BMA

Workplace bullying and harassment of doctors
A review of recent research and policy recommendations

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In 2017 the BMA launched a project on workplace bullying and harassment, in order to improve support for individual doctors who experience it, to work with NHS organisations and others to address it, and to raise awareness of bullying and harassment across the profession. The BMA has also endorsed the NHS Social Partnership Forum's Collective Call to Action aimed at creating 'cultures of compassionate leadership in a supportive culture where staff can flourish and problem behaviours such as bullying disappear'.

Executive summary

Bullying and harassment is at high levels in the NHS

According to the NHS England Staff Survey, in 2016, 22% of NHS doctors and dentists experienced bullying, harassment or abuse from other staff in the preceding 12 months (this compares to 24% for all NHS staff). The proportion of doctors and dentists reporting bullying and harassment doubled between 2011 and 2012 and has remained at high levels since.

NHS Scotland and Wales staff survey findings suggest lower levels of workplace bullying and harassment, compared to NHS England. In Northern Ireland, the HSCNI survey suggests similar levels to England. The NHS England Staff Survey found that, by grade, 23% of consultants, 20% of trainees and 24% of other doctors and dentists (including SAS grade doctors) had experienced workplace bullying, harassment or abuse in the previous year. A BMA survey in 2015 of SAS doctors across the UK, found that more than a third had experienced bullying, harassment or victimisation at work over the preceding 12 months and a similar BMA survey of SAS doctors in Wales found that half had experienced bullying, harassment or victimisation. The GMC's NTS (National Training Survey) indicates that 8% of trainee doctors experienced bullying or undermining in their current placement and 14% witnessed it.

Only a minority of doctors report incidents to their employer

Few doctors formally report incidents of bullying and harassment to their employer. According to the NHS England Staff Survey, only 33% of doctors and dentists who had suffered workplace bullying, harassment or abuse in the past year reported the latest incident, which is significantly below the proportion for all NHS staff (47%). It found that trainee doctors were the least likely to take action.

Only 1% of trainees were willing to submit details of incidents to the GMC NTS survey so that they could be investigated by deaneries or local education and training boards. The most common reasons for not reporting were feeling that it would not make any difference and fearing adverse consequences. The BMA survey of SAS doctors in 2015 also found that only a minority reported incidents and, of those who did report, most were not satisfied with the outcome.

Certain protected characteristics increase vulnerability

Staff with certain protected characteristics are more vulnerable to workplace bullying or harassment. The results of the NHS England Staff Survey show that disabled staff in the NHS are the most likely to experience bullying or harassment (32%), followed by LGBT staff (27-30%). Black staff and those from some other minority ethnic groups are more likely to be targeted than white staff (24% of BME staff as a whole compared to 22% of white staff). Women are slightly more likely to be on the receiving end than men (23% compared to 21%). However, other research shows that women doctors are significantly more likely to suffer sexual harassment in their careers than men.

Bullying and harassment harms doctors and patients

The effects of bullying and harassment are wide-ranging. Research shows negative impacts on patient care and safety. For example, a trainee who is bullied by a senior colleague is likely to avoid seeking help or clarification from them to avoid future incidents, which is understandable, but can compromise patient safety. Researchers have also found an association between high employee engagement and high in-patient satisfaction with hospital care and lower mortality rates in acute NHS trusts. Employee engagement is dependent on there being a positive working environment in which staff feel valued and respected.

Trainee doctors who are bullied report lower overall satisfaction with their placements according to the GMC's NTS. Studies also show demotivation, loss of confidence, anxiety and self-doubt among doctors who experience bullying. Bullying increases the risk of psychological distress and mental health problems among doctors. Women doctors who have experienced sexual harassment report that it has undermined their confidence in themselves as professionals and negatively affected their careers.

There are significant costs for organisations from bullying and harassment, mainly arising from higher turnover and increased sickness absence. Lower productivity, potential costs of litigation and compensation, and loss of public goodwill and reputational damage also need to be considered.

Autocratic management, hierarchy and work intensification fuel bullying culture

In recent years, there has been growing recognition of the role of organisational culture in encouraging and permitting bullying, which explains why some workplaces have higher levels than others. Among the factors identified as likely to lead to a bullying culture are: autocratic, target-driven management styles; poor job design; work intensification; and pressures arising from restructuring or organisational change, especially when radical and top-down.

NHS-based research has identified workload pressure and stress as contributory factors. Another factor that has been found to contribute to bullying in the medical profession is hierarchy. Both the hierarchical nature of the profession and workload pressure increase the likelihood of 'silent bystanding' – a failure of colleagues to speak out – which allows bullying behaviour to continue unchallenged.

Formal anti-bullying policies and procedures may be insufficient

There have been very few formal evaluations of current interventions to stop bullying and harassment in the NHS or other healthcare settings. However, a recent evidence-based review of interventions to address workplace bullying and harassment for ACAS identified the limited effectiveness of the traditional approach of relying solely on formal anti-bullying policies and procedures.

The barriers to this succeeding include:
– placing the onus on the bullied individual to formally report the problem
  when surveys and research show an unwillingness to
– a reliance on formal complaints mechanisms prevents early resolution
– a reluctance to impose formal sanctions on 'high value' individuals
– a desire to avoid litigation or protracted formal proceedings which can result in
  pressure to find against the complainant or force them out

Calls for a more comprehensive approach

There is a call for more comprehensive organisational approaches that focus on ensuring worker well-being and good workplace relations so that behaviours like bullying do not arise.

Good practice recommendations include:
– developing behavioural standards in collaboration with employees and role-modelling
  good behaviours by senior managers and staff
– early identification of bullying behaviours (e.g. through staff surveys, exit interviews)
  and acting on risk factors like poor management practices and excessive workloads
– empowering people to talk more openly about what is acceptable and unacceptable behaviour
– strong support structures for employees and managers (e.g. union representatives, bullying
  or fair treatment officers, occupational health)
– encouraging informal resolution where appropriate, backed up by clear and accessible formal
  procedures for when early resolution does not work

Introduction

This briefing covers the key findings from recent surveys and research on bullying and harassment which are relevant to the medical profession. It also highlights current evidence-based policy recommendations for eliminating workplace bullying and harassment. It is intended to inform BMA members and others working with doctors or NHS organisations to help shape responses to the problem.

The briefing is divided into five sections covering:
— Definitions
— Prevalence
— Impact
— Causes
— Recommendations

Defining bullying and harassment

Bullying and harassment are terms that are often used interchangeably. They are closely connected but they are two distinct concepts.

Harassment in the UK is unlawful. The Equality Act 2010 defines it as unwanted conduct related to a relevant protected characteristic (age, race, sex, gender reassignment, disability, sexual orientation, religion or belief) or unwanted conduct of a sexual nature. It has the purpose or the effect of violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person. It is possible to prove harassment by focusing only on the effect the behaviour has on someone else. It is not necessary to also show an intent to cause harm.

There is no legal definition of bullying in the UK. A range of definitions are used in the research literature. A common feature is a focus on the impact of behaviour on others. At one end of the scale, it has been stated that if someone feels bullied, then they are bullied.[1] More typical are definitions that describe or give examples of behaviours and the effect they have. For example, Wild et al.'s (2015) study on undermining and bullying in surgical training includes a non-exhaustive reference to behaviours that cause 'persistent humiliation, ridicule or criticism' or tasks that are 'demeaning and inappropriate.'[2]

Some definitions also focus on the recipient's relative weakness. Carter et al.'s study (2013) of bullying and harassment in the NHS highlights that 'the target of bullying has difficulty in defending him or herself against these actions.'[3] Ariza-Montes et al.'s analysis (2013) of workplace bullying among healthcare workers also stresses the importance of the 'target'(s) reactions, and the target's inability to defend [themselves] from such aggression.'[4]

Another common thread in defining bullying is the abuse of power or influence by the perpetrator. The widely used ACAS definition of bullying includes reference to the 'abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.' Pisklakov et al.'s research (2013) states that bullying involves 'an imbalance of power or strength between the aggressor and the victim.'[5] A review of calls to the ACAS helpline about bullying found that it was often top-down, however, it is recognised that it can also arise among colleagues on the same grade and it can be upwards from junior to more senior staff.[6]

A fourth factor that appears in some definitions of bullying is persistence. Some research studies on bullying refer to it as a repeated pattern of behaviour. For example Carter et al.'s study (2013) specifically rules out a one-off incident as bullying.[7] Others including the ACAS definition do not include any reference to repeated incidents. (Note: harassment can be a one-off incident under the Equality Act 2010 definition).

Prevalence of bullying and harassment

Survey evidence suggests that while a minority of healthcare workers and doctors experience workplace bullying or harassment each year, prevalence is high compared to other sectors and professions. In addition, wider concerns have been raised in recent years about unprofessional or disrespectful behaviours in the health sector that may fall short of bullying or harassment but which also undermine morale, affect performance and potentially harm patient care[8] and which could be a precursor of bullying or harassment.[9]

There is a range of survey evidence on bullying, harassment and undermining behaviours in the medical profession and wider healthcare sector. Some of the differences in findings will result from variations in the way questions are asked and the wording of them. Surveys that focus solely on bullying and harassment are more likely to have a self-selection bias because those who have experienced bullying and harassment are more likely to be motivated to complete them. For example, a Guardian online survey on bullying in the NHS in October 2016 found that 81% of the 1,500 doctors, nurses and other healthcare workers who responded said they had been bullied.[10]

It should also be noted that most survey questions (including the NHS staff surveys) do not define bullying or harassment, in which case, the results will be influenced by respondents' subjective views and perceptions of what it is. This may change over time as awareness is raised of what bullying and harassment is.

NHS staff surveys

The NHS England Staff Survey is the biggest, large-scale annual survey of employees in NHS Trusts and CCGs (a response rate of 44% or more than 400,000 staff in 2016). It asks a wide range of questions about working conditions and staff engagement including whether staff have experienced bullying, harassment or abuse in the previous 12 months. As such, the survey provides a relatively good indication of the prevalence of bullying and harassment.

Nearly 30,000 doctors and dentists responded to the NHS England staff survey in 2016. It found that:
— 22% of doctors and dentists employed in NHS Trusts and CCGs (most in this category will be doctors) said they had experienced bullying, harassment or abuse from other staff in the previous 12 months. This compares to 24% of all NHS staff who said they had been bullied or harassed
— 13% of doctors and dentists said they had been bullied or harassed by their manager while 16% said they had been bullied or harassed by another colleague. This is the same or similar to the findings for all staff
— 23% of consultants, 20% of trainees and 24% of other doctors and dentists (including SAS grade doctors) said they had experienced workplace bullying or harassment in the previous 12 months
— The proportion of doctors and dentists saying they had experienced bullying or harassment doubled between 2011 and 2012 and it has remained at high levels since[11]

Figure 1: Rise in the proportion of doctors and dentists experiencing workplace bullying and harassment in NHS England, 2010-2016
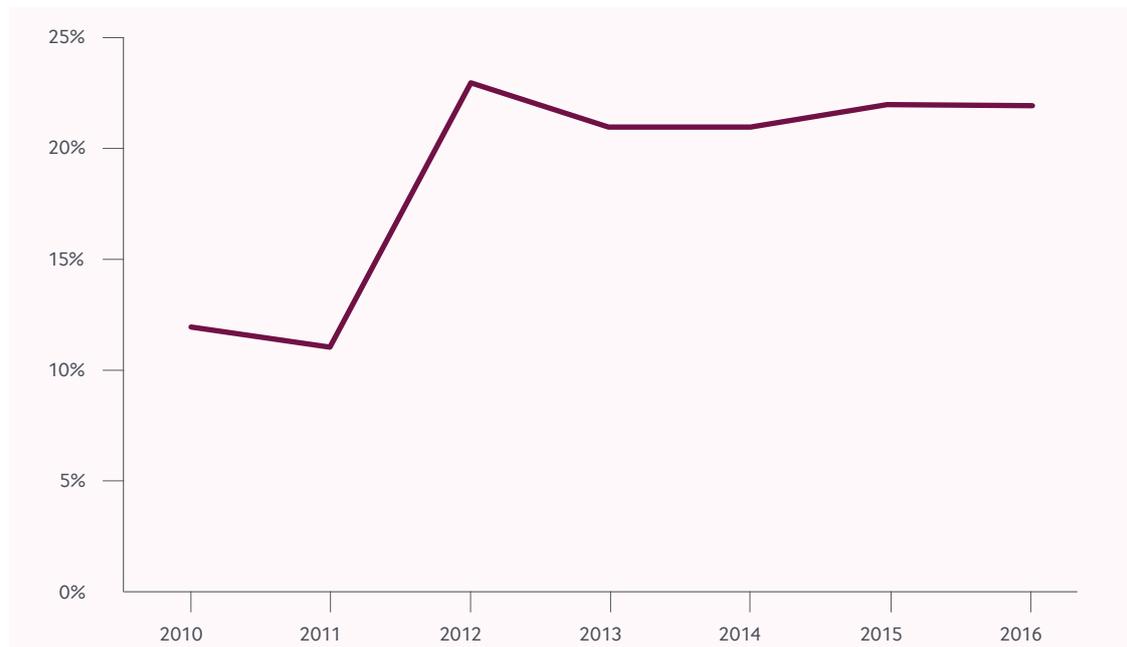
Source: NHS England staff survey, Key Finding 26, unweighted data, for doctors and dentists employed by NHS Trusts, 2010-2016

According to the NHS England Staff Survey, only a minority of doctors and dentists who experience bullying or harassment report it to their employers, which suggests that it will often go unchallenged. In 2016:
— Only 33% of doctors and dentists who suffered bullying or harassment said that they or a colleague had reported it. This is significantly below the proportion for all NHS staff which is 47%
— Among doctors and dentists, trainees were the least likely to report incidents. Only 27% of trainees who had experienced bullying or harassment said they or a colleague had reported it, compared to 33% of consultants and 36% of others (mainly SAS grade)[12]

The lower level of reporting among trainee doctors is likely to be a reflection of their more junior status and temporary placements. As one trainee explained in a GMC report on bullying and undermining in 2014: 'As doctors in training we are near the bottom of a very hierarchical structure and are in a vulnerable situation. If you get on the wrong side of the wrong consultant it might have a big impact on your future career. I've experienced this myself and it definitely makes me think twice about reporting instances of bullying.'[13]

The NHS England staff survey also confirms that certain groups of staff are more vulnerable to bullying or harassment because of their protected characteristics:
— Disabled staff are the most likely to experience workplace bullying or harassment — 32% compared to 20% of non-disabled staff
— Lesbian, gay or bisexual staff experience relatively high rates of bullying and harassment (27-30%) compared to heterosexual staff (22%)
— Responses vary by ethnic background but overall those from a black or minority ethnic background are more likely to be affected than white British staff (24% of all BME staff compared to 22% of white British staff)
— A higher proportion of women than men say they have been bullied or harassed in the past year (23% compared to 21%)[14]

The NHS in Scotland and Wales and the HSCNI in Northern Ireland carry out similar staff surveys (with similar response rates of 38% in Scotland and Wales and a lower response rate of 26% in Northern Ireland). These surveys and the NHS England one are not directly comparable because the latest versions for each nation cover different time periods and some different staff groups and organisational structures. Nevertheless, the results suggest that workplace bullying and harassment is less prevalent in NHS Scotland and NHS Wales than in NHS England and HSCNI.

Figure 2: Staff surveys suggest more workplace bullying and harassment in NHS England and HSCNI than in NHS Scotland and NHS Wales
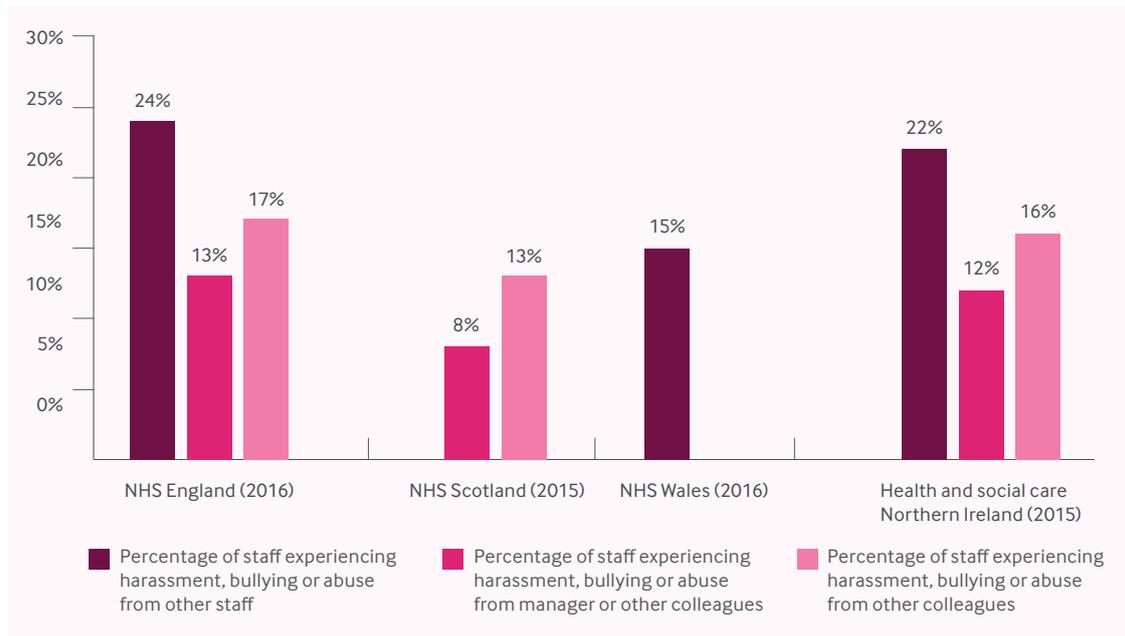
Source: Latest NHS England, NHS Scotland, NHS Wales and HSCNI staff survey responses on workplace harassment, bullying or abuse.

Note: All the staff surveys ask respondents two questions: whether they have experienced bullying or harassment from their manager and whether they have experienced bullying or harassment from other colleagues in the previous 12 months. The NHS England and HSCNI surveys publish results for the two questions separately and a key finding which aggregates the responses. However, in the NHS Scotland survey report there is no aggregate key finding and in the NHS Wales report only the key finding result is presented.

The NHS Wales survey report for 2016 does not include data broken down by occupational group so it is not possible to get information on doctors.[15]

The NHS Scotland survey (2015), which includes general practitioners, shows that salaried GPs are the least likely of all the staff groups to experience workplace bullying and harassment. Only 2% of salaried GPs said they had been bullied or harassed by their manager and 4% said they had experienced bullying or harassment from other colleagues in the previous 12 months. Trainees in NHS Scotland are also among the least likely to experience bullying or harassment according to the survey – only 2% said they had been bullied or harassed by their manager and 10% said they had been bullied or harassed by other colleagues in the past year. For doctors and dentists as a whole in NHS Scotland, 6% said they had been bullied or harassed by their manager and 16% by other colleagues.[16]

In the HSCNI survey, 20% of doctors and dentists said they had experienced bullying or harassment from other staff – 11% from their manager and 14% from other colleagues.[17]

The NHS Scotland survey (2015) also found that only 34% of doctors and dentists who experienced bullying or harassment from other staff reported it to their employers (similar to the latest NHS England Staff Survey findings) and of those who did report it only 29% were satisfied with the response they received. The NHS Wales and HSCNI surveys did not publish data in this area.

GMC NTS (National Training Survey)

The GMC NTS (National Training Survey) is a yearly survey of all trainee doctors and supervisors which asks about various issues including workload, clinical supervision and whether there is a supportive environment at work. The survey allows respondents to give feedback on their perceptions of local training posts and programmes.[18] It has a very high response rate with almost all doctors in training — about 50,000 doctors — completing it.

In 2014, the GMC produced a separate report on bullying and undermining based on the NTS survey responses. It found that 8% had experienced bullying or undermining and 14% had witnessed it in their workplace. (These results should not be directly compared to the NHS staff surveys as the NTS asks about experiences of bullying and harassment over a shorter timeframe — a single placement rather than the previous 12 months).

The GMC also provides a free text box in the NTS, allowing respondents to give detailed reports of bullying or undermining that they have experienced or witnessed. It makes clear that any issues reported there will be investigated by deaneries and LETBs (local education and training boards). Only 1% of respondents chose to report in this way in 2014. An analysis of the comments from those who did report identified that the most common form of behaviour complained about was belittling or humiliation (77%), followed by threatening or insulting behaviour (32%). The least common form that was reported was bullying related to a protected characteristic (13.5%).[19]

Data from the 2016 NTS shows that, again, only 1% of respondents used the bullying and undermining section to report problems.[20] Respondents were asked why they had not used the free text boxes to report incidents of bullying or undermining. Nearly two-thirds said reporting would not make any difference or they feared adverse consequences from doing so.

Figure 3: large proportions of NTS respondents believe reporting will not make a difference or fear repercussions of reporting
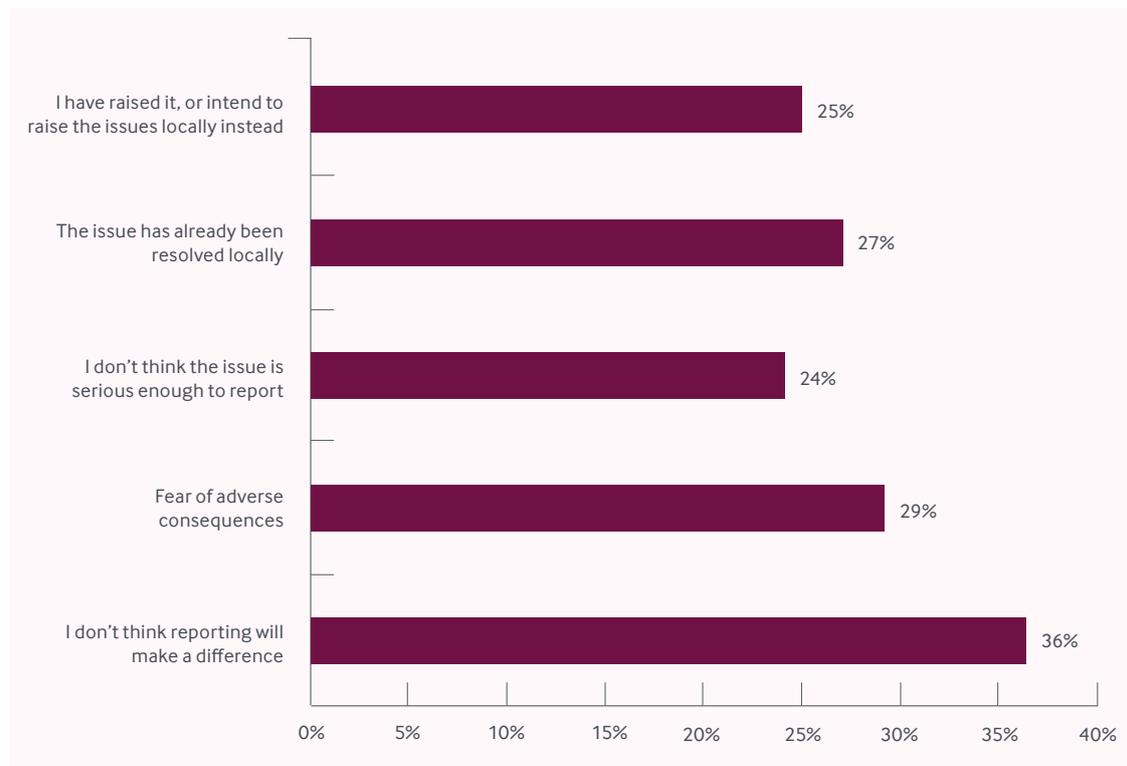
Source: 2016 GMC NTS, reasons given for not reporting bullying or harassment in the National Training Survey

BMA surveys of SAS doctors

In 2015, the BMA carried out a survey of the workplace experiences of SAS doctors in the UK, which had 1,520 responses. It found that 35% had been subjected to bullying, harassment or victimisation in the preceding 12 months. Again it revealed low levels of reporting, with just 39% of those that had experienced bullying or harassment, reporting the most recent incident. The most common reasons given for not reporting were: nothing would be done about it (46%), fear of future discrimination or harassment (41%), and fear of reprisal from the perpetrator (32%). Those that had reported the most recent incident were asked what had happened and only a minority reported a satisfactory outcome – 45% said that to the best of their knowledge no action was taken, and a further 26% said that the incident was investigated but no action or unsatisfactory action was taken.[21] A similar survey was carried out of SAS doctors in Wales by the BMA in 2014, which received 230 responses (a response rate of 61%) and asked about a range of workplace issues. Half (49%) of SAS doctors said they had experience of bullying, harassment or victimisation in their directorate or department.[22] To give added context to these findings, it is worth noting that the SAS grades have the highest proportion of doctors from a BME background – in fact, there are more SAS doctors who are from an Asian or Asian British background than identify as white. There is also a higher proportion of women in the SAS grades than there is in the consultant grade.[23]

BMA and GLADD research on experiences of LGB doctors

The BMA and GLADD (Association of LGBT Doctors and Dentists) conducted a survey of more than 800 LGB doctors in 2016. It found that 12% had experienced one or more type of serious harassment related to their sexual orientation at their place of work or study in the previous two years. This included psychological or emotional abuse, social media or text abuse and physical or sexual violence. In addition, around 70% of respondents said they had experienced behaviour that made them feel uncomfortable or unwelcome at work, such as colleagues making assumptions about their sexual orientation, feeling unable to talk about their private life or intrusive questions about their private life.[24]

RCOG bullying and harassment survey

In 2016, the RCOG (Royal College of Obstetricians and Gynaecologists) conducted a bullying and harassment survey of their consultant members. As the main focus of the survey was bullying and harassment the results are likely to be affected by a self-selection bias. Of the 668 consultants who responded (28% of RCOG consultant members), 44% said they had personally experienced persistent bullying or undermining at work. In addition, between 19% and 45% of respondents, depending on their location, said they believed there was a general problem of bullying and undermining in their unit.[25] Most said bullying came from colleagues who were more senior or close to them in the hierarchy, however, 12% said they experienced so-called 'upward bullying' from juniors.

Comparisons with other sectors and countries

To put the findings on workplace bullying and harassment in the NHS and medical profession, in context, it is useful to look at data for the whole economy. For example, the Fair Treatment at Work Survey, which asked employees from across Great Britain about workplace experiences, found that 7% of employees said they had personally experienced bullying or harassment in the previous two years (based on interviews with 4,000 individuals), when it was last carried out in 2008. It found that employees in the public sector, including the NHS, were more likely to say they had experienced bullying or harassment than those in the private sector.[26]

The UK results from the Sixth European Working Conditions Survey 2015 also found a higher prevalence of 'adverse social behaviour', which includes bullying and harassment, in the public administration, education and health sectors compared to other sectors. 30% of employees working in public administration, education or health said that they had experienced such behaviour, which was ten percentage points higher than for the UK as a whole.[27]

Across the whole of the EU, workers in health sectors were the most likely to experience adverse social behaviour (20%), according to the European Working Conditions Survey. Within this, 8% said they had experienced bullying, 8% humiliating behaviour, 7% physical violence and 2-3% sexual harassment or unwanted sexual attention. These figures were higher than the results for all the other sectors covered by the EU-wide survey.[28]

Recent surveys of doctors in other developed countries confirm similar issues with bullying and harassment in the profession. For example, Askew et al.'s 2012 survey, which asked Australian doctors about a range of workplace experiences, found that a quarter reported being bullied in the previous 12 months.

A 2016 survey in the US (Jagsi et al.) of more than 1,000 medical academics found that 30% of women respondents had experienced sexual harassment in their careers, compared to 4% of men.[29] (The questions about sexual harassment and gender bias featured towards the end of a survey on wider career experiences to avoid self-selection bias.) In 2015, the Australasian Royal College of Surgeons carried out an independent investigation of sexual harassment, discrimination and bullying following high profile comments about it being endemic in the specialty.[30] These findings and developments were reported in the Student BMJ with examples suggesting that it may be a problem in the UK too.[31]

Impact of bullying and harassment

The effects of bullying and harassment are wide-ranging. It impacts on patient care and safety, healthcare delivery, doctors' careers and well-being, and organisational costs.

Patient safety and care

The Francis Inquiry into the failings of the Mid-Staffordshire NHS Foundation Trust published in 2010 identified a link between the bullying behaviours of some managers and senior staff at the Trust and the culture of fear that compromised patient care and safety and prevented staff from raising concerns. Comments made by one patient's relative to the Inquiry also highlighted how bullying behaviour among staff was mirrored in how patients were treated. Describing some of the staff on the ward where her mother died she simply said: 'They were bullies. They bullied… the other staff and they bullied the patients. There was no word for it.'[32]

West and Dawson (2012) have shown that higher levels of employee engagement, as reported in the NHS England Staff Survey, are strongly associated with higher levels of hospital in-patient satisfaction with care. Higher employee engagement is also significantly associated with lower patient mortality rates in acute NHS trusts. They explain that wider research literature suggests that achieving high employee engagement is dependent on creating a positive work environment in which staff feel valued, respected and supported.[33]

The GMC's 2014 report on bullying and undermining of trainee doctors identified that when individuals are on the receiving end of bullying behaviour, it is natural for them to avoid the colleague responsible to avoid future incidents. However, this compromises patient safety. As Leape et al.'s study (2010) explains such a reaction may be expressed 'by a reluctance to call a disrespectful attending physician with questions for clarification of an order, or for clinical concerns that are not clear-cut.'[34] As such 'there is an increased risk of errors being made or of vital patient information not being shared.' Longo & Hain's 2014 report highlights the 'hidden threat' to patient safety of bullying, citing a 2008 study in the US indicating that 67% of respondents felt that there was a linkage between disruptive behaviours and adverse events.[35]

Career satisfaction and development

The GMC report on bullying and undermining in 2014 found that the overall average satisfaction score for trainees who are bullied is 14.8 percentage points less than for those who are not. Whiteside et al.'s study of physiotherapy students on clinical internships highlighted that students 'frequently internalised negative cognitions of their bullying experience. This created self-doubt with students interpreting the bullying behaviour 'as being their 'fault'' and consequently questioning 'their own ability and future in the profession.'[36]

Bradley et al.'s 2015 investigation of rude, dismissive and aggressive communication between doctors showed that 40% of respondents stated that this kind of behaviour moderately or severely affected their working day, leading to professional demotivation as well as personal misery.[37]

Bullying and harassment also has consequences for wider equality of opportunity. For example, Jagsi et al.'s 2016 survey that asked about experiences of sexual harassment and gender bias found that 59% of the women respondents who had experienced sexual harassment felt that they had lost confidence in themselves as professionals and 47% reported that these experiences negatively affected their career advancement.[38]

Organisational costs

Woodrow and Guest's comparative study of three healthcare organisations in the UK identified that bullied individuals report more intention to leave the organisation.[39] Hogh et al. (2011) identified that within the healthcare workforce, the risk of turnover increases with frequency of exposure to bullying behaviours – risk of turnover was three times higher among respondents who were 'frequently bullied' and 1.6 times higher among those who were 'occasionally bullied', in comparison to the non-bullied respondents.[40]

Doran et al.'s 2016 study on why GPs leave practice early, which was based on interviews with 143 GPs who had left general practice before the age of 50, identified a 'bullying culture' as one of the factors. One of the respondents had commented that there was a 'really aggressive, vicious bullying culture that permeates management in the NHS. That then flows all the way down to whoever your locality middle managers are. It's a dreadful, awful, bullying culture and to shift from that to a non-overseeing, facilitative, hands-off, trusting culture is … I don't know if people are capable of that cultural shift.'

In 2008, the BBC reported that a study compiled for the Department of Health, which was obtained through a Freedom of Information request, had estimated that the financial costs of bullying in the NHS amounted to £325 million a year.[41] This figure reflected the costs of replacing staff who left their jobs as a result of bullying and the costs of increased sickness absence from bullying. The costs are likely to be even higher today given the higher proportion of staff saying that they have experienced bullying or harassment in the NHS staff surveys.

Evesson et al (2015) identified further organisational costs from bullying including: lost productivity, lower performance, poor service quality, costs of compensation resulting from litigation, and loss of public goodwill and reputational damage.

Mental health

The impacts on mental health of workplace bullying are also evident within the medical workforce. The BMA's counselling service for doctors received around 3,000 calls from December 2015 to November 2016 from doctors in distress and, of these, about 5% specifically concerned bullying and harassment at work and it was sometimes a dimension in other calls.[42]

Brooks et al.'s 2011 literature review highlights bullying as one of the key structural occupational risk factors, alongside 'problematic relationships', 'conflicts with colleagues' and 'lack of cohesive teamwork', contributing to 'psychological distress' for doctors.[43] Stanton & Randal's 2011 study of 11 doctors accessing mental health services also cited that 'bullying and lack of emotional safety' as one of the key factors influencing their decisions to use psychiatric services.[44]

Ekici et al.'s 2014 report found that there is a strong association between performance, depression and experienced violent behaviours.[45] Imran et al.'s study of junior doctors in Pakistan highlighted the fact that 'victims of bullying may themselves go on to harass others when they themselves become seniors, thus continuing the cycle of abuse.'[46] This issue has also been highlighted in the UK in Timm's 2014 report on undergraduates' experience on their first placement year, which flags the risks posed by 'mistreatment and toxic role-modelling.'[47] This can have the effect of reproducing unwanted and damaging behaviours in future generations of the medical workforce.

Causes of bullying and harassment

Early literature on workplace bullying focused on the psychological factors that were likely to lead to an individual becoming a bully, such as chain reactions of abuse, feelings of powerlessness, anxiety, anger and envy, and psychopathic personalities.[48] This focus on individual factors led to recommendations for employers to adopt formal anti-bullying or harassment policies and procedures to investigate complaints and deal with these individuals. Such policies and procedures are now widespread.

In recent years, and particularly when trying to identify why some sectors or organisations have a higher prevalence of bullying and harassment than others, there has been more of a focus on the role of workplace culture. Evesson et al (2015) comment in their policy discussion paper for ACAS on effective approaches for dealing with workplace bullying: 'traits associated with bullying may not be displayed unless brought to life in workplace environments in which the behaviour is ignored, tacitly encouraged, or seen as positive.' Illing et al (2013) explain how new staff are socialised into these cultures and may be encouraged to believe that such behaviour is acceptable or even the right way to behave.[49] With the shift to focus more on organisational culture in recent years as a cause of bullying, there has been a shift in the recommended approach for dealing with it towards one that calls for earlier and more informal resolution of problems and the need to identify and role model positive behaviours.

Organisational culture

The Francis inquiry identified organisational culture, which it defined as 'the predominating attitudes and behaviour that characterise the functioning of a group or organisation', as a cause of the problems at the Mid-Staffordshire NHS Foundation Trust. It is clear that similar cultures predominate elsewhere in the NHS. A survey of 81 chief executives across UK acute, mental health and community trusts shows that many have experienced bullying. They talked of a 'bullying culture' and a 'climate of fear', wherein they are 'preoccupied with avoiding blame, with over a third saying they feel unable to take risks or speak out.'[50]

Evesson et al (2015)'s policy discussion paper identifies some of the factors that shape organisational culture and give rise to a climate in which bullying behaviours are more common. In terms of leadership or management, they identify 'autocratic styles, where force or pressure is used to achieve targets'. They also highlight factors such as 'poor job design', 'work intensification' and 'job stress' as being common in workplaces where bullying is high. Finally, they explain that 'Pressures arising from restructuring and organisational change have likewise been closely connected with increased rates of reported bullying – in particular where there is rapid and radical management-led change, driven by cost and productivity considerations. Links have been drawn, for instance, between increases in bullying in the public sector and austerity measures and their impacts.'[51]

Workload pressure

Other research supports the view that workload pressure, particularly managerial targets, fuel bullying behaviours in the NHS. Interview responses in Carter et al.'s study highlight that 'often the people doing the bullying are actually stressed' and 'under more pressure', resulting in aggression 'in how they approach and manage people'.[52]

Professional hierarchy

International research has highlighted the hierarchical nature of the medical profession as being another factor that allows bullying behaviours to flourish.[53] Allen (2015) highlights the view that the more hierarchical an organisation is, the more likely it is to show increased incidence of bullying.[54] Healthcare settings are among the most hierarchical – individuals are often intimidated by superiors and are reluctant to question decisions or offer alternative views.[55]

Bystander silence

While all the factors listed previously contribute directly to the development of bullying and harassing behaviours, silence allows such behaviours to continue unchallenged. Data identified previously shows the scale of underreporting and the fear of adverse consequences if bullying or harassment is reported. Doctors who are targets of bullying or harassment may often take a conscious decision to choose silence over risking repercussions through reporting such behaviour.[56]

Oppressive and closed structures in which individuals are not encouraged to speak out contribute to 'silent bystanding'.[57] When coupled with the workload pressures of rotating shifts and consistent daily challenges, doctors may often feel that the last thing they want to do is speak out.[58]

Evidence-based policy recommendations for eliminating bullying and harassment

Evesson et al's (2015) research-based policy paper for ACAS on effective strategies for dealing with workplace bullying and harassment across the economy, highlighted the limitations of the traditional approach favoured by most large employers. They explain that 'anti-bullying policies are widespread in Britain's workplaces' but 'it would appear, as we have seen, that this has not led to an overall reduction in bullying'.

Evesson et al (2015) go on to say 'too heavy a reliance on this kind of approach flies in the face of current research evidence about [its] limited effectiveness'. They identify the barriers to success as:
— an onus on bullied individuals to formally report when surveys and research show an unwillingness to
— an insistence from HR and managers that issues cannot be dealt with until a formal complaint is made which prevents earlier resolution
— a reluctance to impose formal sanctions on a bullying individual who is 'high value' to the organisation
— pressure to find against complainants during internal investigations to avoid tribunal claims
— a desire to get rid of complainants so they do not have to deal with protracted grievance and disciplinary proceedings

They call for more comprehensive organisational strategies that focus on ensuring worker well-being and good workplace relations to prevent problem behaviours like bullying arising. A review of existing evidence and literature, together with practical insights from dealing with problems reported to the ACAS helpline, led them to conclude the key features of good practice are:
— Bullying should be viewed as an organisational problem requiring an organisational response
— An organisation-wide commitment is needed to align behaviours with values centred on respect and wellbeing
— Behavioural standards should be developed in collaboration with employees, and role-modelled by senior managers
— Agreed behavioural standards should be regularly promoted, reviewed and updated
— Practical measures for the early identification of bullying behaviours are critical. Collating information from informal and formal complaints, surveys, and exit interviews can help identify patterns and enable action to deal with contributory factors such as poor management practices or excessive workloads
— People need to be empowered to talk more openly with each other about the line between acceptable and unacceptable behaviour. Employees at all levels should feel able to 'challenge' unwanted behaviours that they receive or witness
— Well-resourced and well-informed support structures should be in place to help both those experiencing bullying and managers responding to bullying (e.g. occupational health, bullying or fair treatment officers, or union representatives)
— Informal resolution should be encouraged where appropriate, including encouraging open conversations in teams and between individuals, and ensuring that line managers are equipped to be proactive and responsive. In some circumstances, mediation can help in finding agreement on acceptable future behaviours
— Formal procedures need to be in place for situations where early resolution does not work. These need to be clear, accessible and inclusive
— Managers at all levels must have strong people management skills. This may require training to give managers the confidence and skills to recognise the causes and signs of ill-treatment and to engage effectively in early, informal and formal resolution
— Managers should be aware of how easily management action can cross over into, or be perceived as, bullying. Performance management must be consistent, clear and fairly applied[59]

There has been relatively little research on effective interventions for eradicating workplace bullying and harassment in healthcare settings. Quinlan et al. conducted a review in 2014 of the effectiveness of recommended interventions, looking at healthcare organisations in Canada, the UK and Australia. Overall, they found a lack of considered evaluation of different strategies and, as such, only 8 initiatives were identified and analysed. Despite the limited review, they concluded that there is a 'compelling case for interventions based on participatory principles and including employees from all levels of the organisation in the co-creation of intervention goals and implementation goals as well as their evaluation strategies.'[60] They found that interventions that are intended to improve workplace culture had more promising outcomes when staff had the chance to discuss and feed into what needed to change.

A report by Walton (2015) on equality, discrimination and harassment in Australian medical workplaces emphasises the importance of medical colleges setting a precedent against bullying behaviours from the outset. Mirroring the importance of good people-management skills in the workplace identified by Evesson et al, Walton states that: '...clinical supervisors need to have knowledge and skills in the areas of teaching methods, different learning styles, ethics, patient safety and sexual stereotyping. Being a senior doctor is not a qualification for teaching in itself, and the assumption that it is exposes medical education to the risk of nothing changing.'[61]

Conclusion

This review of existing survey data, recent research and policy recommendations has confirmed that workplace bullying and harassment within the medical profession and health care sector is a problem. It has also highlighted that only a minority of doctors are likely to formally report incidents of bullying and harassment to their employer, usually because they do not believe anything will happen or they fear adverse consequences for themselves if they do. This suggests work must be done to build trust and to show that complaints will be effectively resolved.

Research has shown that bullying and harassment compromises patient safety and care, it results in higher turnover, sickness absence and other costs for organisations, and it harms doctors' well-being, career satisfaction and professional development. Therefore, the case for tackling it is strong.

There has been growing recognition of the role culture plays in permitting and encouraging bullying behaviours in some workplaces and preventing individuals from speaking out. It is suggested that formal anti-bullying policies and procedures are of limited use in reducing bullying and harassment. Action must also be taken to address the underlying factors that shape a bullying culture such as workload pressure, target-driven management, poor workplace relations, and weak people management skills. It appears that the most promising interventions in reducing bullying and harassment are those that involve staff in identifying what needs to change and allowing them to shape strategies. Enabling staff to discuss what is acceptable and unacceptable behaviour in the workplace and role modelling good behaviour among senior staff and from the outset at medical schools is also important.

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