

Bullying in trauma and orthopaedics: a survey of staff in orthopaedic departments in the UK

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Abstract

Background/aims An orthopaedic department requires good teamwork and communication to function. This is undermined by bullying and harassment, which may affect the victim's health and career.

Methods A 26-item questionnaire was sent to all delegates who registered for a free orthopaedic webinar teaching series via email and social media. This study includes the responses from all those who had worked in a UK orthopaedic department.

Results There were 168 respondents from varying backgrounds; 17.9% had experienced bullying or harassment in their orthopaedic department, while 36.3% had witnessed it. Women and people from ethnic minority backgrounds suffered 10.2% and 6.9% higher rates of bullying than their male or white counterparts respectively.

Conclusions The results demonstrate that despite attempts to reduce bullying in orthopaedics, it remains prevalent, and particularly affects women and those from ethnic minority backgrounds. Orthopaedic departments must adapt to reflect changes in society.

Key words: Bullying; Harassment; Orthopaedics; Racism; Sexual harassment

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Introduction

The staff of a typical orthopaedic department in the UK comprise a diverse cohort of people, from different socioeconomic, ethnic and religious backgrounds, of different ages and with different interests and roles. For the department to run effectively, smooth communication, teamwork and a motivated, confident workforce are required.

This is often not the case – a 1999 survey of 1100 multidisciplinary NHS staff found that 38% had been bullied in the previous year, the majority of those who had taken action regarding the bullying were dissatisfied with the outcome and bullied staff had higher rates of job dissatisfaction, stress and anxiety (Quine, 1999). The 2021 NHS Staff Survey found that staff reported rates of bullying of 18.7%, 11.6% and 27.5% from managers, colleagues and patients and their relatives respectively (NHS Staff Survey Coordination Centre, 2021).

The General Medical Council's (2019) dignity at work policy defines harassment as 'any unwanted attention or behaviour due to a protected characteristic that a person finds objectionable or offensive, and which makes them feel threatened or uncomfortable, leading to a loss of dignity or self-respect', whereas bullying is a more general form of harassment not necessarily based on a protected characteristic. Bullying and harassment may include unwelcome touching, shouting, social exclusion or inappropriate comments, among others.

Bullying adversely affects the mental health of the victim, and can lead to burnout, or cause the victim to leave medicine or have suicidal thoughts (Hu et al, 2019; Zhang et al, 2020; Holzgang et al, 2021). Furthermore, departments with bullying have worse patient outcomes – bullied staff may be too afraid to ask for help or raise concerns, and an association has been noted between reports of bullying by a surgeon and the complication rates of that surgeon (Paice and Smith, 2009; Cooper et al, 2019; Holzgang et al, 2021).

Bullying and other toxic workplace behaviours have long been recognised as an issue within surgical departments worldwide (Crebbin et al, 2015; Ling et al, 2016; Chrysafi et al, 2017; Halim and Riding, 2018; al Omar et al, 2019; Balch Samora et al, 2020; Clements et al, 2020; Holzgang et al, 2021). Studies also suggest that surgical specialties have higher rates of bullying than medical specialties (Chrysafi et al, 2017). Witnessing

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bullying or harassment was reported by 73% of respondents to a British Orthopaedic Trainees Association survey (Monsell, 2017).

Various factors play a role in bullying, including some seniors being motivated by a desire to improve performance among staff and attempting to achieve this through bullying behaviours (Paice and Smith, 2009); competitive surgeons and team members working within a hierarchical structure; orthopaedics in the UK having the lowest percentage of female surgical trainees and consultants of all surgical specialties at 11% (Moberly, 2018), and orthopaedic trainees having reported the majority of harassment to come from senior male surgeons (Whicker et al, 2020). Behaviours and attitudes have been passed down through the generations in orthopaedics, and are often accepted as an appropriate method of teaching (Huang et al, 2018).

Recent years have seen major cultural and societal shifts on several fronts: the Me Too movement encouraged women experiencing sexual harassment in the workplace from more powerful men to come forward (Brown and Battle, 2020), stigmatisation surrounding mental health issues has reduced in the UK in the past decade (Henderson et al, 2020), and a younger generation more accustomed to ethnic diversity and major international campaigns such as Black Lives Matter and athletes 'taking the knee' has raised the profile of racism within society (Sawyer and Gampa, 2018; Bennett and King, 2021). Although methods of orthopaedic training are well established, they must adapt to the needs and demands of future trainees with modern perspectives.

To better understand the experiences of orthopaedic staff in the UK, this study investigated the frequency, nature, perpetrators and response to harassment and bullying within orthopaedic departments.

Methods

A 26-item questionnaire was developed by two authors (AM and KS); its validity was assessed by distributing it among staff in the local orthopaedic department for feedback. The questionnaire was distributed as part of a registration form for a free live orthopaedic webinar series, held between 22 and 29 September 2021. The series was aimed at junior doctors wishing to gain the knowledge required to become an orthopaedic registrar, but attendees included more senior orthopaedic surgeons and allied healthcare professionals, such as physiotherapists and physician associates. On completion of the questionnaire, respondents received a hyperlink giving them access to the webinar, reducing the risk of selection bias as completing the questionnaire was compulsory for those who wished to attend the webinar.

Questions covered baseline demographics, orthopaedic training experience, characteristics of bullying experienced and the outcome of the experience. Only completed questionnaires were included in the study. Results were restricted to those from respondents from the UK, irrespective of their gender, ethnicity, sexuality or religious backgrounds.

The data were analysed using Microsoft Excel. Most data were categorical in nature, with two questions allowing free-text responses.

Results

A total of 168 UK-based respondents completed the questionnaire. **Table 1** summarises the respondents' demographics.

Types of bullying and harassment

When asked whether they had personally been bullied or harassed, 30 respondents said yes, 134 said no and four preferred not to say; 61 stated they had witnessed bullying, 104 had not witnessed bullying and three preferred not to say.

Table 2 summarises responses on specific behaviours by frequency. Most respondents experienced being subject to excess criticism or gossip; 16% of respondents reported having experienced rude and demeaning remarks monthly, 20% weekly and 2% daily.

Perpetrators

Figure 1 summarises the responses to the question about who perpetrated the bullying. Orthopaedic consultants were the most frequent perpetrators of bullying and harassment at

Table 1. Demographic data of survey respondents

Characteristic		Number of participants (%)
Gender	Female	57 (34%)
	Male	107 (64%)
	Transgender or non-binary	0 (0%)
	Prefer not to say	4 (2%)
Ethnicity	Arab	9 (5%)
	Asian or Asian British	58 (35%)
	Black, African or Caribbean or Black British	14 (8%)
	Mixed	2 (1%)
	Prefer not to say	13 (8%)
	White: British, Irish or any other white background	72 (43%)
Religion	Buddhist	8 (5%)
	Christian including Catholic, Church of England, Protestant and all other Christian denominations	49 (29%)
	Hindu	10 (6%)
	Jedi	1 (1%)
	Muslim	23 (14%)
	No religion	51 (30%)
	Prefer not to say	22 (13%)
	Sikh	4 (2%)
Sexuality	Bisexual	1 (1%)
	Gay or lesbian	5 (3%)
	Prefer not to say	19 (11%)
	Straight or heterosexual	143 (85%)
Grade	Medical student	11 (7%)
	Foundation year doctor	33 (20%)
	Core trainee doctor	46 (27%)
	Trust senior house officer or junior clinical fellow	42 (25%)
	Registrar	19 (11%)
	Consultant	2 (1%)
	Orthopaedic nurse practitioner	2 (1%)
	Physiotherapist	8 (5%)
	Physicians associate	5 (3%)

56 (33%), followed by registrars at 48 (29%). There were 20 (12%) responses identifying orthopaedic senior house officers and foundation doctors as the perpetrator of the bullying.

Gender

Table 3 breaks down the responses to whether the respondent had been bullied or harassed based on their gender; women were 10% more likely to have responded yes. Table 4 gives

Table 2. Experiences of bullying and harassment type behaviours by frequency

How frequently do you experience the following?	Never	Less than once a month	Monthly	Weekly	Daily
Rude, demeaning remarks	60	44	27	33	4
Being shouted at	86	47	21	12	2
Excess criticism	66	46	31	21	4
Subject of gossip	77	39	30	14	8
Intimidating, threatening behaviour	107	26	19	14	2
Exclusion	90	38	23	12	5
Physical violence	142	14	9	1	2
Unwelcome personal comments	98	33	27	8	2
Inappropriate sexual comments	119	25	14	8	2
Inappropriate physical touching	135	19	9	4	1
Racism based on religion	134	21	9	1	3
Racism based on race	119	30	9	6	4
Homophobia	131	27	8	0	2
Sexism	105	31	19	6	7
Ageism	119	31	13	1	4

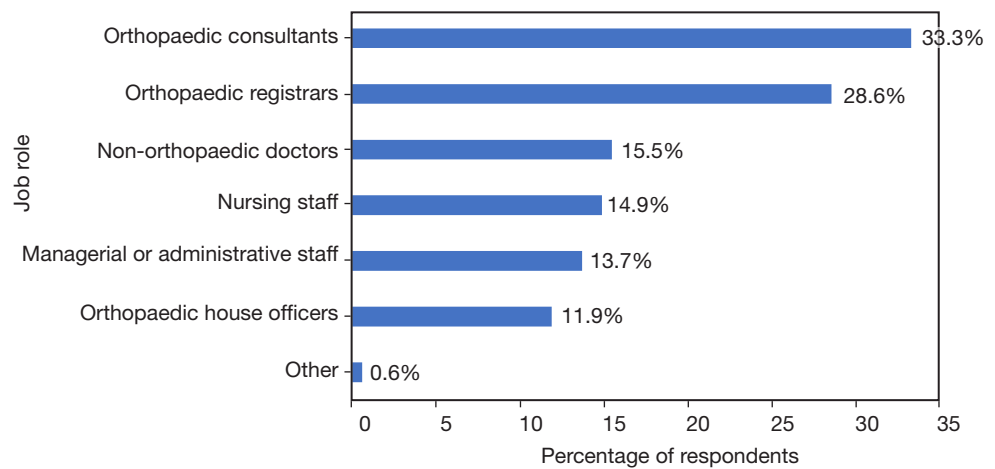


Figure 1. Perpetrators of bullying categorised by job role.

examples of different behaviours that women are more likely to experience than men, including sexism, inappropriate physical touching and inappropriate sexual comments.

When asked to rate on a scale of 1–5 how much they agree with the statement ‘women are treated fairly in orthopaedics’, the average response was 3.4 for men and 2.8 for women. This indicates that men may be less aware of the experiences of women in the workplace, including instances of workplace sexism and other forms of bullying that women in orthopaedic departments experience.

Table 3. Experiences of bullying and harassment by respondents of different genders

Gender	Yes	No	Prefer not to say
Men	16 (14%)	92 (83%)	3 (3%)
Women	14 (25%)	42 (74%)	1 (2%)

Table 4. Experiences of bullying or harassment type behaviours by respondents of different genders by frequency

		Never	<Month	Monthly	Weekly	Daily
Sexism	Men	78 (70%)	20 (18%)	9 (8%)	2 (2%)	2 (2%)
	Women	27 (47%)	11 (19%)	10 (18%)	4 (7%)	5 (9%)
Inappropriate physical touching	Men	93 (84%)	12 (11%)	5 (5%)	0 (0%)	1 (1%)
	Women	42 (74%)	7 (12%)	4 (7%)	4 (7%)	0 (0%)
Inappropriate sexual comments	Men	85 (77%)	16 (14%)	6 (5%)	2 (2%)	2 (2%)
	Women	34 (60%)	9 (16%)	8 (14%)	6 (11%)	0 (0%)

Table 5. Experiences of bullying or harassment by respondents of different ethnicities

	Yes	No	Prefer not to say
White British or white other	10 (14%)	60 (83%)	2 (3%)
Other ethnicities	20 (21%)	74 (77%)	2 (2%)

Table 6. Experiences of racism by respondents of different ethnicities

		Never	<Month	Monthly	Weekly	Daily
Racism based on religion	White British or white other	64 (89%)	7 (10%)	1 (1%)	0 (0%)	0 (0%)
	Other ethnicities	70 (75%)	14 (15%)	8 (9%)	1 (1%)	3 (3%)
Racism based on race	White British or white other	58 (81%)	13 (18%)	1 (1%)	0 (0%)	0 (0%)
	Other ethnicities	61 (65%)	17 (18%)	8 (9%)	6 (6%)	4 (4%)

Race

Table 5 shows the responses to whether the respondent had been bullied or harassed by race; respondents of ethnicities other than white were 7% more likely to have experienced bullying. Table 6 shows illustrative examples, including racism based on religion and race, which ethnicities other than white experience more frequently.

When asked to rate on a scale of 1–5 how much they agree with the statement ‘ethnic minorities are treated fairly in orthopaedics’, the average score from white respondents was 3.5 and from ethnic minorities was 2.9. As with the previous section regarding the opinions of men and women, there was a discrepancy between the opinions of those who are white and those of ethnic minorities on the level of fairness of orthopaedic departments.

Dealing with bullying

Respondents were asked to choose reasons for not raising complaints about instances of harassment or bullying: 39% reported concerns regarding career progression, 20% had a lack of faith in the complaints procedure, 18% reported being intimidated by staff members’ seniority, 12% reported a lack of time and 9% reported having a lack of knowledge about the complaints procedure.

Among those who had personally escalated concerns or knew a colleague who had escalated an instance of bullying or harassment, 33% stated it had been handled appropriately or justly, and 67% stated that it had not. When asked to rate their familiarity with the complaints procedure and confidence in escalation pathways on a scale of 1–5, respondents’ average scores were 3.1 and 2.8 respectively.

Bullying in orthopaedics

When asked to rate on a scale of 1–5 whether they feel bullying is more common in orthopaedics, respondents’ average score was 2.9; 17% of respondents stated that their

experience of bullying had made them consider an alternative career. A total of 55% of respondents agreed with the statement that bullying impacts patient care in orthopaedics.

International comparison

In addition to the 168 UK-based respondents, 80 respondents were based outside the UK. These results were not analysed because the respondents were based in many countries, so the responses could not be accurately applied to any particular healthcare system. Most were middle or lower income countries, and the most common countries of origin were Pakistan (24) and Egypt (8).

Overall rates of bullying were higher among respondents based outside the UK than those from the UK: 29% of international respondents reported experiencing bullying, while 43% reported witnessing bullying.

Discussion

The results of this survey of 168 UK orthopaedic staff show the diversity in gender, religion, ethnicity and sexual orientation of this group. It also found that 18% had experienced bullying or harassment, while 36% had witnessed it. The worst perpetrators of these behaviours were seniors in the department, and there were poor levels of satisfaction regarding the handling of these issues when they were escalated. Women and people from ethnic minority backgrounds reported higher rates of experiencing these behaviours, and there were differences within orthopaedics in the awareness of how these issues affect these groups.

Numerous factors have been identified as causes of orthopaedic workplace bullying: individual sources, such as personality traits and conflict management styles; organisational factors, such as ambiguity in professional roles; a perception, often resulting from having previously been on the receiving end of such behaviours, that bullying improves performance; and a male-dominated culture in orthopaedics that often excludes women (Paice and Smith, 2009; Kim et al, 2017; Huang et al, 2018; Whicker et al, 2020).

Inability to appropriately deal with such conflicts and behaviours in a department affects the victim, the department and patient outcomes. A multi-cohort study across Denmark and Sweden involving 79 201 people found that the population attributable risk for cardiovascular disease was 5.0% for workplace bullying and 3.1% for workplace violence (Xu et al, 2019). A study of American surgical residents with 6956 responses noted that 10.4% of frequently bullied surgeons had suicidal thoughts compared with 3.1% of those who were not bullied (Zhang et al, 2018). Over time, bullying, and its effects on physical and mental health, may lead to burnout – the prevalence of burnout has been noted to be higher among surgeons than in other medical specialties, and higher in women than men (Hu et al, 2019; Holzgang et al, 2021). Bullying has been associated with taking sick leave: Moayed et al (2006) noted that the rate of medically certified sick leave for bullied staff was 51% higher than that for non-bullied staff, while self-certified sick leave was 16–23% higher. Kivimäki et al (2000) found that victims of bullying were 20% and 50% more likely to take self-certified and medically-certified sick absences than their non-bullied colleagues.

Most respondents agreed that bullying impacts patient care, and this has been found in other studies. An American study, involving 13 653 patients operated on by 202 surgeons, found a significant association between complications and co-worker reports of behavioural issues. For surgeons with 1–3 reports of bullying, the adjusted complication rate was 14.3% higher. The authors suggested that departments seeking optimal outcomes should consider the surgeon's behaviour towards colleagues (Cooper et al, 2019). Paice and Smith's (2009) UK study on bullying included 33 329 trainees. They found that respondents who experienced bullying were also more likely to be in situations that they did not feel competent to deal with and supervised by somebody who they did not feel was competent; more of these respondents reported working prolonged hours and wanting to pursue an alternative career than those who had not experienced bullying. Bullying of individual staff has effects throughout the department, ultimately reflected in patient outcomes – hostility among staff members should therefore be seen as a patient safety issue.

Respondents to this survey reported that orthopaedic consultants and registrars were the two main groups perpetrating bullying (33% and 29%); they also reported non-orthopaedic doctors, orthopaedic senior house officers, nursing and managerial staff as responsible for 12–16% of cases of bullying. Other studies have found similar rankings, yet all found consultants to be the main perpetrators of bullying (Paice and Smith, 2009; Crebbin et al, 2015; Ling et al, 2016; Halim and Riding, 2018). Bullying tendencies tend to develop early in a surgeon's career, and may become so ingrained in the surgeon's behaviour and wider surgical culture that they do not realise that their actions are bullying (Paice and Smith, 2009; McNally, 2016; Halim and Riding, 2018). Identifying and rapidly addressing these behaviours early will pay dividends when the trainee becomes a consultant themselves.

Respondents from ethnic minorities reported higher rates of bullying than their white counterparts, with 26% reporting discrimination based on religion and 35% reporting discrimination based on race at least monthly. Despite medical training and professional organisations making efforts to address bullying in the UK (Adebowale and Rao, 2020), numerous studies and tribunals show this issue remains prevalent. In Clements et al's (2020) survey of 1412 surgical trainees from the UK and Ireland, 21% reported witnessing racism. An employment tribunal involving a urological consultant ruled against the General Medical Council, finding that they discriminated against the doctor of mixed heritage on the grounds of race, and noted that 'UK graduate ethnic minority doctors are 50 per cent more likely to get a sanction or warning than white doctors' (Bamrah et al, 2021). A review into diversity by the Royal College of Surgeons found the college was not an inclusive institution reflecting society or the changing profession, and included testimony from Middle Eastern colleagues who had been referred to as the 'departmental terrorist', displaying overt religious-based discrimination (Mapara et al, 2021).

The results of this survey found that women were 10% more likely to experience bullying than men, and frequently endure behaviours including inappropriate touching and sexual comments; this is in keeping with the stereotype of orthopaedic surgeons as being masculine and aggressive, and surgical organisations such as the Royal College of Surgeons being felt to be an 'old boys club' (McNally, 2016; Mapara et al, 2021). Previous studies into surgical workplace behaviour have consistently shown that women experience bullying, harassment and other forms of discriminatory behaviour, both in the UK and internationally. Holzgang et al's (2021) survey of 840 European surgical trainees found no men reported sexist comments, whereas women reported being taken less seriously and refraining from getting involved in learning opportunities because they received sexist comments. Crebbin et al's (2015) survey of 3156 Australian surgeons found that rates of discrimination, bullying, sexual harassment and harassment ranged from 2–34% for men, and 26–58% for women. Those who attempted to balance work and family life with a less than full-time role frequently reported undermining behaviour because of their role (Clements et al, 2020).

Orthopaedic departments must have mechanisms in place that allow for escalation of bullying and harassment concerns and resolution of these incidents. The results of this survey, specifically in relation to recipients acting on instances of bullying and harassment, point towards an environment of fear, with staff not escalating complaints because of concerns about career progression, intimidation by senior colleagues and poor satisfaction in outcomes. This reflects previous surveys: surgeons may be reluctant to report bullying because of a fear of repercussions or belief that the complaint will be ineffectual (Ling et al, 2016; Freedman-Weiss et al, 2020). With sexual harassment, people may be concerned about damage to their personal reputation (Balch Samora et al, 2020).

Various organisations and professional bodies have started campaigns that aim to increase awareness of the impact of bullying, but it is unclear how this will improve complaints procedures and it is hard to see whether they have had any benefit (Huang et al, 2018; Fleming, 2019). An example of a positive initiative is the Royal College of Surgeons of Edinburgh Let's Remove it Campaign, which developed an online resource hub of legal information to support those being bullied (Lavelle-Jones, 2017). Other authors have suggested measures such as teaching and assessing professionalism at medical school, including sexual harassment as part of the surgical trainee curriculum, and role play

Key points

- Bullying and harassment are common in orthopaedic departments, which are hierarchical and male dominated. This leads to negative effects on the health and careers of staff, departmental efficiency and patient outcomes.
- In this survey on bullying within orthopaedics, out of 168 respondents, 18% had experienced bullying or harassment at work and 36% had witnessed it.
- Women and people of ethnic minorities were more likely to have experienced bullying, and were less likely to believe that women and people of ethnic minorities were treated fairly within orthopaedics, indicating that male or white colleagues do not appreciate this scale of the issue.
- Much of the bullying and harassment originates from senior staff members, which may explain the poor engagement with the complaints process.
- Social attitudes towards racism, sexual harassment and mental health are changing rapidly. These changes will permeate into orthopaedic departments, and staff must evolve their behaviour and complaints procedures to accommodate this progress.

exercises in which students and trainees take part in simulated workplace scenarios to better prepare for how they would manage bullying (Halim and Riding, 2018; Freedman-Weiss et al, 2020). The responses to this survey indicated a theme of wanting a clear and reliable escalation pathway, as well as a change from a less ‘boisterous’ atmosphere to a ‘safer’, ‘approachable’ and ‘open’ one.

This survey required the respondent to give their name and email address; this lack of anonymity may have led to lower rates of reporting bullying and harassment. Other limitations of this survey included the data being self reported with no means of verification. Participants completing the survey were from a range of different UK-based hospitals and experiences at certain hospitals may have been more positive than others but specific hospitals are not named in this survey.

Conclusions

Orthopaedic methods of training in the UK are well established, run by institutions that may be resistant to change. However, recent social movements, such as Black Lives Matter and Me Too, have brought massive awareness internationally to the issues of racism and sexual harassment. Orthopaedic departments and institutions must change in tandem with society to embrace progress and ensure that they provide top quality training and patient outcomes. Although the results of this survey show the ongoing existence of bullying, racism and sexism, entrenched by hierarchical departments, shifts in social attitudes may provide the impetus for change in orthopaedics.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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