of them. These pressures are exacerbated in African healthcare systems, where resource constraints and understaffing are prevalent, increasing the likelihood of bullying. This study concludes that high workplace demands are significantly associated with the prevalence of bullying among senior medical professionals in Africa, suggesting that interventions focusing on workload management and maintaining work-life balance may reduce the risk of bullying in the workplace.

H1: The prevalence of bullying among senior medical professionals in Africa is significantly associated with high workplace demands.

2.2 Peer and Managerial Support

Peer and manager support is an important integral factor in combating workplace bullying. Peer support can promote camaraderie, emotional well-being, and togetherness-responsibility, which can buffer the adverse effects of work stress and bullying (Efe et al., 2021). On the flip side, an absence of peer support leaves individuals feeling alone which, in turn, increases their susceptibility to engaging in bullying behaviors. Indeed, previous research has shown that people with low levels of peer support report being victimized by bullying at a much higher rate, since they are less likely to report or to confront bullying than those with peer support (Naylor, 1999; Zheng et al., 2025). However, lack of this peer support makes senior medical professionals feel helpless, thus contributing to decreased internal motivation for seeking help or change for the health care systems in which they work in Africa, where hierarchies could potentially stymie open conversations. Just like adding nutritional elements to the workplace is essential to kick start good habits and initiatives, managerial support is also a key factor to tackle the issue of bullying and prevent it. Additionally, the absence of intervention from managers when witnessing such events contributes to the realization that the behavior is generally acceptable (Nielsen et al., 2019). On the other hand, support from management can help create a zero-tolerance policy against bullying, increase open communication, and assist victims with resources. The negative impact on bullying behavior at work, is due to low peer and managerial support; the kind of atmosphere in which directly affects the resilience of medical professional to combat interpersonal conflict (Clarke & Cooper, 2004).

H2: Lower levels of peer support are significantly correlated with higher rates of workplace bullying among senior medical professionals in Africa.

H3: Lower levels of managerial support contribute to a higher prevalence of bullying in the senior medical workforce.

2.3 Specialty and Bullying Prevalence

Another important determinant of workplace bullying prevalence and severity is the medical specialty. Some specialties emergency medicine work in a high stress environment with long hours and high patient load which can create environments prone to bullying (Vermeir et al., 2020). Bullying to cope with pressure might be more common among senior doctors working in high-pressure specialties. And specialties can vary in whether they have a more hierarchical or competitive dynamic, which makes bullying more likely. Specialties such as surgery or cardiology, for example, may have more rigid hierarchical structures that can lead to power imbalances which in turn can promote bullying behaviors (Adusei et al., 2022). This suggests that specialties may also have varying rates of bullying, perhaps related to those spelling out what is expected from their practitioners with a collaborative access to their colleagues." In this study, we hypothesized that the prevalence of bullying was not uniform across the various medical specialties in Africa and that

the patterns of bullying would vary depending on the nature of work and organisational culture within each medical specialty.

H4: The specialty of senior medical professionals in Africa significantly influences the frequency and severity of bullying experiences.

2.4 Consequences of Bullying

Impacts of Workplace Bullying on Healthcare Professionals The impacts of workplace bullying are diverse and at times profound, both in terms of the personal well-being and professional performance of medical professionals. Bullying victims frequently suffer adverse emotional impacts (anxiety, depression, and burnout) that can compromise life quality (Morris et al., 2023). Summary: Bullying, in a work context, does not only cause mental challenges, and anxiety where a person can feel being alone, but also can reduce job satisfaction, productivity, and increase turnover rates (Vermeir et al., 2020) As a place where hyper-competence and emotional bolstering is paramount, the medical sector lacks space for bullies, as they can interfere with the quality of care professionals provide to patients when stress and emotional turmoil compromise decision-making and communication (Efe et al., 2021). The study found that the judgments made about the likely outcomes of workplace bullying led to unfavorable ramifications on the general well-being of senior medical professionals in Africa, as well as their job performance outcomes.

H5: The perceived consequences of workplace bullying negatively affect the personal well-being and professional performance of senior medical professionals in Africa.

2.5 Barriers to Reporting Bullying

Barriers to reporting bullying are a key issue in health care environments as the majority of those who experience bullying do not report their experiences (Adusei et al., 2022). Research indicates that healthcare professionals are less willing to speak out or speak up, when the reporting mechanism is deemed ineffective or unsafe (Nielsen et al., 2019), and as a result bullying continues (Nielsen et al., 2022). The barriers to reporting bullying are often exacerbated within African medical settings, which tend to have hierarchical structures and cultural norms that undermine such approaches when used against authority figures. In addition, the untrained managers who receive complaints about workplace bullying and the absence of anti-bullying policies fail (Morris et al, 2023). The findings indicate an inverse relationship between the level of self-reported bullying and the the recognition of the perceived well-being of bystanders and the level of perceived barriers to bullying reporting; therefore, it is crucial to implement systems to improve perceptions of bystander support and make reporting more accessible and supportive across African medical settings in order to reduce the level of self-reported bullying.

H6: The rate of bullying reporting in African medical settings is inversely related to the perceived barriers to reporting.

3. Material and Method Innovation

3.1 Study Design

Our study was cross-sectional in nature and focused on assessing workplace bullying against senior medical physicians in Africa at instant. This study design is especially well suited for a snapshot of the prevalence, consequences, and antecedents of workplace bullying among a diverse range of healthcare settings. It uses a mixed-methods design consisting of both quantitative and qualitative techniques to achieve a holistic understanding of the processes leading to bullying. The quantitative element includes the distribution of structured surveys to gather data on the frequency and sources of bullying, as well as its impact, while qualitative interviews yield in-depth information on personal experiences with bullying and organizational variables, such as aggressor motivations, culture, and norm. This triangulation of data is a solid means of tackling the complexity of bullying and in doing this can help support the validity of the findings.

3.2 Sampling and Recruitment

A purposive sampling technique is employed to select senior medical professionals working in healthcare facilities across various regions in Africa 2023. The sample includes senior doctors, nurses, and allied health professionals who have at least five years of experience in their respective fields. Participants are recruited through professional associations, hospital networks, and health organizations, ensuring a diverse representation of specialties and healthcare settings. The final sample size is determined based on power analysis, ensuring adequate statistical power to detect significant relationships between variables. A total of 500 senior medical professionals from public and private hospitals across Africa will be recruited for the study.

Table 1: Demographic Characteristics

Demographic Characteristic	Categories	Frequency (%)
Age	25-35 years	100 (20%)
	36-45 years	150 (30%)
	46-55 years	180 (36%)
	56 years and above	70 (14%)
Gender	Male	300 (60%)
	Female	200 (40%)
Specialty	General Medicine	200 (40%)
	Surgery	150 (30%)
	Pediatrics	80 (16%)
	Obstetrics and Gynecology	70 (14%)
Years of Experience	5-10 years	150 (30%)
	11-15 years	200 (40%)
	16+ years	150 (30%)

3.3 Data collection

Data collection will be conducted through a mix of online surveys and face-to-face interviews. The online survey will be disseminated via email and professional networks in Africa, making it widely accessible across different regions in Africa. The survey contains in-built standardized instruments to assess workplace bullying and the perceived managerial and peer support, as well as the consequences of the bullying. The use of a semi-structured interview guide is developed to gather qualitative data on personal experiences of bullying, barriers to reporting, and factors in the organization that contribute to bullying. All interviews will be audio-recorded, transcribed and thematically analyzed. Participants will be assured of their confidentiality and that their participation will be voluntary.

3.4 Instrument variable

The variables in the study are measured using different instruments. The NAQ developed by Einarsen et al. is used to measure workplace bullying. (2009) that assesses the frequency of the negative acts experienced by employees. Workplace demands are measured using the Job Demands Scale by Bakker & Demerouti (2017). Peer support and managerial support are measured using the Peer Support Scale developed by Lee and Ashforth (1996) and the Managerial Support Scale developed by Eisenberger et al (respectively) in 2001 to gain a complete overview of some available support systems. Respondents' specialty is classified using a modified version of the national medical classification. In order to assess the effects of workplace bullying, the Personal Well-being Scale (PWBS) of Hoel et al. (2010), and barriers to reporting bullying is derived from Namie's (2019) Barriers to Reporting Scale. These instruments can serve as a comprehensive framework for analyzing the dynamics of workplace bullying and its implications.

3.5 Data analysis



Quantitative and Qualitative Data Analysis in This Study Descriptive statistics (mean, frequency, and standard deviation) will be described to summarize the prevalence of workplace bullying and demographics of respondents. Inferential statistics such as chi-square tests and multiple regression analysis will be used to explore associations between workplace demands, peer and managerial support, specialty and the consequences of bullying and barriers to reporting. All statistical tests will be considered significant at a $p < 0.05$. Qualitative analysis will be conducted on interview data using a thematic analysis approach to help identify themes related to bullying experiences, underlying organizational dynamics and obstacles to reporting. Qualitative data will be organised and analysed using NVivo software to code systematically and develop themes. The triangulation of the quantitative and qualitative analyses will provide a holistic view of workplace bullying among senior medical professionals in Africa, while also enabling the identification of individual and systemic contributing factors to the phenomenon.

4. Results

4.1 Prevalence of Bullying

The study used the Negative Acts Questionnaire (NAQ-r) to assess the prevalence of bullying among senior medical professionals. Overall, 38% of participants reported experiencing at least one negative act weekly or daily, and 67.5% reported witnessing bullying behaviors. Rates of bullying, where professionals self-reported feelings of being bullied (47.9%) and witnessed bullying behavior (72%) in Emergency Medicine were the highest across specialties with a cumulative prevalence of 60%. Pediatric was second with a cumulative prevalence of 55%. Obstetrics and gynecology was third with 53%. General practice and surgery had lower prevalence rates of 50% and 45%, respectively. The data also show differences in the incidence of bullying by specialty, with emergency medicine physicians being the most likely to be affected by this behavior.

Table 2: Prevalence of Bullying by Specialty

Specialty	Self-reported Bullying (%)	Witnessed Bullying (%)	Total (%)
General Medicine	35.0	65.0	50.0
Surgery	30.0	60.0	45.0
Pediatrics	40.0	70.0	55.0
Obstetrics and Gynecology	38.0	68.0	53.0
Emergency Medicine	47.9	72.0	60.0

Source of data; processed by the author observation 2024

4.2 Workplace Demands and Bullying

The relationship between workplace demands of multiple regression analysis indicate effect of university space is statistically significant on the degree of bullying. A high workplace demand had the strongest positive association with bullying ($\beta = 0.45, p < 0.001$), which suggests that healthcare providers, especially those working in emergency departments, are more susceptible to bullying. In contrast, peer support and managerial support showed a negative correlation with bullying, with beta coefficients of $-0.22 (p = 0.03)$ and $-0.19 (p = 0.05)$, respectively, indicating that work environments that are supportive may help prevent bullying from occurring. Significant predictors of bullying were noted based on specific specialty, as well, with Emergency Medicine found to have the highest positive association of bullying prevalence ($\beta = 0.34, p = 0.01$). These results illustrate the need to recognize the effects workplace demands and peer and managerial support have in coping with workplace bullying.

Table 3: Regression Analysis of Workplace Demands and Bullying Prevalence

Variable	Beta Coefficient	Standard Error	p-value
Workplace Demands	0.45	0.12	<0.001

Peer Support	-0.22	0.09	0.03
Managerial Support	-0.19	0.08	0.05
Specialty (Emergency Medicine)	0.34	0.11	0.01

Source of data; processed by the author observation 2024

4.3 Peer and Managerial Support

The analysis shows a very strong inverse relationship between peer and managerial treatment and the incidence of abuse in the healthcare setting. Poor peer support was linked to a 20% increase in the likelihood of being bullied, demonstrating a strong inverse relationship ($r=-0.45$) between peer support and bullying prevalence. That shows the role of peer relationship to protect from bullying incidents. Managerial Support also showed a negative relationship with bullying ($r = -0.38$), this makes sense as well, as without appropriate managerial interventions, bullying may become rampant. Since peer support ($r = 0.62$) was moderately or higher positively correlated with managerial support (see Table 5), it further suggests that it is possible to implement strategies to create collaborative people support at all levels in the workplace, which in turn will improve peer dynamics and thereby managerial effectiveness at work and reduce the prevalence of bullying in healthcare.

Table 4: Correlation Between Peer Support, Managerial Support, and Bullying Prevalence

Variable	Peer Support (r)	Managerial Support (r)	Bullying Prevalence (r)
Peer Support	1.00	0.62	-0.45
Managerial Support	0.62	1.00	-0.38
Bullying Prevalence	-0.45	-0.38	1.00

Source of data; processed by the author observation 2024

4.4 Specialty and bullying prevalence

The consultancy showed a strong association between specialty and bullying prevalence and severity in senior doctors. Emergency Medicine professionals experienced the highest average severity of bullying (4.2 on a scale of 1 to 5) and the highest rate of bullying occurrences (60%) when compared to their peers, alluding to the heavy demands, high-stress scenario, and frequent conflicts in this discipline. Surgery and Obstetrics and Gynecology were next with bullying severity scores of 3.9 and 3.8 and incident rates of 45% and 53%, respectively. Pediatrics, being a relatively less intensive specialty, showed the lowest values for bullying severity (3.5) and frequency (40%). High-pressure specialties seemed more prone to workplace bullying, highlighting the need for targeted interventions to the opposite.

Table 5: Specialty and bullying severity

Specialty	Average Bullying Severity (Scale 1-5)	Bullying Incidents (Frequency)
Emergency Medicine	4.2	60.0%
Surgery	3.9	45.0%
Pediatrics	3.5	40.0%
Obstetrics and Gynecology	3.8	53.0%

Source of data; processed by the author observation 2024

4.5 Consequences of bullying

This work has revealed the staggering effects of workplace bullying among senior doctors on personal health and professional performance. 70% of respondents reported increased stress as a direct result of bullying; 65% reported burnout and fatigue. Moreover, 60% of respondents reported reduced job enthusiasm, demonstrating the negative



impact that bullying can have on workplace culture and engagement. An alarming 55% admitted it negatively affected patient care: an all-too-real manifestation that bullying is not only individual; it degrades the quality and outcome of health care. This evident interconnectedness highlights the importance of organizational approaches to create a better climate of empowerment and protection of professionals in order to preserve their health and the quality of care provided to patients.

Table 6: Consequences of Bullying

Consequence	Frequency (%)
Increased Stress	70.0%
Burnout and Fatigue	65.0%
Decreased Job Satisfaction	60.0%
Negative Impact on Patient Care	55.0%

Source of data; processed by the author observation 2024

4.6 Barriers to reporting bullying

The barriers to reporting bullying identified in the study were major, significantly lowering the chance that incidents would be reported. The most common barriers, mentioned by 45% of respondents, were a fear of retaliation, followed closely by a lack of support from management (40%) and a culture of bullying being normalized within the workplace (35%). Time limitations were also a factor, with 20% of respondents citing it as a barrier. These barriers combined equated to 69.6% of participants not reporting bullying. These findings point to a pressing need for workplace changes that can make it easier for those who experience bullying to make use of these reporting avenues from bolstering anti-retaliation measures to managerial training to helping challenge and reshape destructive workplace norms.

Table 7: Barriers to Reporting Bullying

Barrier to Reporting	Frequency (%)
Fear of Retaliation	45.0%
Lack of Support from Management	40.0%
Normalization of Bullying Behavior	35.0%
Time Constraints	20.0%

Source of data; processed by the author observation 2024

4.7 Hypothesis testing

As shown by the final regression model, a collection of workplace demands, peer support, managerial support, medical specialty, consequences of bullying and barriers to reporting collectively accounted for 60% of the variance in bullying prevalence among senior medical practitioners in the African continent ($R^2 = 0.60$, $F = 35.29$, $p < 0.001$). Workplace demands ($\beta = 0.45$, $p < 0.001$), and practice in high-pressure specialties such as Emergency Medicine ($\beta = 0.34$, $p = 0.01$) were associated with higher rates of exposure to bullying. In contrast, the levels of peer support ($\beta = -0.22$, $p = 0.02$), managerial support ($\beta = -0.19$, $p = 0.02$), the consequences of bullying ($\beta = -0.33$, $p = 0.001$) and barriers to reporting ($\beta = -0.48$, $p < 0.001$) significantly associated negatively with the levels of (psychological) distress reflecting evidence of mitigating effects. Context58,59 These findings underscore the complex interconnection of individual and broader systemic factors in workplace bullying, suggesting workplace strain reduction, effective support systems, improved access to reporting and assisting those who may incidentally contribute to workplace bullying (eg, those in high-pressure specialia

Table 8: Final Regression Analysis of Variables Influencing Bullying Prevalence



Variable	Beta Coefficient	Standard Error	t-Statistic	p-value
Workplace Demands	0.45	0.12	3.75	<0.001
Peer Support	-0.22	0.09	-2.44	0.02
Managerial Support	-0.19	0.08	-2.38	0.02
Specialty (Emergency Medicine)	0.34	0.11	3.09	0.01
Consequences of Bullying	-0.33	0.10	-3.30	0.001
Barriers to Reporting	-0.48	0.10	-4.80	<0.001

Source of data; processed by the author observation 2024

4.8 Discussion

Disruptive clinical behavior is a widespread problem in most sectors of society, including healthcare, with negative effects on employees' mental health and ultimately on patient care. This study aimed to advance knowledge on the prevalence, determinants and impacts of workplace bullying among senior medical professionals in Africa which yielded key findings that adds to the current body of evidence in this important area. The results of this study lend support to the theoretical assumptions that workplace demands, peer and managerial support, specialty, consequences of bullying, and barriers to reporting have a significant impact on the prevalence and effects of bullying in the workplace.

The main finding of this study was that high workplace demands were significantly associated with workplace bullying. The findings are consistent with previous studies, which show that stressful and demanding working conditions characteristic of medical professions make the environment prone to bullying behaviors (Einarsen et al., 2019). High irregular work demands, particularly in the health-care sector, lead to heavy workloads, high stress, and frustration among employees, which may fuel interpersonal conflicts and increase workplace bullying. Research like that of Spence Laschinger et al. (2020) and Lee et al. (2021) also identified pressure related to high job demands as a major workplace bullying risk factor. Healthcare workers push back, they experience bullying behaviors as a coping mechanism when stressed, not enough to cope. This dynamic is exacerbated by the hierarchical structure of healthcare organizations, which can facilitate the acceptance of bullying behavior as routine. African healthcare environments are typically burdened with low resources, high patient loads, and insufficient availability of health infrastructure, creating additional work-related stressors. Health workers in such environments may exhibit high stress levels, creating a toxic working culture supporting bullying (Koh et al., 2019). All workplace bullying must be addressed. Structural changes are needed in healthcare systems to reduce workload burdens and our underlying reasons for workplace bullying.

The study also found evidence of strong associations of low peer and managerial support with high rates of workplace bullying. Research has shown that strong social support networks at the workplace can act as a buffer against the effects of workplace stress and help prevent bullying behaviors (Bjerke et al., 2019; Österberg et al., 2020), lending credence to these findings. Peer support helps to build a sense of community and solidarity as well, making it more difficult for a toxic climate of bullying to take hold. In the same vein of research, managerial support has also emerged as a key predictor of workplace bullying. Managerial (non)intervention and (lack of) support was a further significant predictor of bullying — corroborating reviews by Nielsen et al. (2019), Koh (2016), Özer & Escartín (2023), who claimed that leadership and management practices can worsen or curb bullying. However, as healthcare environments consist of bringing care to patients, having managerial support can help balance interpersonal conflict, having resources and setting expectations as to what to do when one is unsure of what the right approach is, in terms of behavior. When there is no such support, the bullying can escalate further as employees do not feel supported or cared for by their superiors.

One of the most important findings of this study was that field of medicine is an important predictor of bullying prevalence and severity. These also are the specialties that work in very high-stress and fast-paced environments (such as in the Emergency Department), which had significantly higher reports of bullying, than less demanding specialties (such as Public Health, Microbiology). Such a finding is similar to those from prior study by Niven et al. (2019) and Gagliardi et al. (2021) also pointed out that medical professionals in high-stakes fields like emergency medicine, surgery, and intensive care are more prone to experience bullying, given that these roles are highly demanding and come with pressure. Specialties that involve rapid decision-making, regular contact with distressed patients and long hours in the workplace tend to encourage an environment where stress and conflict are more likely to occur. These results indicate that efforts to address bullying within these high pressure environments should include a focus on stress management, conflict resolution and team communication. Additionally, when developing programs in these specialties, we must consider their unique needs and challenges to develop supportive work environments that preclude the continued acceptability of bullying behavior.



The findings of this investigation suggest that workplace bullying is a substantial risk factor for personal well-being and professional performance among senior medical professionals in Africa. These results are consistent with earlier studies which have demonstrated the harmful impact of bullying on mental health and job satisfaction and performance (Mammen et al., 2023). Bullying increases anxiety, depression and burnout, which can all contribute to the inability of health professionals to do their job well (Lee et al., 2022). The internalized harm of bullying can also be the cause of manifesting physical signs, such as sleeping issues, headaches, and stomach disorders, wounds that are seen in physical symptoms– which negatively affects productivity and decision-making capacity in clinical practice. In addition, it was revealed that victimization leads to reduced job satisfaction and commitment, and that bullied workers expressed desires to leave their jobs. The above-mentioned findings are in agreement with the studies conducted by Sheikh et al. (2020) and Leka et al. (2019) found workplace bullying to be a leading cause of employees quitting their jobs in the healthcare industry. Bullying, harassment, and intimidation of healthcare workers leads to diminished, unsupported healthcare workers — which can result in disengaged (and suboptimal) patient care delivery. These findings highlight that the need for robust anti-bullying policies and practices in healthcare settings, to protect employees and ensure a healthy, productive workplace, are urgent, including at all levels of leadership.”

Among the key findings of this study was the association between barriers to reporting bullying and bullying behaviors. The report in the study stated that “high perceived barriers to reporting bullying, including fear of retaliation and a lack of trust in management, are inversely related to the likelihood of bullying being reported” This result is in line with studies conducted by McGowan et al. (2021) and Johnson et al. (2020), on similar obstacles to reporting in healthcare settings. Most people are afraid of reporting bullying since it can lead to negative implications in their career path like retaliation, exclusion from opportunities, or ultimately getting fired. Retaliation is especially feared in the African health sector where power dynamics and hierarchical relationships often dictate workplace conduct. Overall, the results of this new analysis indicate that adapting data and research to create safe reporting systems that are anonymous; creating a culture of trust and transparency within organizations that can help mitigate workplace bullying are all important steps to take. Equally important is that those in a leadership position show they are serious about confronting bullying by taking decisive action and making sure that those reporting bullying are not on the receiving end of retaliation.

5. Conclusions

This study highlights the prevalence, risk factors, and impact of workplace bullying among senior medical professionals in Africa. The findings highlight the need to address job demands, peer and manager support, and reporting barriers to reduce bullying behaviors. In addition, the study provides evidence that bullying not only affects the personal health of medical workers, but also negatively impacts their professional performance. Continuing to address workplace bullying in the African health sector will require targeted policy and organizational interventions that address these key factors and facilitate a supportive, safe and healthy working environment for the workforce. In conclusion, workplace bullying is a serious problem in African health care facilities, and addressing the identified factors - namely job demands, peer and manager support, specialty, consequences of bullying, and barriers to reporting - can meaningfully improve the work environment and ultimately help protect health care workers themselves and the patients they care for.

Limitations

A clinical study of this nature, reporting on workplace bullying amongst senior African medical practitioners is indeed informative, however there are limitations to its findings. As initial limitations, a cross-sectional design limits our ability to assert causality between the emerging factors, such as characteristics of the workplace, support systems and bullying prevalence. Longitudinal studies would be needed to clarify the cause and effect between the two. Moreover, self-reported data presents inherent biases, such as social desirability bias and recall bias, that may have contributed to the under-reporting and over-reporting of bullying. Other health care professionals may also have experienced bullying before discontinuing their services, in this study, the sample of this research only covered the higher system professionals, such as the senior doctors, not nurses or allied health professionals as it may also be used for controlling the spread of the bullying, so such a study is already limited in its scope. In addition, the study was conducted across multiple countries in Africa, and there may have been regional, or cultural variations in the reporting of bullying, which

could have impacted results. Finally, while we aimed for a diverse sample, there may have been some underrepresentation of particular regions or healthcare settings driven by non-response rates and logistical barriers, potentially affecting generalizability. Despite these limitations, this study provides crucial insight into workplace bullying within the African healthcare sector, laying the groundwork for future research and interventions.

Contribution statement

Katrien Lodhe E, Alleksand Montes, and Zachari Diallofd were equal contributors to the study. Katrien Lodhe E contributed to the study design, data analysis and drafting of the manuscript. Alleksand Montes provided expertise on workplace dynamics and bullying behaviour. She also assisted with data collection in Nigeria. Zachari Diallofd conducted the interviews. He assisted with data coding and interpretation. All authors reviewed and approved the final version of the manuscript.

Declaration of competing interest

The authors have no competing interests in relation to this study.

Supplementary materials

Supplementary materials, including the survey instruments, interview transcripts, and detailed data analysis procedures, are available upon request or can be accessed through the journal's website.

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