

Original Research Article

Workplace Bullying Against Certified Registered Anaesthetists in the Tamale Metropolis in the Northern Region of Ghana

ABSTRACT

Background: Workplace bullying is a major occupational hazard globally with negative consequences on employee health and organizational performance. Workplace bullying has significant implications for quality care delivery and care outcomes.

Aim: We sought to investigate the nature and occurrence of workplace bullying and its effects on the health and job performance of Certified Registered Anaesthetists (CRAs) in the Tamale Metropolitan area of the Northern Region of Ghana. The characteristics of workplace bullying against CRAs included assigning unpleasant and menial tasks, spontaneous anger, hostilities, intimidation, unmanageable workload and threats of physical violence or actual abuse.

Methodology: The study was conducted at Tamale Teaching Hospital (TTH), the largest referral hospital in northern Ghana. Data was collected from Certified Registered Anaesthetists, doctors, nurses, and hospital administrators, using interviews, questionnaires, and observations.

Results: Prevalence of workplace bullying was 56.5% by quantitative inventory and 74.2% by subjective inventory. Also, 40.3% of participants had witnessed bullying against a CRA often and 75.3% had suffered physical and psychological effects from bullying, 16.1% were off-duty between 1-20 days within the last 6 months as a result of bullying.

Conclusion: The study concluded there is a high prevalence of workplace bullying against CRAs in the Tamale Metropolis with psychological and physical consequences on the victims that could affect quality patient care, care outcomes and loss of man-hours at work. It is recommended that workplace policy and worker education be undertaken by the metropolitan health directorate to urgently address the issue of workplace bullying.

Keywords: Workplace Bullying, Certified Registered Anaesthetists, Tamale Metropolis, Prevalence, performance

1. INTRODUCTION

Workplace bullying is a major occupational hazard the world over and there is increasing awareness of the negative and destructive impact on employees and consequently organizational performance. Some countries especially developed countries are addressing this defective workplace practice through the formulation of laws and workplace policies to deal with the phenomenon [1]. Workplace bullying may be subtle but dangerously deleterious and a poisonous ingredient when present in the work environment [2]. Several

terms have been used by researchers across the globe to describe workplace bullying including coercion, harassment, victimization, contentiousness, emotional abuse, and psychological harassment or mistreatment at the workplace [3]. Various definitions have also been given to this phenomenon around the globe to explore this devastating workplace related issue, educate the workforce about this form of violence and to assess claims involving allegations of workplace bullying. The most intriguing and compelling eye-catching element that is inherent in all the definitions is the perpetuation of some form of direct or indirect negative workplace behaviour repeatedly exhibited over a prolonged period of time by one or more co-workers. Thus, the victim (target) is unable to defend him or herself against the systemic mistreatment due to a power imbalance between the parties [4]. This negative behaviour may be subtle and disguised with all the right behaviours, but in there lies the treachery [5, 6].

Bullying is not a novel phenomenon among humans. It is said to have been around since the beginning of time manifesting in the form of violence perpetrated by one person or group of persons against another, a natural survival instinct directly aligned with competition and a lack of tolerance for others which is common among living species [7]. It degrades and isolates the victims thus hindering the victim's competence. The victim is then forced into mental isolation, timidity and acceptance of a "low grade human being" (self-devaluation). This further lends dominance to the bully and the victim becomes hesitant to approach the bully [8, 9]. It could justifiably be seen as a means to suppress the other person (victim) and provide the atmosphere for the perpetrator to dominate [10]. The World Health Organization (WHO) has described workplace bullying as an extensive public health problem requiring collaborative efforts, harmonized time and attention of healthcare service providers, legislators and families [11].

Even though sexual harassment has been extensively studied in Ghana, other forms of bullying at the workplace is scanty. A study by Frederick Doe at the University of Ghana on the influence of workplace bullying on the mental and emotional welfare of workers found that workplace bullying results in feelings of helplessness, depressive mood and negative self-worth [8]. Certified Registered Anaesthetist (CRAs) in Ghana are usually nurses who have had a specialized training in the administration of anaesthetics to patients undergoing surgical operations and providing intensive care to critically ill patients. They are certified by a recognized training institution and registered by the Medical and Dental Council of Ghana to practice as anaesthesia providers (Health Professions Regulatory Bodies Act, Act 857, 2013). They are the major providers of anaesthesia services in the country amounting to 92.9% of anaesthesia service providers, and playing a very important role, especially in obstetric surgeries [12]. They are the sole providers of anaesthesia services in the Tamale Metropolis which also serves as the regional capital of the Northern region of Ghana. The metropolis has four major hospitals that render anaesthesia services provided by permanent anaesthesia staff. These include the Tamale Teaching Hospital (directly under the Ministry of Health), Tamale Central and West hospitals under the Ghana Health Service (GHS) and the Seventh-Day Adventist Hospital under the Christian Health Association of Ghana (CHAG).

Anaesthesia which is a specialized branch of medicine is usually considered the sole preserve of physicians. For this reason, training scope, Practice domain and regulation of the CRA has remained a thorny issue in Ghana. A recent attempt by the Medical and Dental

council (MDC) to restructure the training curriculum and to change the name of the CRA to physician assistant and limit the autonomy of the CRA resulted in an industrial strike by the CRAs [13,14,15].

Workplace bullying differs in geographical characteristics of the workplace and the cultural perception of bullying. Therefore, there are variations in bullying between geographical regions, countries and work sectors [16,17,18]. A literature review of thirty internationally published articles from Africa, Asia, Australia, New Zealand, Europe, Scandinavia and North America, shows that predisposition to workplace bullying has wide fluctuations in prevalence among victims and witnesses from within and across continents [1]. The power imbalance in workplaces also has the likelihood to embolden the use of bullying acts, as well as institutional factors such as poor organizational processes and procedures and informal organizational alliances to factions which are all likely to contribute to and encourage bullying behaviours [19].

Studies by [20,21] have shown that such areas as the intensive care unit (ICU), obstetrics (OB) and operation theater produce high levels of stress. The huge quantum of work and complexity in the operation theater setting is said to immensely contribute to bullying [21]. It has been demonstrated that between 74% and 92.5% of nurses, doctors, and health service/hospital administrators reported witnessing or experiencing disruptive behaviour in the operating room area [21]. Also, 75% of surgeons, 64% of anaesthesiologists, 59% of perioperative nurses and 43% of surgical residents have reported witnessing disruptive behaviour in the operating room area [20].

Exposure to bullying in the workplace is estimated to be a more incapacitating and a more catalytically devastating problem for employees than all other kinds of work-related stress put together, and is seen by both researchers and targets alike as an extreme type of social stress in the work environment [22].

While the phenomenon of bullying is well documented globally for the nursing and some other professions [1, 23, 24], literature is scanty for nurse anesthesia (CRA for Ghana), advanced nursing practitioners, and physician assistants who frequently find themselves "entrapped in the web" and being bullied by both physicians and nurses with whom they must work closely. The consequential implications are physical, mental and emotional anguish suffered by practitioners with the potential to engender untoward outcomes in patients' care [25,26]. This study sets out to investigate the nature and occurrence of bullying and its effects on CRAs and their job performance in the Tamale Metropolis of the Northern region of Ghana.

2. MATERIAL AND METHODS

The study adopted the explanatory sequential design of mixed methods [27] using a two-phase approach to gather and analyze data to answer the research question. The preceding quantitative method provides the perspective of CRAs on the subject whilst the qualitative

sought to lend a voice to another health professional that would show convergence or divergence of views on the quantitative outcome.

The study was facility centered conducted from June to September, 2020. Sample recruitment included permanent anaesthesia service providers and anaesthesia service providers on MDC's mandatory clinical internship in the Tamale Metropolis of the Northern Region of Ghana. Health facilities that engaged CRAs on a locum basis and have no permanent CRAs were excluded as well as anaesthesia students and interns who have not written the MDC's licensure examination. It also included health service administrators with working experience in a surgical unit, doctors working in surgical units, operation room (theater) nurses and Recovery room (post-anaesthesia care unit) nurses with at least two years of working experience in the surgical unit and willing to participate in the study.

2.1 Sample Size and Sampling Technique

A total population of 73 anaesthesia service providers were targeted for this study. Microsoft excel sample size estimator for small (hypergeometric) populations was employed to calculate the sample size which yielded 62 individuals. The population proportions were set at 0.5. A margin of error of plus or minus 5% was also set at the 95% confidence level. A simple random sampling method was then applied to get the required sample size using Epi Info/ENA computer-based software. This is in conformity with Zmuk et al who compared three sampling methods for small populations and concluded that using at least 70% of units of a small population and applying the simple random sampling procedure will on average provide enough knowledge and information, leading to a narrow confidence interval and provide a quality basis for making a precise and accurate average estimate [28]. Purposive sampling and data collection protocols were then followed to further probe and explain the results from the quantitative phase. These included four (4) doctors and three (3) administrators who work in surgical departments/units, four (4) theater nurses and five (5) recovery room nurses who were willing and ready to participate in the study. A total sample size of 16 was thus obtained for the qualitative phase.

2.2 Data Collection Instrument

A self-administered structured questionnaire adapted and modified from the revised negative act questionnaire (NAQ-R) was used in collecting data in the first phase. Questionnaires were sent out via printed paper (15) while 45 were sent via the internet on google documents using WhatsApp in view of the corona virus-2019 (covid-19) pandemic at the time of data collection. The first section of the questionnaire comprises 24 items, also known as the behavioural experience method. It is an objective approach that indirectly takes inventory of behaviour usually considered negative in the workplace. The next section subjectively measures the perception of the respondents as a victim of workplace bullying by directly asking whether they have been subjected to workplace bullying. This self-labelled approach was preceded by a definition of bullying. Respondents were asked to rate how often they have experienced each of the negative acts in the last six months on a Likert scale of 1-5. The last section comprises demographic questions, an enquiry into job satisfaction and whether respondent knows of any administrative procedure at the workplace to address bullying. Assessment of completeness and eligibility for analysis indicated a 100% effective response rate for the questionnaire completed and returned at the end of the data collection period. The subsequent qualitative phase adopted purposeful sampling using one-on-one interviews of health professionals implicated in perpetuating bullying acts on CRAs in the

initial phase. This was carried out using a structured questionnaire to offer an explanation to some outcomes in the quantitative phase.

2.3 Data Analysis

Data collected in the quantitative phase was first coded, entered into Microsoft excel, inspected and cleaned [29]. The data was then exported to IBM SPSS software version 22 for analysis. Descriptive statistics were used to summarize, describe and present the basic features of the data. Factor analysis was carried out using the principal component analysis technique on variables that have responses on a Likert scale.

A Cronbach's Alpha yielded 0.902 indicating internal consistency (reliability) of the scale and KMO value of 0.772 was considered meritorious and conclusive that the data was perfect for factor analysis. Bartlett's test of Sphericity also had an approximate Chi-Square of 794.04 and the values were all very significant at a p-value of less than 0.05. See Table 1 for details.

Table 1: KMO and Bartlett's test of Sphericity

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.772
Bartlett's Test of Sphericity	Approx. Chi-Square	794.047
	Df	231
	Sig.	.000

A correlation matrix was constructed to show the level of relationship among the variables concerning negative behaviours perpetrated against CRAs at the workplace and the effects on the physical and psychological health, and job performance of the respondents. A total of 22 NAQ-R items were used in generating the correlation matrix and only those that were 0.5 and above were considered significant. Component analysis was carried out to account for any variation in data set and rotated component matrix analysis was employed to determine the amount of variation of each variable. A p-value of 0.05 or less at the 95% confident level was considered statistically significant. A scree plot provided the indication that seven components had eigen values more than one. These accounted for the total variance for each component and were thus retained for further analysis. Extracting a number of components of a large data set to draw conclusions is not without compromising accuracy of conclusions drawn. Therefore, Factor analysis do not provide absolute explanations but only descriptive explanations.

The analysis of the qualitative data involved first examining the data for words and sentences containing descriptions and themes within each that are relevant to the research question. Cross-case analysis was done to identify important themes about persistence across responses and to classify themes, code and sort them out into categories. Responses that embodied views across participants are presented as quotations.

2.4 Ethical Consideration

Ethical clearance was obtained from the University for Development Studies (UDS) Institutional Ethical Review Board for the commencement of the study. Participation was purely voluntary and the preamble of the questionnaire included a statement that states that completing and returning the questionnaire represented a consent to participate in the study. The autonomy, rights, values and wishes of the participants were assured through the preamble of the questionnaire. No direct benefit was assured for participation in the study. Data collection was devoid of any direct linkage to the identity of the health facilities or individuals from whom data was taken from.

Adequate information to allow the experiment to be reproduced. Already published methods should be mentioned with references. Significant modifications of published methods and new methods should be described in detail. This section will include sub-sections. Tables & figures should be placed inside the text. Tables and figures should be presented as per their appearance in the text. It is suggested that the discussion about the tables and figures should appear in the text before the appearance of the respective tables and figures. No tables or figures should be given without discussion or reference inside the text.

Tables should be explanatory enough to be understandable without any text reference. Double spacing should be maintained throughout the table, including table headings and footnotes. Table headings should be placed above the table. Footnotes should be placed below the table with superscript lowercase letters.

Each figure should have a caption. The caption should be concise and typed separately, not on the figure area. Figures should be self-explanatory. Information presented in the figure should not be repeated in the table. All symbols and abbreviations used in the illustrations should be defined clearly. Figure legends should be given below the figures.

3. RESULTS

3.1 Demographic Characteristics of the respondents

This section presents the demographic characteristics of the respondents. As depicted on Table 2 males accounted for 83.9% of the total number of respondents. Also, 83.9% of respondents were aged 30-39 years while the rest were within the age range of 40-49 years. The majority of respondents representing 87.1% were married, 38.7% were senior CRAs and the majority had a bachelor's degree (80.6%). More than half of the respondents (80.6%) worked at the Tamale Teaching Hospital. The details are depicted on Table 2.

Table 2: Demographic distribution of respondents

		Frequency (n=62)	Percentage
Age group (years)	30-39	52	83.9
	40-49	10	16.1
Sex of respondent	Male	52	83.9
	Female	10	16.1
Marital status	Married	54	87.1
	Single	8	12.9
Educational qualification	Advanced diploma	10	16.1
	Bachelor's degree	50	80.6
	Master's degree	2	3.2
Professional grade	CRA intern	13	21.0
	Staff CRA	8	12.9
	Senior CRA	24	38.7
	Principal CRA	16	25.8
	Deputy chief CRA	1	1.6
Type of facility	TTH	50	80.6
	GHS	10	16.1
	CHAG	2	3.2

3.2 Awareness of Bullying as an Abuse of the Victim

This section deals with whether or not health workers are aware that bullying in any form is an abuse of the victims. In responding to this, the researchers used the following codes for the data quotation: Adm= Administrator; TN= Theater (operation room) nurse; RN= Recovery room nurse and Dr= Doctor. The demographic characteristics of the participants in the qualitative phase of the study comprise nine (9) males and seven (7) females consisting of administrators, doctors, theater (operating room) and recovery room nurses as shown in Table 3 below.

Table 3: Categories of respondents

Professional category	TTH		GHS		CHAG	
	Male	Female	Male	Female	Male	Female
Doctors	2	-	1	-	1	-
Theater nurses	1	1	-	1	-	1
Recovery nurses	1	3	-	1	-	-
Administrators	2	-	1	-	-	-
Total	6	4	2	2	1	1

NB: TTH= Tamale Teaching Hospital

GHS= Ghana Health Service

CHAG= Christian Health Association of Ghana

The analysis revealed that all administrators agree that while verbal or physical violence does not occur because of people's knowledge of the law, subtle forms of bullying may be going on unreported for some reasons they gave as the target wanting to maintain a peaceful working relationship with the perpetrator and other staff and therefore simply ignores the bullying acts or the target wanting to maintain a sense of being strong/tough.

"Generally, because people know their rights these days, physical or verbal abuse does not occur. But people may have a domineering attitude or undermine others or behave in a way that put others down. It could be from senior or junior staff and it is difficult for people to report such things because they may want to show that they are tough and can handle it or in order not to create tension by avoiding confrontation with the person with such behaviour" (Adm).

There is no specific policy document on bullying in all the hospitals included in this study. "There is no policy document in particular on bullying, but when it is reported, conflict resolution procedures would be applied in addressing it" (Adm). Almost 43.7% of participants indicated that no form of bullying goes on between CRAs and other health workers. However, there may be issues of temperament with some CRAs who find questions about patients' conditions offensive.

"In my opinion, they (CRAs) are not bullied neither do they bully nurses...because none has bullied me. But some of them get offended when you ask them questions about the patient" (RN).

3.3 Forms of Bullying against CRAs

Table 4 shows the prevailing characteristic form of workplace bullying against CRAs as indicated by the respondents. These included: Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks; Being ordered to do work below one's level of competence or delegating someone to do menial tasks. Being shouted at or being the target of spontaneous anger (or rage); Being exposed to an unmanageable workload; Being ignored or facing a hostile reaction when approaching the bully; Hostile glares or intimidating nonverbal behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way and threats of violence, physical abuse or actual abuse.

Table 4: Prevailing Characteristic forms of bullying

Forms of bullying	Factor loading
Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	0.841
Being shouted at or being the target of spontaneous anger (or rage)	0.825
Being exposed to an unmanageable workload	0.825
Being ignored or facing a hostile reaction when you approach	0.734
Hostile glares or intimidating non verbal behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	0.701
Being ordered to do work below your level of competence or delegating you	0.673

3.3.1 Prevalence

By Leymann criterion of one or more negative acts perpetrated on the target per week over the last six months, the prevalence of workplace bullying against CRAs in the Tamale Metropolis was 56.5% and 74.2% for the self-label method. Of these, 3.2% were bullied several times per week or on an almost daily basis. Respondents who had witnessed a CRA being bullied very often were 3.2%, 40.3% Often, 1.6% very rarely, 43.6 rarely, and 11.3% have never witnessed a CRA being subjected to bullying.

While some of the participants (35.5%) did not know the reason why they were being bullied, 29.0% of respondents indicated they were bullied just because they are CRAs; 6.5% of respondents were bullied because they had a misunderstanding with their bully in the past, yet 4.8% of respondents were just being used as scapegoats.

3.3.2 Perpetrators of bullying

The study found that 48.4% of respondents reported having been bullied by persons superior in the hierarchy, 17.7% by persons at the same level and 8.1% by persons below the hierarchy of the victim. Doctors were responsible for the perpetration of bullying acts against 56.5% of victims followed by recovery room nurses 11.3%, theater nurses at 8.1%, colleague CRAs 8.1% and 1.6% were bullied by other professionals. Also, 63.3% of respondents were bullied by males with higher education, 4.1% by females with more education, male and female perpetrators with less educational level than the victim were 4.1% each, and male and female perpetrators with educational levels unknown to the victim 2.0% each, whilst 12.2% and 8.2% were bullied by male and female perpetrators with the same educational qualification as the victim respectively.

3.3.3 Effects of Bullying on Personal health and Job Performance

Respondents who were exposed to bullying suffered physical and psychological consequences including anxiety and sleep disorder (37.1%), feeling sorry for self (33.9%), headaches (33.9%), chronic fatigue (32.3%), irritability at home (25.8%) and gastro-intestinal problems (4.8%). This resulted in 16.1% of CRAs taking sick leave of 1-20 days in the last six months. Self-labelling as being bullied was found to be significantly correlated to the intention to perpetrate bullying on others at the 1% significant level ($r= 0.382$) and actually perpetrating bullying on others ($r= 0.232$). While there was no correlation found between self-labelling as being bullied and the practice of presenteeism, the practice of presenteeism was correlated to a CRA making medication errors ($r=0.451$). However, there was a significant negative correlation between self-labelling by respondents as being bullied and making medication errors by respondents ($r= -0.513$). Making medication errors was significantly correlated to the intention to leave or quit the job ($r= 0.634$).

Also, 19.4% of respondents will never draw the attention of someone they consider a bully to something he/she is not doing right on a patient, 22.6% will rarely do and 6.5% will do so very rarely. Most participants (71.0%) did not know of any administrative procedure at their facility to address issues of bullying and 25.8% indicated there was no clear administrative procedure at their facility whilst 3.2% indicated it existed but was not being used.

3.4 Typology of Bullying in the Metropolis

3.4.1 Retaliatory (Reprisal) bullying

The study found that 31.3% of participants indicated that some CRAs bully other health workers and therefore other health staff only respond to those CRAs in like manner.

“Sometimes some of them really have attitude and if you are not strong to stand up to them, they can make you miserable. So, if it is bullying, it is the CRAs who do it and we the nurses or some of we the nurses just want to prevent them from riding over us” (TN)

“... Some of the CRAs may use their experience to bully the young and inexperienced doctors and the doctors too, considering their position in the health structure, will also use similar tactics to get back at the CRAs...” (Adm).

3.4.2 Bullying as a means to get work done

The analysis uncovered that bullying has been used sometimes by some health staff on CRAs as a means in an attempt to get work done. This stems from fear of some untoward outcome for the patient. This, though, is not considered bullying by the perpetrator.

“Sometimes you have a patient who needs immediate attention and someone seems to be delaying the process, so you have to do what you think will get the patient to be operated on. In the process, someone might interpret your actions as bullying, but it will be unreasonable to physically abuse someone. Tempers may rise and words may be used, but in the end, we all know it was because of the patient and that ends it. I mean, nobody really takes those things serious outside the theater unless maybe, you are new to the system” (Dr).

In summary, reasons for using bullying are varied among health staff and may not necessarily be considered bullying by the perpetrator even though the victim may consider him/herself as being bullied, resulting in psychological and physical health problems as shown by the results in the quantitative phase of this study.

4. DISCUSSION

4.1 Characteristic forms of Bullying

Bullying in the health sector may be subtle, concealed and seemingly meek but corrosive [30]. Workplace bullying (WPB) includes being rude, using threatening gestures, public criticism of others or “put down syndrome”, and abusive language in work-related situations [31]. This could be vertical among staff at different levels of the organizational hierarchy [32, 33,34], or horizontal (lateral) among persons of the same level of hierarchy (peers) [35, 32, 36,19].

The present study suggests that workplace bullying against CRAs is mainly characterized by being shouted at or being the target of spontaneous anger (or rage). This form of bullying was also featured in a study in Bangladesh [37]. The results also found being exposed to unmanageable workload as a characteristic form of bullying used against CRAs in the Tamale Metropolis. Various studies conducted in Bangladesh and Italy show similar findings that included unnecessary task assignment, work overload, inadequate supply of resources and materials to execute job tasks and deliberately not involving the victim in decision making that affects the victim’s job performance or being asked to complete duties assigned in an unrealistic time frame as characteristic features of workplace bullying in the health sector [37]. Being ignored, hostilities, intimidating nonverbal behaviour such as finger-

pointing, invasion of personal space, shoving, and blocking/barring the way of a person are some other characteristic features of bullying perpetrated against CRAs in the Tamale Metropolis that were also found in Bangladesh [37].

The study found that bullies often undermine the professional competency of the victim and thus ordering the victim to carry out work deemed below the victim's level of competence. This was also reported by [36, 37] in their respective studies.

Threats of physical violence or actual abuse perpetrated on CRAs, though, not as significant as the other six features (factor loading of 0.617), were not anticipated since threats of physical violence or actual physical abuse are known criminal offences prosecutable by the Ghanaian law. However, this study was limited in assessing what legal redress was used in addressing such circumstances.

Both vertical and lateral bullying have been perpetrated against CRAs with the highest perpetrators attributed to senior colleagues. This is quite different from a study conducted in USA which found no horizontal (lateral) bullying among CRNAs [26]. It is however consistent with other studies conducted in Pakistan, the USA and Bangalore [28, 39, 23].

4.2 Prevalence of Bullying

The prevalence of workplace bullying against CRAs was found to be higher than the pooled prevalence of workplace bullying in Asia (47.1%), Australia (36.1%), Europe (18.4%) and North America (24.5%) [40]. It is also higher than the prevalence of workplace bullying among health professionals drawn from both public and private sectors in a European study which discovered a prevalence of 41.2% [3]. It is however consistent with a study in Pakistan on doctors which reported a prevalence of workplace bullying against doctors as 63.8%. This was attributed to the Pakistani cultural norms inculcated in a child that authority figures (elders and teachers) are to be obeyed without questioning. Thus, victims become bullies and a revolving cycle is set up [38]. This is considered a means to enforce authority and that is similar to cultural norms in Ghana.

The results are also consistent with a Zimbabwean study which reported 72.5% prevalence among nurses with 25.5% experiencing bullying on regular basis [41]. This may be an indication that the higher humane orientation attributed to Sub-Saharan Africa [16] is fast eroding as evident by the high prevalence of workplace bullying in Sub-Saharan Africa.

Respondents who witnessed a CRA being subjected to acts of bullying represented 88.7% with 40.3% witnessing the behaviour often, suggesting bullying is endemic in health facilities and needs attention. This could have implications for healthcare delivery and care outcomes. A Norwegian study has reported a lower prevalence 8% of respondents having witnessed bullying in their department, 3.5% reported witnessing bullying in another department, and 2% reported witnessing bullying both in their departments and another department [42]. This is attributable to the low tolerance of workplace bullying in Norway. Witnessing a co-worker being subjected to acts of bullying in the absence of procedures to seek redress can trigger anxiety in the witness and affects job performance as the witness begins to think of when it will be his/her turn to be on the receiving end. This is more distressing than physical assault from patients [35].

4.3 Perpetrators of Bullying Acts

CRAs experience bullying behaviour from nurses, colleague anaesthetists, doctors and other health workers. Similar results were found for bullying perpetrated against certified registered nurse anaesthetists (CRNA) in the USA [43]. Doctors were the most perpetrators of workplace bullying against CRAs in health facilities. Elmlad [39] and Savaşan and Özgür [44] also found similar results in their respective studies. The hierarchical socialization of medical training that sets up unquestionable obedience to seniors [45] has a rippling effect that could explain why doctors top the list of the perpetrators of negative acts in the health sector.

Theater nurses come after recovery room nurses in perpetrating bullying against CRAs possibly because whatever the anaesthetist does with the patient intra-operatively put more or less stress on the recovery room nurse whose duty is to make sure the patient is completely recovered from the anaesthetics without any untoward events happening. The results could also be an indication that there is minimal work-related interaction between CRAs and theater nurses which explains why fewer CRAs are being bullied by theater nurses as compared to doctors and recovery room nurses. Horizontal bullying is also eminent among colleague CRAs as was reported in other studies [35,32, 36,19]. This is an indication that bullying is endemic in health facilities in the Metropolis and there is the possibility of the bullied turned bully phenomenon among health staff.

4.4 Effects of Bullying on the Personal health and Job performance of the victim

CRAs who were exposed to acts of bullying experienced anxiety and sleep disorder, headaches, irritability and chronic fatigue. This has implications for the alertness and vigilance of the anaesthetist that can have serious repercussions for patient safety during anaesthesia and surgery. It could also trigger in the victim the use of psychotropic drugs and induce in the victim a loss of self-esteem and feelings of isolation, burnout, irritability, post-traumatic stress disorder and suicidal ideation [46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57].

Man-Hour lost to absenteeism from illnesses resulting from bullying could negatively affect performance and internally generated funds (IGF) of the health facilities and dwindle the patient care efforts [58, 59, 19, 60, 61]. The present study did not find any correlation between bullying and making medication errors or intention to quit as was discovered in other studies [62, 58, 59,19,60, 63, 64,61]. There is the possibility of social desirability effect on this outcome since making medication errors has legal and ethical implications for a CRA. There is, however, a correlation between being bullied and the intention to perpetrate or actually perpetrate bullying acts on others. This results in a vicious cycle of bullying that becomes endemic and considered part of the job [60]. CRAs who are bullied would also refrain from drawing the attention of a bully to something he/she is not doing right on a client as the victim becomes hesitant to approach the bully and this has implications for quality care and care outcomes as articulated in other studies [65, 8, 9].

The use of bullying as a means to get back at CRAs considered as bullies or domineering can result in cyclical bullying. These "fightbacks" also have the potential of soring interprofessional relationships among healthcare staff with negative effects on patient care and care outcomes. These findings are consistent with [50] findings that workplace violence and bullying breed reprisal attacks or spiteful obedience in the healthcare setting. Bullying is

inimical to performance and interpersonal relationships. It is also injurious to personal health and the negative outcome is enormous to be used as a means to increase performance. As observed by [50], workplace bullying leads to loss of concentration and thwarts creativity. Ikyanyon and Ucho, [66] found a significant negative association between workplace bullying and job satisfaction. They also found that employees who experienced low levels of workplace bullying performed better at their jobs than those who experienced high levels of bullying at work.

Social desirability influences the acceptance of being a bully and for this same reason, people who are victims of bullying behaviour will find it difficult to report the behavior. This could be accountable for the absenteeism from work as a result of being bullied at the workplace as observed in the first phase of this study. This implies that people would rather take a sick leave than report the bully. It could also be inferred that conditions for reporting bullying behaviour are not favourable at health facilities in the metropolis to encourage reporting of bullying behaviour. Chatziioannidis et al., [67] found that most bullying goes unreported for fear of the consequences, personal self-dealing and ignoring it as a non-important problem, and being afraid of the potential impact on professional progress or non-recognition of the problem. These were also alluded to in this study. Unfavourable conditions for reporting bullying behaviour make the victim suffer silently and consider it a "part of the job" phenomenon, become disgruntled and wished to quit [60]. The victim's output dwindles and this further lend credence to the use of bullying behaviour [46,47, 48,49,50. 51, 52, 53, 54, 55, 56, 57].

CONCLUSION

There is a high prevalence of workplace bullying against CRAs in health facilities in the Tamale Metropolis. Common perpetrators are superiors, males with more education than the target. Doctors are the most perpetrator of bullying acts against the majority of CRAs and the effects of bullying include personal health effects, absenteeism from work and potentially poor quality of care and care outcomes as victims and witnesses of bullying will look on unconcern when misdiagnosis and inappropriate procedures are being carried out on patients. In view of these, it will be mitigating for the municipal director of health together with heads of health facilities to institute in-service training and seminars on workplace bullying for health staff in the municipality. Modalities should be fashioned out to track and deal with the incidence of bullying through a reporting system and a chain of appropriate actions to be taken in addressing these issues. Media involvement in public education could further re-enforce the confidence in reporting and dealing with such issues. National data is required to formulate a national policy on bullying and to curb the occurrence of workplace bullying.

CONSENT (WHERE EVER APPLICABLE)

This is not applicable in this study.

ETHICAL APPROVAL

There were no ethical issues in this study. However, the authors still sought ethical clearance from the University for Development Studies. All respondents were assured of anonymity and the confidentiality of their responses, except where the respondents explicitly stated that to be quoted directly. Even with that, authors tried to use pseudo names.

UNDER PEER REVIEW

COMPETING INTERESTS DISCLAIMER:

Authors have declared that no competing interests exist. The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

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