Time to stop bullying and intimidation

Brendan Hicks

Bullying remains a familiar part of the health professional culture, despite the caring nature of doctors' work. Trainee doctors who feel threatened in the clinical workplace develop less effectively and are less likely to ask for advice or help when they need it. Most people who bully are not intrinsically bad people, but they must be helped to change, in the interests of patients as well as staff.

INTRODUCTION

In early 1999, several disturbing incidents of bullying affecting junior doctors in training in South Thames were causing concern. Around this time Lyn Quine published a report (1999) revealing a high prevalence of workforce bullying in an NHS community trust in the south of England. Of 1100 employees studied, 38% had experienced bullying in the previous year and 42% had witnessed bullying of others. This included 49 doctors of whom 15 (31%) claimed to have been bullied recently.

In a study reported in 1997, 53% of UNISON members in the public sector had experienced bullying, 14% within a 6-month period. It became clear that the extent of bullying behaviour, intimidation and harassment was indeed very much larger than the small sample which was coming to our notice.

'BULLYING' *VS* 'HARASSMENT'

What we in the UK call 'workplace bullying' translates in Northern Europe as 'mobbing' and in North America is variously referred to as 'workplace harassment/employee abuse/mistreatment at work/petty tyranny', which says a great deal about the spectrum of behaviour and underlying attitudes running into prejudice which the terms embrace. One NHS hospital trust defines bullying and harassment, for all its staff, in these terms (Brighton Health Care Trust, 1999):

'To bully is to threaten, oppress or tease, either physically or morally, and can include: public humiliation, persistent criticism, personal insults, professionally undermining a person's professional ability, consistently undervaluing effort, and abuse of power. Bullying is not necessarily face to face, it may be by written communication, e-mail, or telephone.'

Harassment, in general terms, is unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, sexual orientation, religion, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.

Postgraduate deaneries have a particular duty of care to doctors in training in the NHS, as well as a responsible awareness that other NHS employees are also bullied. The South Thames Deanery therefore made quite explicit, through a widely distributed 'statement', the fact that:

'The Deanery is not prepared to tolerate bullying or intimidation of doctors in training. The Deanery requires Trusts (and general practices) to have in place appropriate policies and, where bullying is discovered, to take suitable action independently or together with the Deanery and/or the appropriate Royal College. The Deanery is to be informed of any such situations and of measures taken.'

and this statement is now incorporated in each of the Deanery–Trust contracts. The expanded version of the statement says more about what is and what is not 'bullying' in the context of postgraduate medical education.

WHAT IS BULLYING?

It helps to give examples in the particular clinical context of the proposed policy and the trainees concerned. The following extract from the deanery position statement was written with an acute trust in mind.

Distinguishing constructive supervision from bullying behaviour

Bullying should not be confused with the firmness and oversight that is required to develop a doctor or dentist in training. It is important to distinguish between bullying behaviour, which is always undermining and destructive, and effective supervision, which is developmental and supportive.

The General Medical Council (GMC) guides *The New Doctor* (GMC, 1998a) and *The Early Years* (GMC, 1998b) provide more information about the duties and responsibilities of educational supervisors. The GMC's other booklet, *Good Medical Practice* (GMC, 1998c), is explicit about the requirement that doctors work with colleagues in the 'ways that best serve patients' interests'. Doctors must therefore always treat all colleagues fairly, must not discriminate against colleagues and must not denigrate another doctor's skills or knowledge in front of patients.

Dr Brendan Hicks is Regional Postgraduate Dean Director, South Thames Postgraduate Deanery, 33 Millman Street, London WC1N 3EJ

Identifying the problem on the ward and in the clinic

Bullying can take the form of verbal, written, mental or physical intimidation, and in medical education could typically include derisory remarks, shouting or threats. The person who bullies may not be aware of the effect their behaviour may have, but those effects can be catastrophic.

Examples of bullying behaviour in medical education

- Teaching by humiliation
- Undermining status and credibility, e.g. criticism in the presence of others, possibly patients or the public
- Using threats, abuse or swear words, or shouting inappropriately
- Excessive criticism over minor things
- Undervaluing or even ridiculing contribution and/or genuine effort
- Changing objectives or expectations without consultation or explanation
- Deliberately setting unreasonable objectives or tasks with impossible deadlines
- 'Sending to Coventry', ignoring or devaluing
- Exclusion from meetings that an individual might reasonably expect to attend
- Unrealistic expectations/demands concerning the trainee's out of hours responsibilities.

PROVIDING SUPPORT

If bullying is to be tackled successfully, it is essential that an organization is able to provide support to all of those involved:

- Anyone who has suffered from the bullying behaviour of others should be offered direct support including mediation and counselling
- Third parties who might be aware that bullying is taking place should feel empowered to challenge it directly or to raise it with the management of the trust or the practice concerned
- The person who is bullying should be offered support to enable him or her to change their behaviour and learn different ways of interacting with colleagues.

Some organizations will already have policies in place for dealing with bullying and intimidation. However, for those organizations which have not developed such a policy, we are interested in collaborating in the development of a caring, practical and legally robust model.

WHY DOES BULLYING HAPPEN?

The literature is extensive and fascinating, and conclusions complex: a thoughtful review which is particularly helpful, being both deep and critical yet accessible, is that of Hoel et al (1999), which helpfully embraces much of the extensive, high quality Scandinavian work on the whole subject of workplace bullying. The factors that contribute to the phenomenon of bullying seem to include:

The bully

Some argue that personality or behavioural traits are implanted early, strongly influenced by the parent–child relationships, and by subsequent modelling both in the home and during training; the bullied may become the bully; at school or in the workplace, those who are accused of bullying frequently see themselves as the victims of others who bully them (Crawford, 1992).

The bullied

The question arises as to whether 'victims' of bullying are in some way more vulnerable, less confident, with lower initial self-esteem, or do the findings which appear in published studies mainly reflect the effects of being bullied? Most reviewers conclude that the jury is out on this (Hoel et al, 1999): there may be a 'vulnerable personality' but policies to discourage intimidation are probably a higher priority than reviewing selection processes.

The interactions

The distribution of power, psychoanalytic models around projection and scapegoating, people having poor coping strategies — all these mechanisms have their proponents, but convincingly so only in a minority of incidents. On the other hand, the environment in terms of management culture and leadership — through partnership, involvement, collaboration, rather than dictat and 'petty tyranny' — is shown to matter.

CASE REPORT 1

While on call, a specialist registrar (SpR) was obliged to discuss several difficult cases with a particular consultant. On a number of occasions, the consultant made it clear that he did not wish to be bothered when on call and made a number of unsubstantiated allegations, threats and personal remarks, such as:

- That the doctor in training should try a less challenging specialty, if he found his current specialty too demanding and stressful
- That the SpR had not attended a patient when requested to by nursing staff — although this was wholly without foundation
- That he should not bother the consultant over something that should be within an SpR's capabilities
- That he would be complaining to the trainee's educational supervisor and to the head of department
- That national guidelines on certain case managements did not apply to that Trust.

CASE REPORT 2

A consultant conducted the weekly ward round with his trainees in an intimidating manner. This included:

- Aggressive quizzing of the trainees on the patients they had presented
- Meeting their answers with derisory remarks and gestures
- Reducing trainees to tears
- Belittling trainees in front of patients and colleagues
- Setting impossible targets so that the trainees were bound to fail.

HANDLING THE PROBLEM

Prevention

In a seminal publication Brodsky (1976) declared, with convincing argument, that workplace bullying cannot exist or continue without being directly or indirectly condoned or 'tolerated' by management. The importance of the moral role, reflected in overt, practical policies and actions, is evident in the literature (especially Resch and Schubinski, 1996) and in everyday experience. In the NHS context, senior doctors share this role and the associated professional responsibility, as regularly affirmed in recent times by the GMC in its statements and guidance documents. Prevention is also, however, enhanced by effective handling of incidents as they occur.

Acknowledgement and exploration

If anything compounds the pain of being bullied, it is finding that one is not being believed. A prompt response, genuine listening, with no immediate value judgments, in a safe environment, is essential. While the alleged bully will also deserve the natural justice of a fair 'hearing', the trainee who sees him/herself as a target of intimidation or harassment needs to explore the issues promptly and thoughtfully with a person appropriate to the nature of the behaviour in question.

This 'appropriate person' might be the clinical director of a department, some other trusted colleague in the hospital, or a professional more detached from the trust with but with clear responsibility such as a postgraduate dean. It may be an independent counsellor, or an agency such as the British Medical Association. In the end, the line will need to come 'back to base' if the next stage is to be managed effectively.

Mediation

Often the 'parties in conflict', such as the trainee and the trainer, will need to continue a relationship, either in the same post or the same trust, geographical area or specialty. For that reason, as in other bullying situations, informal processes designed to remove the tension, reconcile people, correct inappropriate behaviours and negotiate subsequent fair, professionally appropriate 'rules of engagement' are preferred to confrontational or formal proceedings with a disciplinary edge.

The latter may be necessary if all else fails but they often have a long-lasting damaging effect on both the individuals principally concerned and even on departments or teams. The handling of these problems should be consistent and skilled, and human resource departments have such skills and experience, particularly in those NHS trusts (a minority, sadly) which already have policies for preventing and handling bullying.

CASE REPORT 3

A clinical tutor expressed concerns about a preregistration house officer (PRHO) in general surgery who had been bullied by other members of her firm. In a review with the PRHO, he observed that she was 'distressed and weepy'. She felt that:

- She had been unfairly criticized by her specialist registrar (SpR)
- This had happened in front of her patients and other staff
- Her senior house officer was beginning to adopt a similar approach.

The PRHO moved subsequently into a post which she completed satisfactorily without further complaint. The SpR had been through two annual reviews, at which no comments or anxiety regarding behaviour or attitudes had been recorded. It emerged that the SpR had been required to apologise to another consultant for the manner in which he had debated a clinical issue. The SpR's educational supervisor described the SpR as bright, challenging and maybe 'over-argumentative'. The clinical tutor had had a problem with the SpR who had refused to co-operate with the hospital policy around the introduction of protected rest at night for PRHOs. The allegation of intimidation and aggressive style, handled sensitively in a private interview with a postgraduate dean, came as a complete surprise to the SpR. He was concerned that he had caused distress, and that others had considered his behaviour unprofessional: he agreed to reflect on events, to examine his attitudes to other staff and his discussion style, and to learn from the episode.

Remediation

Some people who bully need help. Some who need help will decline it, but need pressure applied to accept it. It must be made clear to all concerned that in the end, persistent bullying, harassment, intimidation, just cannot be tolerated. The legal issues around 'bullying' per se are somewhat complex but outlined with great clarity in *Workplace Bullying: The Legal Position* published by the Andrea Adams Trust (1998).

Confidentiality

Our own attempts to draft a model trust policy have proved to be challenging, principally on the issue of confidentiality. We wish to respect the confidence of the complainant who sees themselves as a victim of bullying and harassment, and the professional culture has assumed that we will respect that confidence, absolutely if insisted upon. The legal situation for employers, however, is complex: it could be regarded as quite unacceptable for an employer, once informed of unsatisfactory or threatening behaviour by any of its employees, to stand by, given the fact that other employees would be at risk from the same behaviour.

Most employer policies therefore 'assure confidentiality' but only 'in so far that it is consistent with progressing the complaint', or words to that effect. This may leave serious anxieties in the minds of trainees in a close-knit, hierarchical profession such as medicine.

WHY DOES BULLYING MATTER TO THE NHS?

There are many studies, reports and anecdotal accounts of consequences such as anxiety, depression, stress symptoms, loss of concentration and effectiveness at work, and of course the personal distress that we see in cases that surface in trainee doctors is only too evident.

The impact can be dramatic: total loss of personal confidence, disillusion with a previously-favoured specialty, or even medicine as a whole, break-ups of relationships, or thoughts of suicide. As we have plumbed new depths in this area, we are struck by the number

of trainees bullied by trainees, and the (junior) consultants and/or managers who are being bullied by their (senior) colleagues.

Our particular anxiety, based on observation, conversations with trainees, and an informed awareness of how clinical teams work, is that the care of patients will suffer in an atmosphere of intimidation. Intimidated, demoralized doctors will fail to seek advice or help when they need it, and will not report mistakes or admit uncertainty, possibly putting patients at risk. Unhappy units are bad for carers and those being cared for. These are serious issues for quality assurance and clinical governance.

CONCLUSION

The problem of bullying is not new, but we believe it is time to take a firmer line on a culture which is outmoded and damaging. Inaction in the face of unacceptable behaviour is collusion. All NHS organizations, including deaneries and all involved in training, should have in place policies defining their moral position and structures for implementation, in relation not only to equal opportunities and harassment in general, but quite explicitly to forms of behaviour falling within the realm of workplace bullying. **HM**

Conflict of interest: none.

The author would like to thank colleagues who contributed to the development of Deanery thinking and policies, including Jeremy Bolton, Helena Feinstein, Ri Hornung, Nicole July, Zoë-Jane Playdon, Hugh Seeley, Penny Smyth-Pigott and other members of the South Thames Working Party on Workplace Bullying; also Helge Hoel, Louise Potts, Lyn Quine and Les Smith for conversations and guidance.

Andrea Adams Trust (1998) *Workplace Bullying: the Legal Position.* Andrea Adams Trust, Portslade, East Sussex BN41 1WA

Brighton Health Care Trust (1999) *Bullying and Harassment at Work Policy.* Brighton Health Care Trust, Brighton

Brodsky CM (1976) *The Harassed Worker*. Health and Co, Lexington MA

Crawford N (1992) The psychology of the bully. In: Adams A, ed. *Bullying At Work: How To Confront and Overcome It.* Virago, London: 69–86

General Medical Council (1998a) *The New Doctor.* General Medical Council, London

General Medical Council (1998b) *The Early Years.* General Medical Council, London

General Medical Council (1998c) *Good Medical Practice.* General Medical Council, London

Hoel H, Rayner C, Cooper CL (1999) Workplace bullying. *Internat Rev Industrial Organizational Psychology* **14:** 195–229

Quine L (1999) Workplace bullying in NHS community trust: staff questionnaire survey. *Br Med J* **318:** 228–32

Resch M, Schubinski M (1996) Mobbing: prevention and management in organizations. *Eur J Work Organizational Psychology* **5:** 295–307

UNISON (1997) *UNISON members' experience of being bullied at work.* UNISON, London

KEY POINTS

- Workplace bullying takes many different forms, but results in intimidation of and distress in the victim.
- Bullying may reflect prejudice, personality problems, poor 'systems', or a serious failure in communication or relationships skills.
- Bullying is common in the health service, as in other workplaces, occurring within and between all levels of staff.
- Bullying damages doctors, especially those in training, often seriously.
- Clinical environments in which bullying occurs are probably less safe for patients.