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Killing ourselves with laughter … mapping the interplay of organizational teasing and workplace bullying in hospital work life

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Abstract

Purpose – The purpose of this paper is to explore the interplay of organizational humorous teasing and workplace bullying in hospital work life in order to investigate how workplace bullying can emerge from doctors and nurses experiences of what, at first, appears as "innocent" humorous interactions.

Design/methodology/approach – Based on an ethnographic field study among doctors and nurses at Rigshospitalet (University Hospital of Copenhagen, Denmark) field notes, transcriptions from two focus groups and six in-depth interviews were analyzed using a cross-sectional thematic analysis.

Findings – This study demonstrates how bullying may emerge out of a distinctive joking practice, in which doctors and nurses continually relate to one another with a pronounced degree of derogatory teasing. The all-encompassing and omnipresent teasing entails that the positions of perpetrator and target persistently change, thereby excluding the position of bystander. Doctors and nurses report that they experience the humiliating teasing as detrimental, although they feel continuously forced to participate because of the fear of otherwise being socially excluded. Consequently, a concept of "fluctuate bullying" is suggested wherein nurses and doctors feel trapped in a "double bind" position, being constrained to bully in order to avoid being bullied themselves.

Originality/value – The present study add to bullying research by exploring and demonstrating how workplace bullying can emerge from informal social power struggles embedded and performed within ubiquitous humorous teasing interactions.

Keywords Denmark, Health care, Power, Workplace bullying, Ethnographic fieldwork, Workplace humour

Paper type Research paper

Introduction

Workplace bullying can result in a devastating impact on victims' health and well-being owing to the risk of depression, anxiety and post-traumatic stress (Einarsen and Nielsen, 2014; Reknes *et al.*, 2014). Moreover, bullying results in heavy economic expenses in terms of sick leave, loss of productivity, absenteeism, turnover and legal costs (Nielsen and Einarsen, 2012). The literature on this subject (Zapf *et al.*, 2011) has demonstrated persuasively the worldwide prevalence of workplace bullying that has prompted governments, trade unions and industries to enhance the number of initiatives aimed at psychosocial work environment improvements (Duffy, 2009). Likewise, research on workplace bullying has increased in Europe, where it originated, and subsequently has spread worldwide.

Institutions in the health care sector are high-risk settings for workplace bullying (Zapf *et al.*, 2011). This ethnographic study takes place at The Danish National Hospital in Copenhagen, Denmark, and is conducted by the lead author of this paper. In 2011, 13 percent of the 8,000 employees at the hospital reported that they had been exposed to

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workplace bullying within the last 12 months. However, the results varied remarkably among departments at the hospital. At local departments, up to 48 percent of employees reported that they had been exposed to workplace bullying. The present study aims to investigate the possible explanations for these relatively high reports of workplace bullying by exploring possible different forms, practices and manifestations of bullying within hospital practice.

In this field of research, two different concepts, "bullying" and "mobbing," are used to describe workplace harassment (Zapf and Einarsen, 2005). "Bullying" refers to a single person who harasses other individuals, whereas mobbing refers to a group of people who harass an individual. Both concepts define and categorize the workplace bullying process according to three delimited individual roles: those of bully, victim and possible bystander (Tehrani, 2012; Zapf *et al.*, 2011; Zapf and Einarsen, 2005). The occurrence of bullying is largely explained by an intra-psychological focus on coherence between the role of bully or victim, and specific kinds of personal traits. The rigid roles of bully and victim are perceived as fixed and irreversible because they are linked to specific identifiable individuals (Fox and Freeman, 2011; Guy, 2009; Linton and Power, 2013; Mathisen *et al.*, 2011; Pilch and Turska, 2015). Consequently, single organizational members are held responsible for bullying incidents that lead to negative psychological and physical consequences for those accused of workplace bullying (Jenkins *et al.*, 2011).

A broad body of literature (Brennan, 2011; Collinson, 1988; Cooper, 2008; Korczynski, 2011; Lynch, 2009; Rees and Monrouxe, 2010; Schnurr, 2009; Schnurr and Chan, 2011; Terrion and Ashforth, 2002; Tracy, Myers and Scott, 2006) has investigated organizational joking practice in different workplace settings. However, the interplay between teasing and workplace bullying remains underinvestigated; in particular, ethnographic studies of contemporary workplace bullying are non-existent, and therefore we know little about possible connections between organizational joking practice and workplace bullying. Based on five months of ethnographic fieldwork, this analysis aims to investigate the nature, mechanisms and consequences of teasing by doctors and nurses. Based on our empirical analysis, we identify a form of omnipresent institutionalized bullying practice we term as "fluctuate bullying," wherein every doctor and nurse alternately bully and are themselves victims of bullying. Finally, we cover how doctors and nurses feel constrained to participate in the bullying practice because they risk being socially excluded if they refrain. Ultimately, doctors and nurses end up in a "double bind" position characterized by the absence of any proper moral choice.

Contextualizing the present study

Workplace bullying

According to Zapf and Einarsen (2005), the research on workplace bullying uses two different labels, "mobbing" and "bullying," to describe harassment at work. Both concepts share a victim-oriented focus. Researchers using the term "bullying" have focused primarily on the bully and therefore define "bullying" as one employee harassing other employees. Researchers using the term "mobbing" have focused exclusively on the victim and define "mobbing" as a group of people harassing a single employee (Zapf and Einarsen, 2005). However, both concepts agree on defining bullying as "repeated and persistent negative acts towards one or more individual(s), which involve a perceived power imbalance and creates a hostile work environment" (Salin, 2003, p. 1214). Moreover negative acts are defined as "harassing, offending, socially excluding someone or negatively affecting someone's work task" (Parzefall and Salin, 2010, p. 763). The aspect of hierarchical power imbalance between bully and victim is often stressed. Meanwhile, studies indicate (Zapf *et al.*, 2011; Zapf and Einarsen, 2005) that power imbalance often arises from sources other than organizational hierarchy,

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for example, from informal sources of power related to factors such as knowledge, experience and social support.

A broad body of the quantitative literature (Einarsen and Nielsen, 2014; Hansen *et al.*, 2006; Mikkelsen and Einarsen, 2002; Reknes *et al.*, 2014) has documented the severe psychological and health impact of bullying on victims. To a large extent, the research on workplace bullying centers on the perpetrator from a psychological perspective, emphasizing the role of his or her deviant personality (Fox and Freeman, 2011; Guy, 2009; Linton and Power, 2013; Mathisen *et al.*, 2011; Pilch and Turska, 2015). Likewise, the general public associate bullies with psychopaths (Caponecchia *et al.*, 2012).

Recently qualitative interviews (Lutgen-Sandvik *et al.*, 2007; Lutgen-Sandvik, 2008; Lutgen-Sandvik and McDermott, 2011; Tracy, Lutgen-Sandvik and Alberts, 2006) and one auto ethnography study (Sobre-Denton, 2012) have provided insight into how victims personally experience, suffer from and resist workplace bullying. Also covered is the victim's perspective on how co-workers may play a role in target's ability to withstand bullying (Tye-Williams and Krone, 2015). To a more limited extent, researchers have applied a social constructionist perspective to identify different empirical understandings of workplace bullying (Lewis, 2003), as well as to investigate how these perceptions become institutionalized (Liefooghe and Davey, 2010). Qualitative research rooted in emotional sociology (Bloch, 2012a) has tried to uncover the views and motivations of bullies and the role of the bystander (Bloch, 2012b). With the aim of illuminating the sometimes blurred delimitations of bully and victim, the perspective of the accused bullies has been investigated, yielding the conclusion that a number of alleged perpetrators viewed themselves as targets of bullying (Jenkins *et al.*, 2012).

Research on the dynamics of trust between human resources (HR), employees and managers suggest that HR professionals rarely judge situations as bullying where managers are accused due to a perceived risk to their own relationships with managers (Harrington *et al.*, 2012). Moreover, HR professionals emphasize the importance of perpetrator intentions and third-party witnesses to confirm the occurrence of bullying and in order for the label to be correctly applied (Cowan, 2012). The unitarist human resource management ideology appears to play an important role both in limiting the targets' chance of redressal (D'Cruz and Noronha, 2011) and in restricting the bystanders' chance of supporting targets of workplace bullying (D'Cruz and Noronha, 2010). The research on the perceptions of HR professionals and, following on from this, their use of anti-bullying policies has revealed a paradox wherein HR professionals feel convinced by their companies' existing anti-bullying policies despite the fact that the policies do not mention the term "bullying" (Cowan, 2011). Likewise, the National Hospital in Denmark has, for years, provided managerial levels, working environment organizations and employees with anti-bullying policies, plus intervention strategies, to handle and prevent bullying from occurring yet without the desired effect. This accumulated experience and knowledge indicate a need for further exploration of basic conditions and social mechanisms in the emergence of bullying.

Organizational communication scholars (Lutgen-Sandvik and Tracy, 2012) argue that workplace bullying calls for a more complex multilevel analysis because it not only occurs within the organization, but also is tightly connected to larger social systems of meaning and policy. By moving beyond the organizational surface, researchers can question hidden power relations, enabling a critique of taken-for-granted beliefs and patterns of organizing that might be inherent in acts of bullying (Lutgen-Sandvik and Tracy, 2012). Workplace bullying is interpersonal by nature because it implies more than one individual. Still, research remains characterized by an individual and measurable approach focused on the victim's perception of workplace bullying. The roles of bully and victim are understood through the lenses of individual personalities and not according to how these roles

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constitute each other. Communications scholars (Lutgen-Sandvik, 2006; Lutgen-Sandvik and Tracy, 2012) therefore conclude that the dialectic nature of power in social relations is overlooked in present research, which furthermore lacks *in situ* investigations of how the process of workplace bullying unfolds (Lutgen-Sandvik and Tracy, 2012; Parzefall and Salin, 2010).

Nevertheless, based on a critical conception of organizational power, Liefooghe and Davey (Liefooghe and Davey, 2001) introduce the concept of de-personalized/ institutionalized bullying. Call center agents in the study describe and view a number of management enacted organizational practices – for example, statistical surveillance of employees, public humiliation through showing employee results to the whole team, withdrawal of overtime, threats of dismissal and discipline – as a mixture of blatant and covert bullying. he authors argue that superiors are equally oppressed by the mechanism of organizational control and, furthermore, that employees experience this as an illegitimate use of organizational power whereby the practice becomes perceived as bullying.

D'Cruz and Noronha (2009) elaborate on the concept of de-personalized bullying in their studies of work conditions for call center agents within the IT-support sector in India. The de-personalized bullying here consists of an oppressive work regime that stems from the companies' service-level agreement with clients. Long work shifts with only a few breaks, widespread management monitoring and surveillance, emotional labor, public humiliation and punishment are some of the features that characterize the oppressive work regime resulting in physical and mental strain. In return for material gains and the perception of a valuable professional identity (D'Cruz and Noronha, 2012), the employees accept and thereby participate in their own oppressive work regime. Analysis reveals that de-personalized bullying entails a dualistic response from targets in which well-being and strain coexist (D'Cruz and Noronha, 2015). Targets perform resistance via different coping strategies in order to overcome their oppressive work environment and maintain their perceived benefits (D'Cruz and Noronha, 2013). Ultimately, the origin of de-personalized bullying is rooted in organizational design as a socio-structural and institutionalized phenomenon enacted by managers and supervisors who pursue organizational goals at the expense of subordinates (D'Cruz, 2015).

The concept of "compounded bullying" highlights the coherence between interpersonal bullying and de-personalized bullying that is emerging in the context of organizational change (D'Cruz *et al.*, 2014; D'Cruz and Noronha, 2014). Studying lay-off procedures in the IT sector, D'Cruz *et al.* find that superiors use their organizational position to further a personal agenda of dismissing specific employees on the pretext of organizational change due to budget cuts. The authors argue that their revelation of the prominent lack of support from HR professionals for the targets of bullying implies that union action and collectivization would be the only sustainable solution to workplace bullying (D'Cruz *et al.*, 2014; D'Cruz and Noronha, 2014).

The participants in our study neither describe a socio-structural, oppressive work regime nor interpersonal conflicts as the cause of their bullying experiences, and therefore the experiences do not constitute a form of de-personalized or compounded bullying. Instead, the participants report an experience of irreversible necessity to participate in and cope with bullying in the form of teasing. Through analysis, we trace back this socio-psychological pressure to a regulation of membership in workplace communities. Hence, we will argue that the social power struggles are double-edged; nurses and doctors simultaneously empower themselves and discipline colleagues in order to construct and maintain social order and control within workplace communities.

Workplace humor

According to Fine and De Soucey (2005), the joking culture is embedded, interactive and referential, securing the regulation of group members through social control. Humor is a

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metaphorical construction and means more than what it says. Decoding humorous interactions – both individual instances of humor and the broader process – reveals the underlying meaning of the social system within the group and the rules it is bound by (Fine and De Soucey, 2005). A considerable body of research has demonstrated that the joking culture, defined by humor and teasing, can make for a distinctive part of organizational culture.

Several research studies have demonstrated how joking practice plays a significant role in organizational life: Humor affects the quality of workplace relationships (Cooper, 2008) and serves different organizing functions in organizational practice, such as fostering group identity (Terrion and Ashforth, 2002), managing gender identity and working-class resistance (Collinson, 1988; Rodrigues and Collinson, 1995), performing "emotional labour" (Brennan, 2011), negotiating power relations (Rees and Monrouxe, 2010), constructing leader identities (Schnurr, 2009; Schnurr and Chan, 2011), shaping and maintaining professional identity (Fine, 2006; Lynch, 2009; Tracy, Myers and Scott, 2006), generating informal collective resistance (Korczynski, 2011), expressing distrust toward management motives and authority (Taylor and Bain, 2003) and serving as a disciplinary technology (Godfrey, 2016). Butler (2015) argues that the literature on workplace humor tends to view instances of humor as either rebellious or disciplinary. However, Butler suggests that "laughter tends to be collective and corrective in its manifestations [and] plays a socially normative role in organizations through processes of ridicule and embarrassment." (p. 43). Plester discusses workplace humor as "bounded social activities" (Plester, 2009, p. 595). We agree that humor bounds social activity and plays a significant role in regard to ensuring social compliance, resisting and making sense of organizational life. However, we wish to push the analysis and discussion further to investigate how workplace humor not only inspires merriment, identity and resistance in organizational life, but also possibly constitutes a basis for workplace bullying.

Recently, studies point out a "darker side" to the joking culture (Billig, 2005; Butler, 2015; Plester, 2016), thereby identifying a possible hurtful aspect of humorous interaction (Kahn, 1989; Kowalski, 2000). Hogh *et al.* (2005) argue that teasing is a form of expressing aggression and categorize it as workplace bullying. However, the concept of teasing is not further defined, and therefore the possible double-edged aspects encompassing both fun and strain are not explored. One item from the well-known self-labeling general standardized questionnaire (negative acts questionnaire (NAQ)) defines excessive teasing and sarcasm as a key aspect of workplace bullying (Nielsen *et al.*, 2011). But neither the possible different forms of teasing nor the consequences of teasing in organizational practice have been investigated in the research on workplace bullying. The research on humorous coping strategies related to "patient care" in the health care sector has demonstrated how humor increases employee job-satisfaction (Wanzer *et al.*, 2005) and positively affects patients' stress level (Facente, 2006). However, these findings neither investigate mutual teasing among colleagues nor explain why it emerges.

We know from the bullying literature that poking fun at another at their expense, joking and mocking can define a bullying practice (Cowan, 2012; Fox and Cowan, 2015). When we refer to teasing practice in our study, the concept covers joke-telling, banter and mocking, sometimes in an ironic and/or sarcastic way. The teasing covers different themes, ranging from the sexual and physical aspects of participants and their mutual relations to the professional and personal aspects of individuals.

By demonstrating that nurses and doctors experience an incriminating and detrimental side to what at first appears an "innocent," self-imposed and inexhaustible source of fun and merriment, we argue that joking and teasing also may constitute a form of bullying.

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Methods

This research is based on ethnographic fieldwork carried out at the National Hospital in Copenhagen, Denmark, where the lead author conducted participant observation among doctors and nurses for five months. Participant observation was performed during the day, night and weekend shifts at the hospital, equaling a full-time job. Methodologically, studying a phenomenon in its natural setting helps to provide insight into the "thickness" of everyday life (Geertz, 1973), for instance, the complexity, fluidity, velocity, multiplicity, indeterminacy and narrativity. As such, ethnography involves an ongoing attempt to place specific encounters, events and understandings into a fuller, more meaningful context. Because the working life of doctors and nurses is so different from the everyday academic world to which we – the authors – belong, understanding the hospital setting depends not simply on identifying its distinctive features but on grasping all sorts of ordinary, everyday details (Geertz, 1983). It is only through immersion over a long period that one can become properly acquainted with all the small details of working life in a hospital setting. Hence, by entering into a close and relatively prolonged interaction with doctors and nurses in their everyday working lives, we, as researchers, can better understand the beliefs, motivations and behaviors of doctors and nurses than by using any other methodological approach (Hammersley and Atkinson, 1995).

The methodological principle behind the present fieldwork may be referred to as observation of participation (Tedlock, 1991). This is a reflexive fieldwork technique in that the researcher includes her own narratives of emotions, thoughts and reactions. This approach is particularly relevant to this study of bullying/teasing practices because the lead author, through her participation in the everyday working life of the hospital, exposed herself to social processes and interactions similar to the ones that doctors and nurses are part of each day during work hours. Field notes were written in a diary format in a narrative style and related what the lead author had observed, been told and experienced each day (Jackson, 1990). These notes included descriptions of tasks and working procedures, conversations and different kinds of jokes and teasing practices. Consequently, the personal experiences of the lead author form a major part of the analysis (Haas, 1977), providing details of situations in which she found herself having to judge right from wrong and choosing between taking on teasing practices in line with those of the medical staff or not.

The research was organized in cooperation with the hospital top management, middle management and with the management of the specific departments/wards that were included in the fieldwork. All employees were invited to participate in several meetings communicating about the aim of the research, as well as the implications of the fieldwork for everyday routines, and the work of the medical staff.

The fieldwork took place in three different departments (see Table I) that represented both high and low self-reported exposures to workplace bullying in the 2011 survey.

The fieldwork began in a bed ward with a focus on the nurses' internal relations, as well as their collaboration with the doctors. From there, the fieldwork shifted to the various operating theaters of a surgery ward and focused on the workflow and

Location	Time	Objective
Bed ward	6 weeks; day, night and weekend shifts	Interaction between groups of staff
Surgery ward	6 weeks; day, night and weekend shifts	Workflow and collaboration between doctors and nurses
Following surgeons	6 weeks; day, night and weekend shifts	Daily work life and conditions for surgeons at work

Table I. Organization of participant observation during fieldwork

collaboration between doctors and nurses: Different surgeons undertook different operations according to their medical specialities, but the anesthesia and theater nurses remained the same throughout a single day in one operating theater. Therefore, it was relevant to observe different constellations of working relations within the same group of nurses but with different doctors, as well as to interact with the various groups. The fieldwork ended with following a group of surgeons wherever they went during their day at work. This final stage of the participant observations was devoted to the perspective of the surgeons and aimed to achieve insight into the daily work life and conditions for surgeons at a hospital.

During the fieldwork, the lead author participated in approximately 180 operations ranging from 30 minutes to 4 hours. She also participated in daily routines such as serving food, cleaning wounds, patient registration and discharge, ward rounds, patient interviews and conversations, preparation for and even assistance during operations.

Shortly after the ethnographic fieldwork, two focus groups involving the participation of five anesthesia nurses were held, followed by six in-depth interviews with individuals: three with theater nurses and three with surgeons. Participants in the focus groups and individual interviews were doctors and nurses who were involved in the participant observations.

All interviews and focus groups were tape-recorded and transcribed verbatim. Field notes and interview transcriptions were then imported into the software NVivo and coded as close to the data as possible, using either "in vivo" terms or descriptive words or phrases. In the second step, all codes were bundled together thematically after the principle of inclusion (one code may belong to several categories) in order to maintain the complexity of the data. In the third step, these categories were organized into even broader categories. The coding process was performed without determining any fixed coding themes beforehand in order to "open inquiry widely" (Berg, 2001, p. 251) with the aim of identifying themes that were important to the further analysis.

Analysis

The analysis consists of two parts: In the first, we investigate and illustrate how teasing practices serves to regulate the social aspect of work communities. The analysis reveals that the teasing practice covers five different themes related to personal, social and professional aspects of hospital work life. However, the different teasing practices share a common disciplinary purpose; they all serve to position doctors and nurses within the social communities at the hospital. In the second part of the analysis, we account for the teasing practices as a form of bullying as demonstrated by the doctors' and nurses' experience of severe strain caused by the derogatory, patronizing and humiliating aspects of this practice.

Teasing as a form of social power regulation

> "Let's see if she can stand the pace […] if she can handle the tough talk around here, ha ha ha […]" It's my first day at the hospital. The nurses have decided that I should follow the nurse who's in charge of the patient with the biggest post-operative wound in the section. Just to see if I can handle the pressure. Smirking, she and a couple of other nurses tell me how to manage the possible indisposition I might experience once exposed to the patient's wound: "If you feel unwell, sit down with your back against the wall and your head between your knees so that you don't vomit on the patient, ha ha ha", they instruct me with a grin. I have prepared myself for the participant observations by watching operations and other forms of hospital work on television. "You can't prepare yourself for what you're going to experience in here", a senior nursing officer tells me. "It's like giving birth to a child. You can attend prenatal classes, but the reality's beyond your wildest imagination." (Field notes)

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One teasing theme is "proving resilience." Smiling broadly, nurses and doctors repeatedly and mutually challenge every group member's robustness, including that of the newly arrived lead author. To be accepted as a pertinent and dignified member of the group, everyone must pass resiliency teasing tests and prove the ability to withstand the pace of the medical work – a world so extreme that it exceeds one's wildest imaginings. Doctors and nurses refer to this kind of teasing as "the Tarzan Syndrome": those who prove themselves resilient enough to put up with any challenge at work rank above others and empower themselves through the honor of being referred to as "Tarzan." On the other hand, those who reveal weakness and vulnerability are ranked the lowest within the social hierarchy and suffer from a lack of respect from colleagues. In this sense, teasing serves to test each working group member's ability to handle specific conditions in hospital work life, including the nudity and mutilated bodies as illustrated.

"Educational status" provides another disciplinary teasing theme:

> During surgery, a couple of nurses and a surgeon talk about a medical student who has just left the room. "She's so annoying!" one says.
>
> "Yes, she worms herself into the operating area and starts talking", another responds.
>
> I just listen quietly to their conversation. After a short while, the surgeon looks at me and says to the others: "Is this the annoying student over here, ha ha ha […]?" We all laugh out loud. (Field notes)

In the eyes of the interlocutors, a group member's behavior is deemed inappropriate based on the rules governing educational status and rank; for example, she is "only" a medical student. Another present person is "only" trained as an occupational psychologist. Hence, they are both designated as targets for teasing. In this way, everyone present is taught about appropriate behavior both for new arrivals and old-timers. The teasing for inappropriate conduct regulates a social status by illustrating that slander, behind your back, will occur if you overstep the social rules of appropriate conduct in relation to educational status. When the lead author asks a surgeon one day if a big black shadow on an X-ray represents the patient's heart, he replies by asking whether she is an academic. By means of his joke, he insinuates that not knowing how to interpret an X-ray implies not being a competent academic. He thereby elevates his own status above that of another working group member by implying that he constitutes the more worthy academic. In this way, his scientific status surpasses that of the lead author.

"Personality" addresses a third disciplinary teasing theme:

> "Hey listen up, the professor [one of the two operating surgeons] must need some psychological help, since (name of the researcher) has to do research on him, ha ha ha […]" an anaesthesia nurse, Adam says while smirking.
>
> Sara, a theatre nurse, adds, "Yeah, the professor needs to be examined by a shrink, ha ha ha […]"
>
> Smiling, I respond, "Unfortunately, I can't assist the professor with his need for therapy, since I'm not trained as a clinical psychologist. But I can easily recommend one of my colleagues at the department of psychology at the university." We all laugh. Then Robert, another anaesthesia nurse, says,
>
> "I would very much like to make a donation for the professor so he can go to a shrink!" Everybody laughs out loud. (Field notes)

By proposing that the professor be examined by a psychiatrist, Adam, Sara and Robert insinuate his possible mental illness and consequent need for therapy. In no time, the authentic reason for a group member's presence (a current research project) is teasingly

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turned into an interpretation of possible insanity concerning the doctor responsible for the operation in progress. Indirectly, group members toy with the professor's weakness and vulnerability in order to raise their own social status within the group; he may be insane and they are not. While attending a clinic managers' meeting, the lead author, at one point, is referred to by management and co-workers as "psycho-(name of the lead author)." Referring to a group member's educational background as an occupational psychologist, the doctors and nurses play with the idea that she is insane and a possible psychopath by calling her "psycho" followed by her name. The reference to a psychiatric diagnosis carries the association of craziness, suggesting that she may rank lower in intellectual and social status than the others.

"Sexual dominance" also constitutes a disciplinary teasing theme.

After the morning conference, the surgeons hold a meeting. They talk about some missing information and who is to blame for it. Suddenly, the male chief of the section walks directly toward me. I am sitting on a chair like everybody else:

> "This is not something for (name of the researcher) to hear, ha ha ha […]" he says, just before stopping in front of me with his back turned to the others.
>
> He wraps his hands around my head to cover my ears. Because I'm sitting down and he's standing up, his genitals are right in front of my face. I can neither hear what he's saying, nor see the other surgeons' reactions. Everybody laughs when, a couple of minutes later, he takes his hands off my ears. (Field notes)

If one person is sitting down and the other are standing up, an asymmetrical power relationship occurs wherein one person looks down at the other. The male chief prevents the other group member's communicating (non-)verbally with the spectators by blocking her ears and field of vision. Because he stands very close and immediately in front of her, the chief assumes a position that carries sexual overtones for the spectators. He thus dominates her physically and socially in front of their mutual colleagues whereby he elevates his power status at the expense of hers.

Finally, "incompetence" emerges as a fifth disciplinary teasing theme:

> During surgery, the theatre nurse Linda has some problems getting the IT navigation system to work. After a long fight with the equipment, she finally succeeds. The other theatre nurse, Susan, says to her ironically,
>
> "How competent you are!" Linda laughs and on her way out of the room turns towards Susan and says,
>
> "Look I'm also capable of opening the door all by myself." Susan laughs out loud.
>
> I smile broadly at the two women.

Linda is compelled to be self-deprecating in a derogatory way when she jokes about her ability to open a door – this after Susan has joked about Linda's inability to manage the operating equipment. Hence, Linda is obliged to perform self-targeted teasing to avoid a drop in her professional and social status because the less adept doctors or nurses are at responding to and/or initiating teasing, the lower their social status and the more they prove themselves irrelevant to the medical communities. If Linda tried, instead, to defend herself against her colleagues, she would merely attract further teasing. This mechanism of empowering one's own social status involves nurses as well as doctors:

> A consultant surgeon, Paul, and a professor, Michael, ask one of the theatre nurses, Michelle, to hold the legs of the patient while the doctors perform a specific task during the operation. Michelle sits under the draping and therefore cannot see the patient or the surgeons operating. When Paul and Michael have finished their job, they do not say anything to Michelle, who remains seated under the draping.

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After a while she asks, "Do I still need to pull?"

"Yeah, just keep on going until the late night shift!" Paul replies, guffawing. Michael and Melanie, another theatre nurse, laugh out loud, as do I.

Shortly after, Michelle asks, "Do we need to send the X-rays anywhere?"

"Yeah –- it's Christmas soon", Michael responds.

"Facebook!" answers Paul.

We all laugh out loud. (Field notes)

If Paul and Michael succeed in convincing the present group members that Michelle is ignorant and maybe even stupid, Paul and Michael elevate their own professional status within the group. When Michelle chooses not to respond to Paul and Michael, she loses the battle and accepts being relegated to the lowest rank in the professional hierarchy. In a later spontaneous conversation involving the lead author, Paul and Michael, the two men refer to Michelle as "incompetent because she always searches for work failures." When the lead author challenges the statement by drawing attention to the fact that Michelle has worked 18 years at the department, they instantly and simultaneously answer back; "But she does not have the right personality" without being able to describe this "right" personality. Disturbingly, Michelle never receives answers to any of her questions. Instead, Michael and Paul empower their professional status at Michelle's expense by teasingly accusing her of incompetence.

The prevalent teasing rules every work setting, including in the presence of patients. Every doctor and/or nurse present contributes to the teasing practice either by teasing colleagues or by laughing at teasing initiated by other colleagues. The positions of teaser, target and laughing spectator quickly shift among doctors and nurses. Thus, the teasing practice appears fluid because the positions of teasers and targets constantly fluctuate.

The widespread teasing triggers fun and merriment, and instinctively initiates laughter. The acceptance of membership in the medical communities depends on one's ability to master the teasing practice. The appropriate way to handle, respond and thereby participate in the teasing turns out to be a crucial part of acceptance. Shunning insults or embarrassment is pivotal to avoiding exclusion. However, if a group member succeeds in performing "proper" teasing the "correct" way, he or she is then able to be included in the workplace communities and to benefit from a high social, professional and, accordingly, powerful status within the medical communities:

One day the lead author arrives at the hospital with a cold. She coughs and struggles with a runny nose. The surgeon who has agreed to let her follow him that day says:

"You should go home! You're sick."

"Oh no, I only have a cold", I reply. The third time he tells me to go home because I certainly am sick, I say:

"Listen, I know that we women give birth to children, but you men think you're going to die if you just have a cold." He guffaws

"(Name of the lead author), you sound like the leading professor of the department. You should have been a surgeon, not an occupational psychologist, ha ha ha […]" I laugh. (Field notes)

By telling the researcher that she should have been a surgeon instead of an occupational psychologist, he indirectly states that her ability to perform the "proper" teasing conduct has been proved. The capacity to perform the "proper" teasing results in acceptance that allows significant access in several ways: first, one is, to a greater extent, invited to

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participate in conversations, and colleagues openly express an interest in one's personal life and background. Second, one is given access to multiple interesting tasks with greater responsibility. For example, the lead author gets to fully assist the surgeons at close quarters when she begins to tease back and/or to initiate teasing others, as in the example above. The social acceptance influences her ability to contribute professionally to the medical work. Third, one feels the social acceptance, respect and appreciation from fellow group members who openly acknowledge the disadvantages of one's absence. For instance, once the lead author has mastered the teasing, the nurses and doctors start to encourage her to be re-educated as a doctor or nurse and tell her that she is always welcome to return if she ever experiences a lack of employment.

During focus groups and individual interviews, sequences from field notes dealing with teasing and involving the interviewee(s) (like those sequences previously quoted) are read out loud. Strikingly, none of the participants remember any of the episodes yet report that the scenarios sound most likely. It could be that a significant number of the employees at the hospital have very poor memories. A more likely reason for their lack of recall could be that the teasing is embedded and incorporated into their daily practice to such an extent that they no longer notice it. In other words, the teasing practice is an automated and nested practice that contributes to regulating and sustaining social order.

During the entire fieldwork, the doctors and nurses continually reveal how they take pride in their job at the National Hospital and the attributed professional identity. Proving resistance, sanity, power, competence and professionalism by teasing at someone else's expense empowers one's own social status within the medical communities while turning out to be crucial to acceptance and inclusion. Ultimately, doctors and nurses experience and perform a fluid teasing practice, wherein the teaser and the target continually change positions as an irreversible basic condition of medical work; neither old-timers nor newcomers are exempt from this practice. Whoever fails to master these practices ranks lowest within the social hierarchy and potentially risks being socially excluded from the medical communities that everyone depends on so heavily to fulfill his or her work tasks.

Accounting teasing practice as a form of bullying

The demonstrated teasing practice constantly prevails everywhere within the medical practice. It encourages entertainment, fun and laughter among employees and quickly spreads to newcomers. The amusing entertainment enables high spirits in a professional setting where the workload is heavy and performed at the precipice of life and death. The teasing thus triggers moments of joy and creates appreciation of doctors and nurses; the fun generates a sense of valuable membership in important communities. Employees depend on affiliation to work groups. Every member intuitively longs to belong to their work community in order to perform an important task for patients, their relatives and the overall society.

However, when the male chief of the surgical section makes it looks as if he is using the lead author to gratify himself sexually, she appears weak and undignified in front of her colleagues. She feels ashamed and yet she laughs. By asking the lead author whether, because she cannot identify a heart on an X-ray, she really is trained as an academic, the surgeon insinuates that she is stupid or at least an incompetent academic and yet, she laughs. When the senior nursing officer reveals that the top management refer to her as psycho-(name of the lead author), the insinuation is that she is crazy or mentally ill and nevertheless, she laughs.

When doctors and nurses are confronted with field notes during interviews and focus groups, they are asked openly what they think of the incidences of teasing. Every single one

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of them unhesitatingly answers that she or he finds the teasing disrespectful, harsh and demeaning. They spontaneously ask the interviewer, "Wouldn't you?" Interestingly, no one comments on the examples from fieldwork as funny, pleasant or enjoyable, and yet they all participated by laughing and/or verbally elaborating on the teasing.

If the medical personnel consider the teasing practice to be disrespectful and demeaning, it seems obvious they should oppose it. However, doctors and nurses narrate that if they try to resist the teasing by resigning or openly complaining about it, it just increases. They disclose that they have all experienced how former colleagues who opposed the teasing were socially and professionally excluded from the workplace and ended up leaving. Months after the fieldwork, a nurse and a doctor separately, spontaneously and suddenly confide to the lead author, when she happens to meet them in another context, that they have left the workplace because of strain due to the teasing practice. These previous experiences cause a widespread fear among doctors and nurses of their own potential future exclusion from work. Everyone strongly senses that falling behind would lead to her or his own exclusion. A professor at the department, who is both scientifically and socially at the top of the hierarchy, reports during an interview that he experiences exactly the same as everyone else. Nobody seems able to explain why this form of teasing appears so widespread at the hospital. "It has always been this way and always will be," they state. "And if you can't handle the pressure and the tone around here, you might as well find another job," they conclude.

Doctors and nurses also report that the fun and teasing often lead to awkwardness. They narrate how their emotional response to the teasing rapidly switches from one mental mode to another: At first, the teasing incites joy and laughter. For instance, when the consultant surgeon (Paul) and the professors (Michael) joke about the nurse (Michelle), everyone finds the comment funny because they are absurdly humorous. No doctor or nurse would ever release a patient's X-rays to the public. However, with the onset of a bad conscience, the fun is followed by the feeling of "a bad taste in the mouth" and even a sense of shame. The employees present imply that Michelle is incompetent and ignorant because of her "stupid" questions. They respond to her disrespectfully while laughing at her. In a later interview, Michelle describes Michael and Paul's behavior in general, and that specific to the situation, as "poisonous." Even though she laughs, she feels humiliated by their teasing responses to her questions. Paul and Michael separately characterize (during interviews) their participation in the teasing scenario involving Michelle as unacceptable and degrading: "Looking back like this I consider the experiences to be disrespectful behaviour. However […] this is just the way it is […]."

Every doctor and nurse directly describes during interviews how the teasing puts them under strain. They report from experience the necessity of always being prepared for possible future attacks of teasing and of being able quickly to adjust their responses in a teasing manner. As a consequence, everyone develops a specific social awareness. Like a boy scout, everyone is constantly prepared for the next attack – in this instance, of teasing. Some days are worse than others, they state, because sometimes the teasing is more intense. Nevertheless, they describe their constant state of arousal and alertness as an experience of mental overload. Interestingly, they spontaneously reveal how the boy scout analogy makes them feel relieved at being able to verbalize their experiences via an image intelligible to the outside world. In some unaccountable way, they experience a sort of mental relief from the opportunity to verbally externalize their thoughts and emotions about the incriminating teasing practice. By observing their body language, the lead author is struck by the extent to which the interviews make the participants realize and reflect on a crucial – and until this moment – implicit and tacit aspect of their social engagement in work life. They all appear to have got something important off their chest;

they seem pensive and breathe a sigh of relief. Several moments of silence characterize these parts of the interviews.

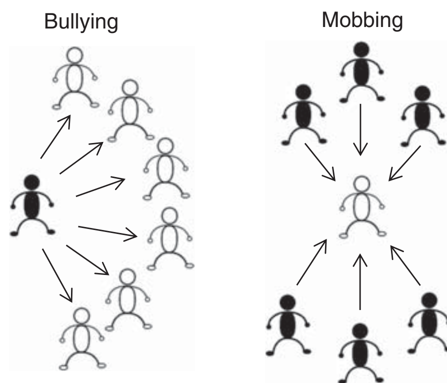
Strain arises from the remarkably derogatory aspect of mutual teasing. As previously stated, a the significant core aspect of the mutual teasing is to joke at someone else's expense, thereby elevating one's own social status within the medical communities. When nurses and a surgeon gossip behind the back of a non-present medical student or tease a present member of the working group, the practice spreads fear of future possible slander that might take place behind anyone's back. Being compelled to perform self-targeted teasing about incompetence, as in the case of Linda, potentially erodes one's sense of human dignity. The same risk exists when colleagues teasingly suggest to the professor that he is insane and needs therapeutic counseling. The constant battle between the butt of derogatory teasing and those who enact it constitutes a heavy fundamental psychological strain for those in the positions of target and teaser. In this wasps' nest, abundant laughter coexists alongside considerable psychological strain. In order to continually demonstrate their value, the medical personnel have to prove sturdy enough to handle continually being ridiculed, but also cynical enough to practice derogatory teasing against colleagues, as well as to laugh at others even when the teasing feels disrespectful and humiliating. Consequently, a bullying practice emerges out of what at first appears to be "innocent," amusing and funny entertainment that, in reality, inflicts strain, anger, humiliation and shame.

Discussion

Based on the analysis of the teasing practice, we have shown that the nature of the teasing is derogatory and functions as a social regulation mechanism through which power relations and social status within medical communities are negotiated, altered or sustained. The oppressive and humiliating aspect of the teasing places doctors and nurses under intense strain, with harmful effects. In this respect, the practice of derogatory teasing among doctors and nurses can be defined as bullying.

As previously clarified, the research into workplace bullying traditionally operates within two different definitions of the concept, "bullying" and "mobbing" (Zapf and Einarsen, 2005), and can be illustrated in Figure 1.

The intensity, direction and content of the prolonged, extremely widespread and frequent teasing practice at the hospital vary, but not a single day goes by without the pervasive prevalence of teasing. Moreover, the positions of perpetrator or target of



Source: Adapted from Zapf and Einarsen (2005)

Figure 1.
Black "individual" perpetrators bully the white "individual" target

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derogatory teasing are not fixed within the medical communities, as traditionally categorized by the established definitions of "bullying" and "mobbing." Conversely, the analysis reveals that every doctor or nurse alternates between the positions of target and perpetrator while the position of bystander is excluded. The perpetrator position, characterized by production or co-production of derogatory teasing, can take the form of verbal utterances but can be defined also as joining in the laughter triggered by somebody else's derogatory teasing. The teasing practice often begins with a nurse(s) or doctor(s) picking on a colleague and joking at her or his expense, as illustrated in Figure 2.

However, quickly – often instantly or sometimes within hours or even days – the teasing process evolves into a situation where the target of teasing becomes a perpetrator. This happens when the former target either begins picking on another colleague or sides with a colleague who continues the teasing process by picking on another colleague present. The former target thus sides with the perpetrator by observing or laughing at the new target. The process can be illustrated in Figure 3.

As an extension of the above, the positions of target and perpetrator continually change for every participant involved in the reciprocal struggle process of derogatory teasing, as illustrated in Figure 4.

Doctors and nurses thus act alternately as perpetrators and targets of derogatory teasing in a constant battle of "every man for himself." This implies that every member must learn to master the positions of both target and perpetrator. In order to embrace this fluid character of the identified bullying practice, we suggest the concept of "fluctuate bullying."

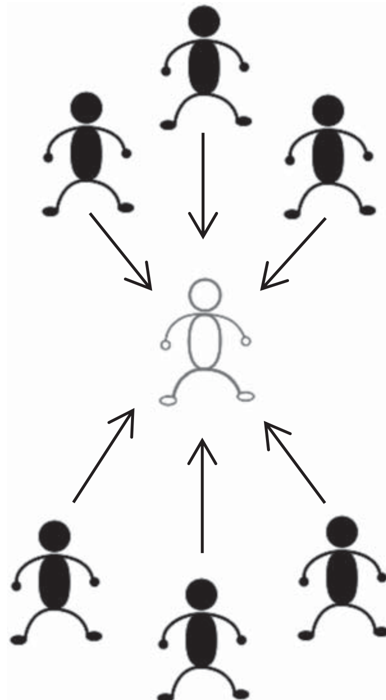

Figure 2.
Black "individual" perpetrators bully the white "individual" target

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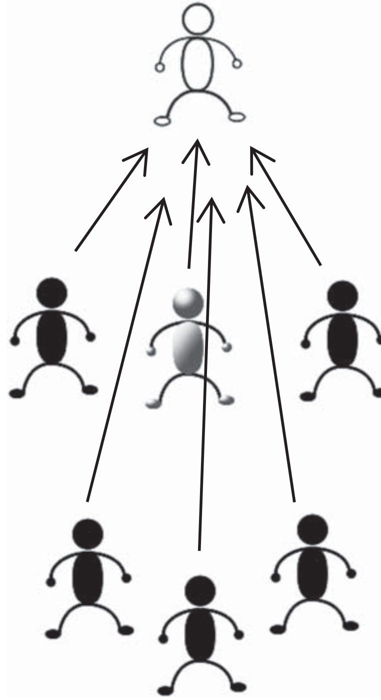

Figure 3.
Black "individual," perpetrator; black/white "individual," previous target, now perpetrator; white "individual," existing target

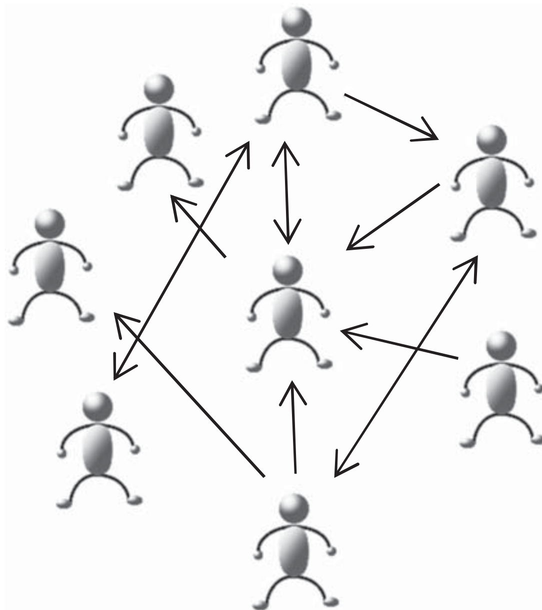

Figure 4.
Black/white "individual," perpetrator and target

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Bateson (1972) provides us with the useful concept of "double bind" to explore and understand the powerful paradoxical dilemma that afflicts doctors and nurses (Bateson, 1972). Relating to his studies of schizophrenia, Bateson (1972) identifies "double bind" as a socio-psychological position characterized by unresolved sequences of external experiences that are responsible for inner conflicts (p. 206). More specifically defined, these experiences involve two or more persons, a repeated experience, a primary negative injunction, a secondary injunction conflicting with the first and, finally, a tertiary negative injunction prohibiting the individual from escaping the situation at a more abstract level (unlike physical escape) (Bateson, 1972, pp. 206-207). With regard to the demonstrated bullying practice among doctors and nurses, the analysis first reveals an experience of injunction to perform derogatory teasing; second, an experience of injunction to put up with derogatory teasing; and, finally, an experience of potential exclusion from workplace communities if the doctor or nurse resists the first or second injunction. The third injunction is experienced as a threat to doctors' and nurses' socio-psychological survival. Notwithstanding that doctors and nurses do not suffer from schizophrenia, their "double bind" position nonetheless results in severe mental strain.

Unlike Plester and Sayers (2007)'s study of workplace humor in the IT industry, our observations and analysis reveal no pattern of formal power imbalance between the perpetrator and the target (as a great deal of the literature claims); on the contrary, no one is immune from teasing, not even the professor at the top of the formal hierarchy. When doctors and nurses continually practice derogatory teasing, they discipline themselves according to the governing social rules of accurate conduct to gain acceptance from their peers. They perceive the derogatory teasing to be an inevitable, unchangeable basic condition of hospital work, which explains why they are unable to eradicate this painful and burdensome bullying. Consequently, they find themselves trapped in this "double bind" situation where they feel forced to perform involuntary incriminating and detrimental bullying acts because they otherwise risk being socially and professionally excluded from the workplace and thereby exposed to bullying. Like Billig (2005), Godfrey (2016) and Plester (2016) we argue that humor contributes to the negotiation of social order and self-regulation through the disciplinary practices of inclusion and exclusion, and that humor permeates the power relations that organize and structure the medical communities. This indicates that every doctor or nurse striving to become part of the medical communities must prove able to master the practice of derogatory teasing, whereby she or he becomes both a perpetrator and a target of bullying. We argue that this perceived compulsion to participate in an unwanted and harmful derogatory teasing practice constitutes a source of informal power. Thus, "fluctuate bullying" emerges as a socially embedded requisite practice that serves to empower social status and negotiate or sustain social order and not as the result of a few specific individuals and their personality traits.

In the literature, "inter-personal bullying" is defined as the interaction between two unequally matched parts and involves the illegitimate use of personal power (D'Cruz, 2015, p. 12). In contrast, "de-personalized bullying," embedded in organizational design, consists of oppressive work regimes enacted by managers and supervisors in a downwards power direction (D'Cruz, 2015, p. 61). Finally, "compounded bullying" entails a mixture of managers personal downwards power and institutionalized and socio-structural power dynamics. Our concept of "fluctuate bullying" is defined by an oppressive derogatory teasing practice, wherein the positions of perpetrator and target constantly shift and, as such, are fluid. "Fluctuate bullying" is not enacted through managers' preservation of specific inexpedient work regimes but emerges from doctors' and nurses' reciprocal social disciplining with the purpose of elevating one's own social status and power within medical communities.

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The literature is almost devoid of teasing as a harmful adult issue (Conoley *et al.*, 2008). However, the exception that underscores the importance of addressing this theme is Hogh *et al.* (2005), who found that teasing in the workplace was predictive of mental health problems five years later. Within the field of health care, MacIntosh *et al.* (MacIntosh 2012; MacIntosh, Wuest, Gray and Aldous, 2010; MacIntosh, Wuest, Gray and Cronkhite, 2010) illustrate how bullying negatively affects work by health care employees and how the meaning women find in work shifts to disillusionment when they are exposed to interpersonal bullying. These findings accentuate the importance of (persistent) research within this field. Yet, there are still many questions to be addressed: our analysis points to five different derogatory teasing themes that differ by content. This finding poses the question: What are the possible different origins for these themes? Is it a matter of organizational structures, gender, work conditions, organization of management or something totally different? The perspective of possible lack of organizational learning also becomes interesting, knowing that the exposure of incompetence – the need for help – may lead to experiences of bullying. As Billig (2005) states, the ridicule experienced from the laughter prevents repetition of the behavior that caused the laughter. Does doctors' and nurses' bullying practice lead to a lack of organizational learning? And what possible impact might this have on quality of care and patient safety?

Conclusion

On the basis of ethnographic fieldwork at the Danish National Hospital in Copenhagen, Denmark, we identify the prevalence of a particularly widespread, persistent and prolonged teasing practice, which we term "fluctuate bullying." We demonstrate how its derogatory nature triggers objectionable behavior among doctors and nurses, and therefore can be characterized as bullying. By mapping the terrain of research on workplace bullying, we have covered the two established yet contrasting definitions of workplace harassment: "bullying" and "mobbing." With this as our point of departure, we have shown how the "fluctuated bullying" practice we have identified cannot be encompassed by either of the two definitions because it is not linked to identifiable individuals with specific personality traits. Instead, every doctor or nurse generates "fluctuated bullying" by alternating between the positions of target and perpetrator. In our approach, both verbal and non-verbal utterances (laughter, for example) are considered to contribute to the act of "fluctuate bullying," wherein everyone becomes a co-producer of the negative, incriminating social interaction and whereby the traditional position of bystander is excluded. Thus, the study describes and identifies "fluctuate bullying" as a type of bullying that emerges and occurs in an organizational setting even when it seems impossible to identify a single or several perpetrator(s). Moreover, the study highlights that negative social interaction can be determined by the situated governing social rules of appropriate conduct. The identified "fluctuate bullying" emerges from doctors' and nurses' experience of an inevitable and involuntary demand to perform derogatory teasing in order to gain acceptance from fellow organizational members, as well as to avoid the risk of being socially and professionally excluded from the workplace.

Based on these findings, we argue that future research, to a greater extent, should approach workplace bullying as a social phenomenon, regulated by powerful inclusion, and exclusion mechanisms that emerges out of concrete organizational practice as workers perform a context-dependent task. This emphasis encompasses great potential for rethinking the future handling and prevention of workplace bullying. If the hospital management wants to defeat and shut down this derogatory teasing practice, blaming individuals and striving to correct their behavior will not suffice. Instead, an organizational change in social practice, regulating social power order, shall prove indispensable.

Consequently, the socio-structural perspective on workplace bullying implies an overall organizational responsibility, including that of all levels of management, in regard to future handling and prevention of workplace bullying.

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