Nursing's future? Eat young. Spit out. Repeat. Endlessly

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They say there is nothing new under the sun. More's the pity. Nursing's "dirty little secret" (Brunworth, 2015) is no secret to anyone involved in our profession, in any country and at any level of seniority (Birks et al., 2017; Johnson, 2009).

Recently on twitter, a UK nurse tweeted about her first ward experience as a newly qualified RN:

Very disheartened after my first day. Five newly qualified nurses on the same ward doesn't suggest good support. Also been told cannot guarantee I'll be allowed time off for my graduation next month. Advised I should already be competent and not require any supernumerary time…

Adding that at this time, she had "no contract" hardly seems surprising.

Another student posted that:

I'm getting tired frankly of hearing of student nurses pushed to the brink by members of our 'caring' profession (Permission from both tweeters was obtained to use their tweets in this paper)

We could only mutter under our collective breath, "You're getting tired of it?" We have been hearing horror stories like this since each of us were student nurses ourselves over 40 years ago. Even a fleeting glance at the professional literature reveals an organizational iatrogenesis problem of staggering proportions. Bullying, incivility and punitive professional malevolence (nowadays sometimes referred to as "gaslighting" (Thompson & Clark, 2018)) are now such a part of the fabric of almost every nurse's and health professional's lives (https://www.theguardian.com/society/2016/oct/26/nhs-staff-bullying-culture-guardian-survey accessed 2 April 2019) and (https://www.bbc.com/news/health-47774648 accessed 3rd April 2019) that such workplace experiences cannot be glossed over as "the fault of a few 'bad apples' when rotten orchards are the real issue" (Darbyshire & Thompson, 2018). Like it or not, this "organizational corruption" (Hutchinson, Vickers, Wilkes, & Jackson, 2009) is nursing's modus operandi, our "business as usual." Until it changes, this is who we are.

What do we do when confronted by such seemingly casual awfulness? It matters little to those on the receiving end whether this bullying is vertical, horizontal, social, circular or omni-directional. What matters is the extensive damage to their lives, health and careers (Hallberg & Strandmark, 2006) and to health service morale, retention and both clinical and education quality in the broader picture (Marchiondo, Marchiondo, & Lasiter, 2010; Todd, Byers, & Garth, 2016). We can almost hear

the pushback that says these new graduate nurses are lucky to have jobs at all and that if they had been properly trained to develop "resilience," they would not be complaining. The other self-comforting response is that we are being "negative" and that we should focus on the positive. Why don't we highlight nurses' exemplary workplaces and encounters? We have done just this in the past (Darbyshire & Thompson, 2014), and at any time on social media, there will be students and qualified nurses describing how they have been welcomed, supported, nurtured and inspired by superb colleagues and stellar clinical settings. All wonderful, but as one of us has pointed out previously in relation to poor care, this is not an "existential card game played with people's lives" (Darbyshire & McKenna, 2013). Five stories of how students had a wonderful clinical experience does not "balance out" the five stories of students reduced to tears, riven with fear, humiliated and belittled or otherwise abused by the very professionals that they wish to join one day.

Nursing's (and midwifery's; Gillen, Sinclair, Kernohan, & Begley, 2009) systemic and self-inflicted injuries should be considered against a background in the UK and globally of a shortage of nurses. We are not suggesting that if there were a surfeit of nurses, that it would be justified to treat newly qualified nurses like this but when it is known that more nurses are leaving than joining the UK NHS (https://www.bbc.co.uk/news/health-42653542; accessed 30 November 2018) and given the kind of story reported above, we should not be at all surprised. The transition from final-year student to staff nurse is already notoriously difficult (Halpin, Terry, & Curzio, 2017)—why make it harder (McKenna, Smith, Poole, & Coverdale, 2003)?

We have known for the last 30 or more years about first impressions, about valuing and developing new staff, and about how existing staff (both clinicians AND educators) often mistreat students and new graduate nurses, while avoiding any consequences via the "centrality" of their "manipulative actions" (Lewis, 2006; p. 58). Yet, we still find this in far too many schools, hospitals and health services, because frankly, no one is held accountable for these situations developing and fewer still even notice that there is a problem here.

Let us look at the situation as described. Five new graduate nurses starting on the same day may not be bad if there were five competent, caring and experienced preceptors or mentors to work with them on their first ward. If they had a carefully considered programme of induction and support to make sure that each of the five gleaned the most positive and beneficial experience from their initial clinical experience as new RNs, that too would be excellent. Somehow we doubt this.

Why would anyone tell a new nurse starting on their first ward that they "may not get the time off to attend their graduation ceremony?" If this were a "one-off" aberration, we could perhaps excuse it, but we have heard of similar power-wielding displays with depressing regularity over many years. Compiling duty rosters while trying to accommodate a range of staff preferences and commitments is certainly not easy, and if someone demands every Easter, Christmas and New Year as time off, there is definitely a place to say, "No. This will not happen." A nurse's graduation ceremony is not small beer, it is a huge day in a nurse's life, the culmination of years of study and effort and an opportunity for celebration with family and friends and, we would hope, with new colleagues.

Imagine if this ward had asked each of the five new nurses WHEN they were graduating and someone had brought in a cake to say "Congratulations." Just imagine the positive effect of a small act of kindness rather than this puffed up display of punitive power. Imagine if these new nurses were to see kindness being modelled rather than thoughtlessness. Please spare us any humbug about "having to cover the ward" and "not being able to promise particular days off." If this said nurse had, perish the thought, broken her leg or been struck down by dysentery, she would assuredly NOT be at work that day and we can guarantee that the ward would have been "covered" and that life would have gone on.

There is a more sinister and disturbing explanation to contemplate here, but it is one that we cannot shirk. This is that nurses know very well the right thing to do and how they should treat new nurses. Some choose, however, to take the more punitive and malevolent path on the perverse "rite of passage" (Birks, Budden, Biedermann, Park, & Chapman, 2018) basis that "in their day" they had to suffer and endure, so why should these "new nurses" enjoy anything different or better? As one New Zealand nurse observed:

You go into nursing and you experience bullying and earn your stars and stripes. That then gives you the right to go on and do it to others coming through. It's almost like an induction process (http://thewireless.co.nz/articles/nursing-can-t-shake-its-bullying-problem; accessed 3 April 2019)

"Why should they have an easy life, when we didn't?" We have each heard this a hundred times or more over the years as indeed has every junior doctor from some consultants. We wonder in our more morose moments, if this self-perpetuating sadism is hardwired into nursing's and health care's DNA. "We had to do x, y or z as students/new staff nurses" and so by default almost, so should every nurse who comes after us.

Even worse, if that is imaginable, is the real possibility that many of these bullies actually enjoy what they do. They derive pleasure from "seeing students squirm" (Smith, Gillespie, Brown, & Grubb, 2016), "reducing that student to tears" or "showing that student or new nurse who's boss." Clinical practice (Burkley, 2018; Tee, Üzar Özçetin, & Russell-Westhead, 2016) and nursing education (Cooper, Walker, Askew, Robinson, & McNair, 2011; Mott, 2014; Seibel, 2014) have sheltered and tolerated such bullies for decades, ensuring that they enjoy protected species status and never have to face consequences for their actions.

The comments about the new RN's expected competence are even more worrying. This is the dreaded "work-ready graduate" claim that keeps popping up and, at first blush, seems so sensible. Would we expect a new RN to be "incompetent"? Of course not, but there is a galaxy of difference between expecting a new RN to be safe, self-aware, questioning, alert, caring, thoughtful, participative, attentive and keen to learn and the perversion of "competent" that expects every new RN to be an expert in every different ward and clinical situation that they may encounter. Understand the former, and new RNs might be able to hit the ground and learn when, where and

how to run. Misunderstand "competence" as the latter, and new RNs will hit the ground and may never get up again.

They do not "know everything," and they cannot "do everything." In those respects, they are exactly like you and us. None of us can, no matter how long we have been nursing. Perhaps one day we will fret as much about work settings being "New Graduate Ready" and analysing everything that is "wrong with them" if they are not. Perhaps.

What can be done? It is a fairly accurate assumption, given the continuing global existence and prevalence, if not worsening, (https://www.abc.net.au/news/2019-02-01/act-health-toxic-bullying-culture-report-reveals/10770022; accessed, 14th April 2019) of current levels of bullying and abuse of students and nurses, that the initiatives and attempts of the last 40 years have failed and do not deserve to be perpetuated. Let us have no more "education" about why bullying is bad. No plea that "more research is needed." No more "mandatory training" that the bullies will sneer and smirk their way through. No more toothless mission and values statements about how respectful and safe our hospitals and universities are. No more platitudes about our supposedly "just cultures." No more fantasies that ephemera like "mindfulness" will solve the problem (Botha, Gwin, & Purpora, 2015; Green, 2018) Let us instead have some principled action that will remove the bullies and not the bullied from health care.

Perhaps the time has come for organizations to take decisive dismissal action against those whose behaviours and attitudes debase their organizations. This would be a sea change away from health and higher education's normal "job for life" culture, but what choice do we have? Are we prepared to blight another generation of nurses and have them bemoan the damaging existence of bullying in nursing in yet another 50 years time? Please tell us that the answer is "No."

This is not a call for a capricious "sacker's charter." Even bullies should have the opportunity to consider and mend their ways. An initial verbal warning would identify the unacceptable behaviours and caution the perpetrator that a second written warning would be issued should any similar behaviour occur in the future. Following this written warning, a third instance of bullying or incivility towards students or colleagues would result in dismissal. While health services may not have successfully eradicated bullying, other companies have and there is much that we can learn from other sectors. One in the UK, Timpson is noted for its radical social justice and positive employee welfare approaches. Their approach to company cheats, incompetents or rude, abusive bullies is clearly stated: "Every drongo (their term) should follow a clear disciplinary route leading to dismissal" (https://www.timpson.co.uk/about/magic-dust; accessed 14th April 2019). No bully working for this company would be in any doubt as to the consequences of their actions if they were to continue unchanged.

If this sounds "harsh," consider that health and higher education services do not exist primarily to provide jobs for those demonstrably unable to live up to the organization's stated values or to the professional values inherent in being a nurse or health professional. Aside from the massive

estimated financial costs to the UK NHS alone of some £2 BILLION per year https://www.theguardian.com/society/2018/nov/07/nhs-bullying-harassment-toxic-staff-costing-billions (Accessed 2 April 2019), the damage that bullying, incivility and destructive professional attitudes and behaviours do to organizational culture, nurse retention, morale, reputation and service quality (Blevins, 2015; Hutton & Gates, 2008; Marchiondo et al., 2010; Porath & Pearson, 2013; Todd et al., 2016) is manifestly too great for nurse bullying to be allowed to exist and for the bullies and their "Killer Elite" ilk (Thompson & Darbyshire, 2013) to be allowed to continue their "reign of terror" (Goldberg, Beitz, Wieland, & Levine, 2013; p. 191).

Is there a "balance" to be considered here? This is a moot point. There will certainly be some pockets of good practice and exemplary health workplaces where bullying is not tolerated or allowed to take hold. Allowing even a small percentage of bullies to poison workplaces and cultures is, however, far too costly and destructive to be allowed to continue. As one business executive noted in this respect: "Every mistake we've made in firing a questionable hire was in taking action too late, not too early." (Porath & Pearson, 2013). We know of no health or higher education organization where the process of dismissing a toxic and destructive employee would ever occur "too early." In the vast majority of cases, it simply would not happen at all.

As Fox (2013) noted: "Bullies don't change their spots unless they're faced with loss of prestige, livelihood, or income (our emphasis). Unless managers at the highest levels of the organization commit to putting a halt to bullying, bullies will always have a platform." It is difficult to find a more succinct, accurate and recognizable assessment of "what to do" about workplace bullying than this.

In 2013, we in Australia saw a masterclass demonstration of what leadership against bullying and abuse could look like. Responding to yet another report of sexual abuse in the Australian army, chief of staff, Lieutenant General David Morrison, took to YouTube® to speak directly to the entire army and to the people of Australia. This blistering, impassioned defence of his organization's people and values was matched only by his emphatic warning that he "would be ruthless" in ridding the army of bullies who believed that abusing, humiliating or "hazing" their colleagues was in any way acceptable. He set out the values and behaviours that he expected and then told the army, "If that does not suit you, then GET OUT." (https://www.youtube.com/watch?v=QaqpoeVgr8U; Accessed 3 April 2019) Small wonder the video has been watched and shared over two million times. Many of us in health care can only wonder what would happen to our supposedly "complex" and "intractable" bullying problems if we had leadership like this (Darbyshire, 2013).

How well has our current generation of managers and leaders both in clinical services and in Schools of Nursing and Midwifery served another generation of nurses? Have the people who lead and manage our health services failed to eradicate this systemic if not institutionalized dislike, suspicion and wariness of students and new graduate RNs and continuing workplace bullying of colleagues? If we have, then we can only hope that a new generation of leaders, educators and RNs can succeed where we have not.