LONDON AND SOUTH EAST MULTIPROFESSIONAL FACULTY DEVELOPMENT

NHS
Health Education England

# Managing Bullying, Harassment and Undermining

## A guide to good practice in postgraduate medical education in London

June 2016

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11. Organisational interventions include: anti-bullying policies and guidance on good practice; engaging leadership; collaboration across specialties and disciplines; emphasising clinical-service links.

# Introduction

This guide has been produced by the Educational Team Development Service at Health Education England (HEE). We hope it will be useful for Directors of Medical Education (DMEs), Training Programme Directors (TPDs) and other medical educators and managers in London. Although it addresses issues relating to London and points to resources currently available here, educators elsewhere in the UK may also find it helpful as a general guide to good practice.

The aims of the guide are:

- To set out the principles of good practice in addressing these problems.
- To describe the resources and strategies available
- To offer guidance in interpreting the National Trainee Survey (NTS) in relation to bullying, harassment and undermining

The Educational Team Development (ETD) Service offers support and advice for London DMEs and other educators to address bullying and harassment. We can help DMEs design specific interventions to address problems locally, including co-ordinated input at several levels in the system. Advice and help is also available from Trust Liaison Deans (TLDs), GP Associate Deans (ADs), Heads of Schools and Foundation School Directors. The Professional Support Unit (PSU) can offer guidance on helping doctors who may have problems with clinical performance, health or conduct.

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**Useful links**

**Educational Team Development Service**

www.faculty.londondeanery.ac.uk/educational-team-development

Or contact us direct by emailing our administrative coordinator Christine Strickett: facultydevelopment@nwl.hee.nhs.uk

**Professional Support Unit**

http://www.lpmde.ac.uk/professional-development/professional-support-unit

# Background

In October 2012, the former London Deanery now HEE set up a project to analyse the scale and nature of bullying and harassment of medical trainees in London, and to come up with a plan to address these.

This guide is one of the outcomes of the project.

The trigger for the project was the National Trainee Survey (NTS). This included a new category of 'pink' outliers, to indicate units in the bottom quartile for these problems. The NTS created this category in response to requests from Deaneries to help identify every unit where these were a significant issue. As a result, the survey identified that a large number of units in London fell into this category. In course of the project we corresponded with the GMC and met with them to clarify questions about the NTS. We spoke to DMEs and other educators about good practice, drawing on their extensive experience of addressing these problems. We sent a callout for information about policies and examples of good practice to Heads of Schools, TLDs, ADs and DMEs, medical schools and to Postgraduate Deans nationwide. In addition, we followed up over 30 responses to our callout, and gathered information including:

- Reports, discussion papers, publications and presentations
- Policies and procedures
- Training programmes and materials, including videos
- Questionnaires and systems for monitoring and feedback
- Narratives of good practice

We identified a major evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviour, carried out for the NIHR Service Delivery and Organisation programme (Illing, Carter et al, 2012). This report is now the gold standard for the subject, and educators wanting a comprehensive and scholarly review should download and read it (see references). Another useful report, supported by the Department of Trade and Industry, and the trade union Amicus examined the problem more widely than the NHS (Rayner and McIvor, 2008). There is also a helpful review of multilevel interventions in workplace bullying by Nicole Saam (2010).

In preparing this guide, we have drawn on all the material we gathered, and on the experience of the ETD Service, which has now offered support to units within most Trusts in London.

### Useful link

**National Trainee Survey**
www.gmc-uk.org/education/surveys.asp

# Definitions

Definitions of bullying vary but the following one from the Chartered Institute of Personnel and Development is widely used:

*'Bullying is persistent behaviour that is intimidating, degrading, offensive or malicious and undermines the self-esteem of the recipient.'*

*'Harassment is unwanted behaviour that may be related to age, sex, race, disability, religion, sexuality of any personal characteristic of the individual. It may be persistent or an isolated incident.'*

According to leading researchers (Illing et al, 2012), in a training context bullying and harassment may include:

- persistent and deliberate belittling or humiliation
- shouting, threatening or insulting behaviour
- persistently and unfairly singling out an individual for unreasonable duties, or for duties with no educational value
- persistently and unfairly preventing access to the normal educational events or opportunities associated with the programme
- marginalising trainees without good reason, so that they are unable to carry out their jobs and make progress in their training

There is no fixed definition of the term undermining but it is usually taken to mean 'lowering someone's confidence or self-esteem.' Until 2011 the NTS included the term in all questions related to bullying, but has now largely replaced this with 'bullying and harassment'. In this guide we have retained the term 'undermining' because we find that educators commonly use it. However, there seems a fine line between behaviour described as undermining and what many people would regard as bullying. In many circumstances it may be best to avoid the term because of the risk of seeming to understate the problem.

The typical kinds of bullying and undermining we have heard about in our work in the ETD service include those in Box 1 below:

**Box 1: Typical examples of bullying and undermining of medical trainees**

- Giving feedback that is poorly matched to the level, resilience or vulnerability of trainees
- Giving feedback that is persistently negative, harsh, or with no opportunity for dialogue
- Paternalistic and overbearing attitudes accompanied by poor skills in adult education
- Criticism in front of others
- Shouting
- Over-or under-estimating trainees' level of competence, and failing to provide appropriate experience to match it
- 'Storing up problems' so that criticism is expressed too late and too aggressively
- A conspicuous lack of interest in trainees' need for support and development
- Demonstrating a belief that clinical service always takes priority over educational needs

- Indifference to levels of workload and not attempt to lessen this where necessary
- Being unavailable, and leaving trainees without adequate cover
- Undermining of junior doctors by senior nurses and midwives through belittling or marginalising them
- Bullying of junior doctors by managers in pursuit of targets or turnover

We have also come across examples of what we would describe as 'institutional bullying', with aggressive and intimidating behaviour modelled by Trust leadership, including chief executives and medical directors, and reproduced at multiple levels in other power relationships within the Trust including trainer-trainee interactions. Related to this, we also encounter systematic devaluing of education, with clinical service always taking precedence, an absence of education from agendas, siphoning of money away from training, and job plans not recognising educational roles.

Harassment in relation to personal characteristics is less common, although we have come across instances of clear sexual harassment.

Our experience in the ETD service, and what we have heard from DMEs, TLDs and clinical teachers generally, confirms the comments of the Illing Report in relation to understanding the causes of bullying and its consequences, and in addressing it: see Box 2:

**Box 2: Understanding bullying**

'Bullying is a persistent problem in many organisational contexts, including in the NHS.

Explaining the occurrence of bullying is a complex endeavour, and is likely to involve:

individual (e.g. target and perpetrator personality), group (e.g. socialisation) and organisational level (e.g. climate, leadership) antecedents.

[Models] predict negative consequences of bullying for individuals (e.g. physical and mental health), groups (e.g. psychological distress of bystanders) and the organisation (high staff turnover, reduced productivity).

Taken together, this evidence demonstrates the far-reaching impact of bullying and the complexity in addressing its potential causes.' (Illing, Carter et al 2012, p48).

It is worth pointing out that, although this guide relates principally to doctors in training grades, many of the narratives we hear about being bullied and undermined come from staff and associate specialist doctors (SASGs or 'middle grades'). It appears that in some ways they are more exposed to these behaviours than career grade doctors, especially when they are in positions without long term job security. Educators should be aware of their responsibilities towards these doctors as well as to trainees.

This guide does not specifically address nurses, AHP, "middle grade" doctors or other NHS workers but Trusts may wish to apply some of the same principles for those professionals as well.

# Principles of good practice

From our discussions and the materials we gathered, we have been able to distil the following principles guiding good practice:

1. There are effective ways of reducing bullying and undermining, but there is no standard package or quick fix, and solutions need to fit the circumstances.

   Every set of circumstances is different. The personalities, interactions, problems and levels of educational skill differ from one unit and organisation to another, so DMEs have to use a flexible approach when drawing up action plans. They may need to make interventions with individuals or groups; with trainers, trainees or both; and within or across disciplines. The work they do may involve training, team building and facilitation, or cross into areas including clinical governance, appraisal, job planning, performance management, or involving Human Resources departments.

2. A neutral analysis of what is going on with a careful plan of action is more productive than a simplistic diagnosis.

   Bullying and undermining can arise from individual teaching styles, trainee resilience, training needs on either side, or wider issues such as changing generational expectations. Linear explanations are unhelpful (e.g. the trainee is ‘difficult and demanding’ or the teacher ‘a tyrant of the old school.’)

3. It is important to support educational and clinical leads, and to develop the local consultant body and faculty group.

   Bullying may occur from only one or two teachers, but it often signifies problems across the teaching team. This can include the training culture, or shortcomings in educational governance. As a result, DMEs and others often need to tackle individuals as part of a wider strategy of faculty development.

4. Bullying and undermining needs to be addressed alongside other reported problems in training.

   Although there are instances where bullying is the only concern, the problem often occurs in conjunction with other issues such as workload, clinical supervision or (commonly) overall satisfaction with training. Because of this, DMEs generally seem to find they need to address problems in the round.

5. Tackling the problem often involves building confidence among trainee groups and demonstrating that reporting makes a difference.

   Bullying and undermining are generally accompanied by a fear for the consequences of whistleblowing. It is important to have multiple channels for reporting, including educational supervisors, training programme directors (TPDs), DMEs and HEE.

6. Systems-wide approaches work best. Bullying may pervade an entire system up to and including chief executive level. According to the evidence:

   - organisations should have a broad-ranging, strategic and embedded approach to bullying and undermining
   - engaging leaders is critical for interventions to succeed
   - a critical mass of staff must be involved, so they become willing and able to apply policy
   - systems for monitoring organisational data and giving feedback are essential
   - convincing examples of tackling bullying well are worth far more than just having policies or power point presentations

# Framework for interventions

A comprehensive range of resources for addressing bullying should offer three different elements: support for individuals, teams and organisations. There are outlined in Box 3.

Not all these elements will be required in every case, and no single organisation will provide the whole range. However DMEs, TPDs and other educators are often able to offer some of these resources themselves. HEE offers guidance and advice through its ETD Service and Performance Support Unit (PSU). The guidance that follows is listed under the headings of individual, team and organisational interventions.

**Box 3: Range of resources for addressing bullying and undermining**

- support for individuals including coaching and mentoring, therapeutic approaches and counselling, and individual training in giving constructive feedback and resilience.
- interventions at the team level including facilities for team-building, training in conflict resolution, mediation, multisource feedback and training that empowers potential witnesses to intervene
- organisational interventions including training for leadership, credible and simple bullying policies, and effective systems for monitoring and feedback

# Support for individuals

This includes the following:

1. **Candid conversations.** When there are concerns that someone is bullying, undermining or harassing trainees, the person should always be told. From many accounts we have heard, it is clear that trying to avoid the conversation (for example by arranging team training in the hope that everyone will 'get the message') is unlikely to have an impact. It may also alienate others who believe that the problem isn't being addressed frankly. We have heard from several DMEs about clinical teachers who have responded positively to challenge, accepting that their training style is outdated and needs to change. Even where this is not the case, it seems that being transparent about concerns is always a good place to start. This is equally the case when bullying is being done by a nurse, midwife or manager, although it may be necessary to enlist the help of someone senior in their own profession.

   Clinical teachers may respond by saying that accusations are unfair. There is no doubt that such accusations do occur. Some trainees have unrealistic expectations about never being challenged, and a minority may unfairly blame their shortcomings on others. Hearing both sides of the story is essential. However, describing trainees as being difficult or 'too demanding' can be a way of avoiding any reflection, or refusing to engage with a changing culture in medical education. It can also be a way of denying how common bullying is. Discussing alleged or even genuinely unfair accusations can be a good entry point for asking trainers to think about what adult educational requires, and how to help trainees develop resilience.

2. **Training.** All clinical and educational supervisors should have completed training in accordance with the Professional Development Framework for supervisors in London. Some DMEs and TPDs are willing to offer informal one-to-one support and instruction to clinical teachers on how to give constructive feedback. The London Handbook for Debriefing is a helpful resource that gives simple guidance on feedback technique. Health Education England Local Teams and Trusts offer a wide range of trainings to help people develop as supervisors. These include faculty development trainings in educational supervision, and dealing with trainees in difficulty. Workshops and courses in supervision skills ('conversations inviting change') provide an opportunity for hands-on coaching in small groups. They are now open to nurses and midwives as well as doctors. Although the evidence shows that training individuals may not always have a great impact, courses can be a good way of helping educators with overbearing styles of teaching to think about better ways of dealing with trainees.

   **Useful links**

   **Professional Development Framework for Supervisors**:
   www.faculty.londondeanery.ac.uk/professional-development-framework-for-supervisors

   **London Handbook for Debriefing:**
   https://www1.imperial.ac.uk/resources/B4F0E6A4-0A0B-4AF1-A39F-23B615EF7922/lw2222ic_debrief_book_a5.pdf

   **Faculty Development training courses**:
   http://store.london.ac.uk/browse/product.asp?catid=2&modid=5&compid=2

   **Essential supervision skills workshops:** http://faculty.londondeanery.ac.uk/courses-and-events/essential-supervision-skills-for-clinical-teachers/?portal_status_message=Changes%20saved.

**Advanced supervision skills courses**: http://faculty.londondeanery.ac.uk/courses-and-events/advanced-supervision-skills-for-clinical-teachers/?portal_status_message=Changes%20saved.

3. **e-learning.** Although face-to-face trainings are more effective where bullying and undermining has been a problem, there is also a wide range of e-learning programmes that may help supervisors to satisfy requirements for accreditation and learn some basic concepts and techniques to apply to adult learning. Multiprofessional Faculty Development now has a specific e-learning module on undermining, aimed to help trainees identify when they are being undermined and to know where to turn. Some of the royal colleges also offer good e-learning modules, especially the Royal College of Obstetricians and Gynaecologists, working together with the Royal College of Midwives. Educators may also want to check resources with their own particular college.

   **Useful Links**

   **Faculty Development e-learning modules**:
   www.faculty.londondeanery.ac.uk/e-learning

   **Faculty Development e-learning module on Undermining and Conflict in the Workplace** :
   http://www.lpmde.ac.uk/professional-development/elearning-support-and-self-review-modules/undermining-and-conflict-in-the-workplace/undermining-and-conflict-in-the-workplace

   **Assessing educational needs**:
   www.faculty.londondeanery.ac.uk/e-learning/assessing-educational-needs

   **Facilitating learning in the workplace**:
   www.faculty.londondeanery.ac.uk/e-learning/facilitating-learning-in-the-workplace

   **How to give feedback**:
   www.faculty.londondeanery.ac.uk/e-learning/feedback/

   **Managing the trainee in difficulty**:
   http://www.faculty.londondeanery.ac.uk/e-learning/managing-poor-performance/

   **Royal College of Obstetricians and Gynaecologists videos**:
   https://stratog.rcog.org.uk/tutorial/frank-bullying/video-4456

4. **Observation of clinical teaching**. A number of educationalists can provide an experienced educational facilitator to observe clinical teaching for three or four sessions and offer confidential, non-judgemental and constructive feedback. Observations may work best when several consultants on a unit, perhaps with varying levels of aptitude, engage with this as part of a programme of team development.

5. **Mediation between a trainer and an individual trainee**. Where conflict has developed between a clinical teacher and one individual trainee, DMEs and other educators sometimes offer mediation. Both parties need to give their consent to this, and not feel pressurised into meeting. It is also important that both sides understand that agreeing to mediation does not close off other options if it fails (e.g. a formal complaint by a trainee, or an adverse educational report.)

6. **Coaching and mentoring**. Coaching and mentoring can help clients understand how they might be perceived as bullies. Trusts may wish to fund sessions of coaching or mentoring for consultants, or ask them to arrange this for themselves. Coaching and mentoring also provide an opportunity to look at wider issues such as stresses in the workplace, or career difficulties. Trainees can also find coaching and mentoring useful, including in regaining their confidence and developing resilience. The Coaching and Mentoring service at HEE offers four free sessions with accredited Mentors for London NHS clinicians whilst in training. (ie a doctor or dentist in a HEE Foundation or Specialty

training scheme, or in the first 2 years of a Return to Practice Scheme; or a healthcare professional in bands 5-8 in a recognised training scheme such as preceptorship or development role.)

**Useful link**

**Coaching and Mentoring**:
www.mentoring.londondeanery.ac.uk/

7. **PHP HEE (London)**. The NHS Practitioner Health Programme (PHP) is a free and confidential NHS service for doctors and dentists with issues relating to a mental or physical health concern or addiction to problem, in particular where these might affect their work. As with coaching and mentoring, doctors need to refer themselves. It is important for them to feel that this is in their own interest rather than being something they are asked to undertake to satisfy others. Although consultations may touch upon issues related to bullying and undermining if the client wants to, the focus will be on the whole range of issues that might be impacting on someone's mental health.

   **Useful link**
   http://php.nhs.uk/

   Trainees can also contact PHP. Details of the services available to them via PHP can be found at:

   http://www.lpmde.ac.uk/professional-development/php-hee

8. **Redeployment away from training.** Not every doctor wishes to teach or has the capacity to do so effectively. When holding candid conversations about bullying, DMEs and others sometimes raise the question of whether a consultant really wants to teach. Occasionally they need to make arrangements for someone to be redeployed away from training. This may involve revised job planning and a rearrangement of clinical services. Although such situations can be delicate, we have come across examples of doing it appropriately and well. This may be preferable to the risk of further complaints from trainees or decommissioning of training placements.

9. **Formal complaints procedures.** Every Trust will have formal complaints procedures and should have a policy for whistleblowing. Trainees who wish to purse complaints formally with their employer can do so by contacting their Human Relations department. In practice only a very small proportion of bullying and undermining behaviour is ever reported formally to Trusts. It seems that the majority of work that DMEs and others do to address these problems happens below the legal and procedural radar. Much good work may be going on in a common sense, low key way and behind closed doors, without ever reaching formal procedures.

10. **Disciplinary procedures.** When bullying or harassment is flagrant or involves discrimination, DMEs have to involve their Trust's human relations department (HR) and discuss disciplinary procedures. Although these are unpleasant and everyone tries to avoid them, it appears these are occasionally the only proper way of addressing the problem. A major impediment to whistleblowing within organisations is the perception that 'in the end, nothing ever happens', and that no-one ever has to face disciplinary proceedings, however badly they behave. Conversely, evidence shows that the best way of building everyone's confidence in an anti-bullying policy is to demonstrate that an organisation is prepared to take every necessary action to enforce it.

Box 4 shows how a range of different support helped a clinical teacher become more effective (all details have been changed)

**Box 4: Helping a clinical teacher become more effective**

Dr S is a 54-year old consultant in histopathology. He is widely recognised as having exceptional knowledge and skills in his specialised field, but until recently was regarded as fierce and intimidating by many trainees during their placements with him.

Following a number of informal complaints by trainees to their educational supervisors, the clinical director for the unit tackled him about this. After an initially defensive reaction, Dr S conceded that he needed to 'move with the times'. He organised some sessions of confidential coaching and mentoring, where he was able to air some of his frustrations about changes in organisational and educational culture. He subsequently agreed that an educator could observe a couple of sessions when he was teaching trainees over laboratory slides, and discuss his strengths and needs as a teacher.

Following this, he attended a course in clinical supervision skills where he learned about the use of open questions and the use of positive feedback. Comments from trainees have been consistently more positive since he undertook these activities. Dr S recently joked with the clinical director that he has turned from 'an old fossil' into 'one of those touchy-feely types.'

# Interventions at the team level

In many instances, bullying by individuals is a symptom of wider difficulties within a unit, or they take place against a background of other problems, including shortcomings in educational governance or team working. Helpful interventions we have come across or assisted include the following:

1. **Building and supporting local faculty groups**. Many 'red and pink outliers' for bullying and harassment appear to occur where local faculty groups are indistinct or non-existent. An LFG usually consists of the educational lead for a specialty within a Trust, along with all the educational supervisors, preferably the clinical lead, and generally two elected trainee representatives (who should be absent during confidential discussions about individual trainees). Where every consultant on a large unit is an approved educational supervisor, three or four of them usually take the lead in attending the group. Membership varies, and in some circumstances a TPD, divisional lead or manager may also belong. Sometimes the function of LFGs is covered by putting educational matters on the agenda as part of a regular clinical or audit meeting. However, it is far better for LFGs to convene separately at least every two to three months, so that they can focus properly on education.

The roles of an effective local faculty group include those listed in Box 5:

**Box 5: The roles of an effective local faculty group**

- signalling that consultants have dual roles as both clinicians and teachers
- raising awareness of professionalization of training in secondary care
- reviewing and spreading information about the changing structures and regulations relating to PGME
- ensuring clinical teachers on a unit are following good practice in areas such as induction, handover, presence and availability on wards and in clinics, and regular educational supervision including needs assessments
- reviewing teachers' compliance with the Deanery's Professional Development Framework and the GMC's competency framework for trainers
- leading on preparation for visits by colleges, lead providers and Deaneries/LETBs, and on implementing recommendations or action plans that arise
- taking soundings from trainee reps on the balance between clinical service demands and training needs, and reviewing rotas to get this right
- reviewing and interpreting the NTS and other sources of information, and organising an
- appropriate response
- preparing proactively for new cohorts of trainees
- planning early support or interventions for trainees in difficulty commissioning local faculty development for clinical teachers

Where bullying and undermining are a problem, support for an effective LFG may be the single most important intervention to change the educational culture on a unit.

2. **Meetings of the consultant body**. Where units have received 'red flags' for bullying and undermining, some DMEs, TLDs and TPDs find an opportunity like an audit meeting to meet with all the consultants to explain the findings and their significance. This can be a good opportunity to remind consultants that they wear educational as well as clinical hats, to bring them up to date with organisational and attitudinal changes in the world of medical education, and to remind them of their responsibility to fulfil their requirements as clinical supervisors.

3. **Team trainings**. A number of organisations including Trusts offer specific trainings to medical or multidisciplinary teams on topics including:

   - clinical and educational supervision
   - dealing with trainees in difficulty
   - giving effective feedback
   - the scale, nature, causes and consequences of bullying
   - how to prevent inadvertent bullying
   - impact of cultural and other factors on the perception of bullying
   - how to handle accusations and rebuild trust
   - discussion of video scenarios

   Team training can help to promote good educational skills and it is sometimes an opportunity for addressing specific local problems with bullying and undermining, although it can sometimes be a way of avoiding difficult problems or dealing with them directly. The ETD service can give advice on whether team training is likely to be a useful part of a unit's strategy to reduce bullying and undermining, and how it can be augmented with other input including observation of clinical teaching, mediation or other forms of help.

4. **Team facilitation**. A number of independent consultancies offer facilitation for teams that need to address issues affecting training. Where appropriate, team facilitation can also include nurses, midwives, managers and others. Setting up good team facilitation requires:

   - openness with the team about the problems that are being addressed (e.g. 'we have a red flag for bullying and harassment, and we risk losing trainee placements if this is repeated.')
   - a period of preparation and planning (e.g. facilitators meeting first with the people who are motivated to address the problems, including the educational and clinical leads)
   - taking soundings from key parties (e.g. Head Of School, TLD, TPD), and keeping them in the loop about the subsequent process and its effectiveness
   - ensuring every trainer attends team facilitation, with a prior understanding of the purpose, and consent to taking part
   - involving nurse educators, unit managers and others in meetings where appropriate
   - maintaining confidentiality regarding the detailed content of discussions
   - a time-limited process so that local educators can take over the next stage.

   In this context it is worth pointing out that it is risky to set up isolated 'Awaydays', as they can expose conflicts without necessarily resolving them. They generally require a great deal of planning and forethought, as well as making sure everyone is committed to attending and addressing the issues at stake. They also require skilled facilitation.

5. **Meetings with trainee groups**. During Quality Visits HEE visitors meet with trainee groups. Sometimes DMEs and TLDs also meet with specific groups of trainees where there are concerns, including bullying and undermining. The advantages of meeting trainees include:

   • establishing the 'fine grain' of problems shown up by the NTS or local surveys

   • signalling that educators LETB's take these seriously

   • providing information about routes for incident reporting and whistleblowing

   • reminding trainees that their teachers have a duty to correct them and fair criticism is part of training

   • helping to inform a strategy for reducing bullying

   • acting as a forum for monitoring improvements

   We have also heard of instances where a DME or TPD has individually interviewed every trainee in a unit confidentially when there have been difficulties unit, to establish the strengths and failings of a training programme.

6. **Trainings for trainee groups**. Trainings are available for trainee groups to explore their expectations from their teachers (including unrealistic ones), build resilience, help them to identify bullying and harassment with confidence, and know where to turn for support and redress. Such training can build up peer support on a unit where bullying has been an issue and is now being addressed. The ETD service can provide advice on trainings for trainees.

7. **Making use of trainee representatives**. Trainee reps can act as a useful conduit for information about bullying, harassment and undermining. They may be able to pass on anonymised information about the types and sources of bullying on a unit. Where the unit is small and any report might identify the complainant, trainee reps can liaise directly with the DME, chair of the Specialty Training Committee (STC), or encourage trainees to report their experiences at their ARCPs. Trainee reps can also help to identify wider problems on a unit, and have sometimes been involved in designing and administering local trainee surveys, as well as collating the results. Some DMEs hold joint meetings with trainee reps from several specialties.

8. **Local surveys**. Local surveys of trainee opinion can highlight the specific forms of bullying and undermining. They can point towards the general source of such behaviour (eg consultants, managers, midwives) or particular individuals. They can also help to monitor whether interventions are making a difference, and can be effective if used on a regular basis to check how well a unit is doing, or completed at the end placements so that subsequent trainees may benefit. Trainees may fear being identified from what they write, or believe the responses will not be kept anonymous. Surveys therefore need to be used with care, as part of a wider programme to build trust and improve training. Questionnaires can be distributed in printed form or electronically, for example using 'Survey Monkey'. Questions can be based on the NTS, but there are also more detailed tools, including ones designed to monitor problems longitudinally. The ETD service can offer advice on questionnaires. Appendix A lists the questions in the NTS, and gives illustrations of simple and more detailed questionnaires.

9. **Joint meetings with the trainee group and their trainers**. Setting up a small working party of a couple of consultants and the trainee reps can be a useful stage on the way to holding a meeting of the whole unit later on, and to promote better dialogue between the trainee and trainer groups. Some external consultancies offer to facilitate meetings of the consultant group together with all the trainees. This builds confidence in the process and ensuring frankness in the discussion.

Box 6 shows how a unit addressed concerns about bullying raised by the National Trainee Survey

**'Box 6: Addressing concerns on an O & G unit**

The department of obstetrics and gynaecology at a district general hospital received seven 'red flags' in the National Trainee survey, including one for bullying and undermining.

The Director of Medical Education met with all the trainees on the unit and heard about a wide range of concerns. These included: criticism of trainees by consultants in front of patients and midwives; allowing trainees to be left without adequate supervision at times; cancellation of teaching sessions because of clinical service pressures; irregular and unfocussed educational supervision; and a reluctance to carry out workplace based assessments.

The DME met with the consultant group to explain the risk that training placements might be withdrawn if the next NTS results were also poor. She arranged for a series of half-day trainings to take place in the department's regular slot for clinical audit: these included trainings in work-place based assessments, managing the trainee in difficulty, and giving feedback constructively. She attended the local faculty group on a regular basis to discuss with the lead educators and trainee reps a range of initiatives to make sure there was always adequate cover, and that all trainees felt confident in using informal channels to report incidents where they felt criticised inappropriately or in front of others.

After six months, a confidential survey of trainees on the unit showed far fewer concerns, and at the next NTS the only red flag was for 'workload', which was recognised to be exceptionally heavy across the Trust.

# Organisational interventions

DMEs and other clinical teachers may have limited opportunities and resources to bring about change at board level or to influence pan-organisational culture. At the same time, their knowledge and expertise as educators makes a difference in many ways, including informing Trust leadership of good practice.

Research relating to organisations highlights the following:

- Organisational climate and culture have a major influence on the levels of psychological distress and workplace bullying.
- Interventions are more likely to succeed if leadership commitment is present at the highest level.
- An anti-bullying ethos requires a broad approach that embraces all organisational activities including employee selection, performance management, appraisal, training and development, early intervention and effective support services.

Recommendations based on NIHR funded research, and from the 'Dignity at Work' project, are listed in Appendix A.

### Possible interventions at the organisational level include:

1. **Advising on bullying policies and good practice**. Every organisation should have an anti-bullying policy. Educational contracts with providers also oblige them to have one. Policies should be short, simple, non-legalistic, practical, and designed specifically for that organisation. There is an outstanding example of a well-written policy for trainers and trainees from Oxford, specifying the responsibilities of both. Research evidence is consistent in showing that anti-bullying policies are of little use unless backed up by monitoring and training across the organisation, as well as visible and fair enforcement. Having a code of conduct which everyone signs is helpful. A culture that encourages bystanders across the organisation to trust their judgement and intervene when they see bullying also makes a difference. DMEs and may have a useful part to play in raising awareness of this, and in informing Trust leadership about the recommendations of the Illing Report (see Appendix A).

   **Useful links**

   **London postgraduate medical and dental eductaion policies and procedures:**
   http://www.lpmde.ac.uk/lpmde/policies-procedures/policies-procedures?searchterm=policies

   **Oxford Deanery schools anti-bullying and undermining policy**:
   www.oxforddeanery.nhs.uk/specialty_schools/school_of_obstetrics__gynae/anti-bullying_and_undermining.aspx

2. **Engaging Trust leadership in addressing bullying**. Effective strategies to address bullying need to demonstrate buy-in at the highest level. Much depends on leadership style, and on leaders at the top who take a balanced approach rather than an aggressive one. In some Trusts, the chief executive and medical director address induction courses to welcome trainees, They state that their Trust has an anti-bullying policy, offer a commitment to implementing it, and explain the routes for reporting concerns. Involving board members offers an opportunity to educate them in some of the principles of good anti-bullying strategy. It may also raise their awareness of the importance of good practice in retaining trainee placements in their Trusts.

3. **Collaborating with other specialties, disciplines and management**. Educators who are dealing with bullying on one unit are likely to find colleagues who are trying to address the same problems in other specialties, in nursing, and among managers and administrative staff. Similarly, there may be initiatives going on in different parts of a trust to engage with related issues such as raising

standards of professionalism, encouraging better multidisciplinary team work, providing skills for conflict resolution, or improving the quality of the patient experience. Projects to reduce bullying and undermining may benefit from linkage to these kinds of initiatives, across traditional boundaries. Some royal colleges like the Royal College of Obstetricians and Gynaecologists offer training resources and events aimed at both doctors and other professions. Simulation training may also provide opportunities for learning how to give feedback constructively both within professions and between them.

4. **Emphasising the link between clinical service and education**. Bullying and undermining may occur especially in units with excessive clinical workload and severe staff shortages. No amount of training or facilitation can overcome these pressures. DMEs, TLDs and other educators play an important role in making trusts aware of the risks to patient safety where trainees feel over-stretched or under-supported. They may be able to point out the longer term risks to clinical services and income if trainees are withdrawn because of persistently poor NTS results, and argue for the creation of new consultant or middle grade posts.

Box 7 gives an example of a programme to change the culture of an organisation in order to reduce the incidence of bullying and undermining.

**Box 7: Culture change across an organisation**

A large hospital trust has undergone reconfiguration and suffered adverse local publicity about medical errors. During this period of turbulence, both the chief executive and medical director resigned. Morale at the hospital was generally low, and this was expressed in many ways including disrespectful interactions between managers and clinicians, different disciplines, as well as consultants in different departments, and teachers and trainees.

Two new people have now been appointed to the posts of CEO and MD. They are widely regarded as peacemakers and 'good news' by comparison with their predecessors. As part of a strategy to restore morale in the hospital, they and the Trust board have launched a high-profile programme to promote respect in the workplace. As part of this, they have introduced a new and simplified anti-bullying policy, and backed this up with focussed trainings for management, professional and departmental leads, where they welcome participants personally. They have set up a confidential helpline and advice service for staff who witness or are victims of bullying, undermining and harassment. There is a general recognition within the hospital that things are going in the right direction, and that it is a more pleasant place to work, and to be a patient, than it was previously.

# References and further reading

Illing JC, Carter M, Thompson NJ et al. **Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS**. Durham University, 2012. Executive summary: www.netscc.ac.uk/hsdr/files/project/SDO_ES_10-1012-01_V02.pdf (accessed 7 February 2013)

**Full report**: www.netscc.ac.uk/hsdr/files/project/SDO_FR_10-1012-01_V06.pdf (accessed 7 February 2013)

Rayner C and McIvor K, editors. **Research Report on the Dignity at Work Project: Proceedings of the Report prepared for Amicus and DTI**. University of Portsmouth, 2008. www.port.ac.uk/research/cord/workplacebullying/researchreports/filetodownload,52783,en.pdf(accessed 7 February 2013)

Saam NJ. **Interventions in workplace bullying: a multilevel approach, European Journal of Work and Organizational Psychology**. 2012; 19: 51-75 www.tandfonline.com/doi/pdf/10.1080/13594320802651403

# Appendix A: Trainee Questionnaires

**Example 1: Questions from National Trainee Survey 2016 (NTS)**

**Supportive environment**

Please state whether you agree or disagree with the following statement about your post.

**GENHQ78** : In general, the working environment is a supportive one.
Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

**GENHQ79:** Staff, including doctors in training, are treated fairly.
Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

**GENHQ780:** Staff, including doctors in training, treat each other with respect.
Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

**GENHQ81**: The working environment is one which helps build the confidence of doctors in training.
Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

**GENHQ82**: If I were to disagree with senior colleagues, they would be open to my opinion.
Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

**Bullying and Undermining**

**GENHQ84:** Have you been the victim of, or witnessed, any bullying or harassment in this post?

- Yes, and I wish to report it here (branches to GENHQ85 )
- Yes, but I don't want to report it here (branches to GENHQ122)
- No

**GENHQ85** :Your bullying or undermining concern ( Free text)

**GENHQ87:** Please specify who has been doing the undermining/bullying described in your concern (please select all that apply)
Consultant/GP (within my post) / Consultant/GP (outside my post) / Nurse/midwife/Other doctor/Other trainee /Management /Patient/relative /Other (please specify)

**GENHQ88:** If you selected 'other' please provide a description

**GENHQ89:** Which behaviour types describe your concern? (Please select all that apply)
Belittling or humiliation /Threatening or insulting behaviour /Deliberately preventing access to training /Bullying relating to a protected characteristic /Other (please specify)

**GENHQ122:** Which of the following describes why you don't want to report this? (Please select all that apply)
The issue has already been resolved locally / I have raised it, or intend to raise the issue locally instead / I don't think the issue is serious enough to report /I don't think reporting will make a difference /Fear of adverse consequence /Other

## Example 2: Simple questionnaire (from a DME)

These questions relate to incidents of bullying or harassment and will be strictly anonymised. Examples might include unjustified criticism in front of colleagues, destructive innuendo or sarcasm, inappropriate jokes or teasing, discrimination (race, gender, sexuality). Please give examples you have experienced. Please also include examples you have witnessed.

1. **Have you experienced bullying or undermining in your recent job on this unit**?

   If yes, can you give an outline of what happened?

2. **Was any staff group or member particularly involved – senior doctors, nursing staff, others?**

3. **Please provide any other information/comments you think important.**

## Example 3: Detailed questionnaire (from a gynaecology unit)

1. **Have you witnessed work colleagues being subjected to workplace bullying from peers, senior staff, or managers**: Yes/No

**Have you been subjected to workplace bullying from peers, senior staff or managers:** Yes/No

**2. Please state who has subjected you to bullying (tick all that apply):**

| | |
|---|---|
| Consultant in O&G | |
| My Educational Supervisor | |
| My College Tutor | |
| The Clinical Director for this unit | |
| O&G Trainee ST3-7 | |
| O&G Trainee ST1-2/F2/GPVTS | |
| O&G Staff Grade/Assoc Specialist | |
| Senior Midwifery Staff | |
| Junior Midwifery Staff | |
| Senior Gynae Nursing Staff | |
| Junior Gynae Nursing Staff | |
| Non O&G Medical Staff | |
| A Senior Manager | |
| Other (please specify) | |

**3. If you were bullied in the last 12 months please state the clinical area where bullying occurred (tick all that apply):**

| | |
|---|---|
| Labour Ward | |
| Antenatal Clinic | |
| Antenatal Ward | |
| Postnatal Ward | |
| Gynaecology Clinic | |
| Gynaecology Ward | |
| Gynaecology Theatre | |
| When providing On-call/Emergency Cover | |
| Administrative duties (dictation/rotas etc) | |
| Clinical Governance Issues (Audit, risk management, M&M meetings) | |
| Other | |

**4. In the last 12 months have you experienced from peers, senior staff or general managers any of the following in the workplace (tick any that apply):**

| | |
|---|---|
| Persistent attempts to belittle and undermine your work? | |
| Persistent and unjustified criticism and monitoring of your work? | |
| Persistent attempts to humiliate you in front of colleagues? | |
| Intimidating use of discipline or competence procedures? | |
| Undermining your personal integrity? | |
| Destructive innuendo and sarcasm? | |
| Verbal and non-verbal threats? | |
| Making inappropriate jokes about you? | |
| Persistent teasing? | |
| Physical violence? | |
| Violence to property? | |
| Withholding necessary information from you? | |
| Freezing out, ignoring, or excluding? | |

# Appendix B. Recommendations for good practice in managing bullying and harassment

*(Illing, Carter et al, 2012, p 175-177)*

- Focus preventative interventions firstly at the leaders and managers. Leaders and managers have considerable power to prevent and manage bullying by role modelling positive behaviours and intervening early using effective conflict management and interpersonal skills. Priority should be placed on their selection, training and development. Leaders need to recognise bullying behaviours and possess the skills and confidence to manage them.
- When an intervention is introduced, leaders and managers should be committed to supporting it. Leaders are critical to intervention success. Single interventions were likely to fail or have little long-term impact on the organisation or team unless they were supported by committed leaders and managers. Support may include explicitly prioritising attendance at training, following up on issues raised (e.g. attempting to reduce sources of work conflict), and acting as a role model by displaying positive behaviours and challenging negative behaviours.
- Formal policies and procedures should be established to outline the organisation's explicit commitment to tackling bullying. Policies should be embedded in the organisational culture, be accessible, and easy to use and apply. Enforcement of the policy should be consistent, fair, and apply to all staff, regardless of their status. Formal investigations should be timely, conducted by trained staff that are independent, have personal responsibility to progress the case, and include the offer of support for both the accused and the target. Enforcement of policies could be developed further using a code of conduct, and could form the basis of bystander interventions and positive norm development.
- Proactive monitoring of organisational data (e.g. bullying prevalence, sickness, turnover, staff satisfaction) can identify patterns and outliers to help target interventions where they are needed.
- Use effective training to prevent and manage bullying. Evidence from the review suggests that training should focus on several key mechanisms: developing trainee insight into their own behaviour and its impact on others; creating a shared understanding of acceptable/unacceptable behaviours; developing interpersonal, communication and conflict management skills and the confidence to apply them via sufficient practice (e.g. role play, cognitive rehearsal) in a safe environment; and identifying local problems and causes of conflict and generating solutions. Training on communication skills, conflict management, and how to challenge incivility may also help bystanders to intervene. Evidence from the review identified important contextual factors for training success: training should be delivered to a critical mass of appropriate staff (particularly managers), and it should be supported by engaged leaders. Content should be relevant to the local context. The behavioural norms of the organisational culture (e.g. bystanders challenging negative behaviours) should also encourage the transfer of new skills.
- Consider mediation for informal resolution of conflict, but be aware of its limitations. Mediation may be effective for the informal conflict resolution, but it is crucial that the mediator is sensitive to the target's fragility, has the ability to manage any power imbalance that exists between the parties, and recognises when serious cases require formal procedures.
- Use counsellors with expertise. If counselling and therapy are offered, counsellors should possess expertise in multiple therapeutic approaches as well as knowledge of bullying.

# Appendix C: Recommendations for good organisational practice

**(Raynor and McIvor, 2008)**

1. Organisations should set up a strategic group to manage their anti-harassment and bullying, processing data to monitor effectiveness.
2. Anti-bullying and harassment policies should be short and simply worded.
3. Organisations need to develop operational ground-level interpretations of their more legalistic and vague policy definitions.
4. Recruitment of managers should include the need for people management capability as much as task-related competence.
5. Management training should include conflict resolution and mediation skills.
6. Incidents of bullying and harassment should be dealt with informally and quickly.
7. Acceptability of bullying and harassment should be reduced to zero, led by all managers.
8. HR and trade union representatives should develop good working relationships to enable them to deal with issues in partnership.
9. As many mechanisms as possible should be available for people to speak out if they see a negative situation.
10. Bystander interventions should be developed wherever possible.
11. Where formal situations evolve, they need to be managed professionally and quickly, ideally using a central case manager and centrally-provided logistics.
12. Outcomes of cases need to be consistent with one another.
13. Everyone involved in incidents (including helpers) need supportive networking.
14. Employees should receive as much feedback as possible.