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CONSULTANTS AS VICTIMS OF BULLYING AND UNDERMINING: A SURVEY OF ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS CONSULTANT EXPERIENCES

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Keywords: Bullying, undermining, consultant, workplace, management

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Abstract

Objective: To explore incidents of bullying and undermining among Obstetric and Gynaecology (O&G) consultants in the United Kingdom, to add another dimension to previous research and assist in providing a more holistic understanding of the problem in medicine.

Design: Questionnaire survey

Setting: Royal College of Obstetricians and Gynaecologists (RCOG)

Subjects: Obstetric and Gynaecology consultant members/fellows of the RCOG working in the UK

Main outcome measures: Measures included a typology of four bullying and undermining consequences from major to coping.

Results: There was a 28% (664) response rate of whom 44% (229) responded that they had been persistently bullied or undermined. Victims responded that bullying and undermining is carried out by those senior or at least close in the hierarchy. Of the 278 consultants who answered the question on 'frequency of occurrence', 50% stated that bullying and undermining occurs on half, or more, of all encounters with perpetrators and two thirds reported that it had lasted more than three years.

The reported impact on professional and personal life spans a wide spectrum from suicidal ideation, depression and sleep disturbance and a loss of confidence. Over half reported problems that could compromise patient care. When victims were asked if the problem was being addressed, 73% of stated that it was not.

Conclusion: Significant numbers of Obstetrics and Gynaecology consultants in the UK are victims of bullying and undermining that put patient care at risk. New interventions to tackle the problem are required, and greater commitments to support such interventions are essential.

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Strengths of the Study

The study is the first College level investigation into bullying and undermining at level of senior physicians. It reveals a hitherto unknown incidence of consultants as victims rather than perpetrators, and the scale of the suffering that that seniors cause each other.

Weaknesses

The large number of variables implicated: male/ female, UK/ overseas trained, location, perpetrator etc. made detailed statistical analysis problematic. Hence there are no speculations on what might be the general case.

It is probable that victims are over represented in the sample. Hence the study does not infer relationships applying to the wider population

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Introduction

Research on bullying and undermining in medicine concludes that the problem is widespread and pernicious in nature and under-reported in NHS units and embedded as an experience from the earliest days of a trainee's career [1-6]. The impact on a victim's personal and professional life may range from a loss of confidence/depression, which subsequently impacts on a doctor's competence and the level of patient care provided, to destruction of health and family life, serious psychological damage, and suicidal ideation. It can distract clinicians' attention from vital information which could in-turn lead to serious or fatal errors, not only confined to operating theatres [6,8,13] Consequences for organisations include absences from work, low job satisfaction, high staff turnover, unnecessary additional financial costs [8-15]

Individuals who raise concerns about problems in their organisation are often treated negatively and subjected to processes described as 'harrowing and isolating' [1,7]. Instances where individuals who raised concerns were treated positively, were found to be within organisations that promote "…a culture of openness, [had] a good knowledge of whistleblowing policies and procedures, [provided support for whistle blowers] during the process, and [maintained] good working relationships with colleagues"[7]. Management and leadership styles are known to influence bullying and undermining in the workplace and play a central role in increasing or decreasing such behaviour [13]. Yet the continued omnipresence of bullying and undermining in the health sector suggests that these best practices are not universal.

A number of interventions to control or stop bullying and undermining behaviour have been described in the literature, [15-18] although as Illing points out trenchantly, few such interventions have been evaluated adequately in healthcare [11]. Some interventions focus on the resilience of the victim, offering "cognitive rehearsal of responses to common bullying behaviour"[16]. Assertiveness and aggression training programmes have been used to assist individuals to deal with difficult situations in the workplace [17]. Others include social and behavioural skills group training, inclusion of interpersonal skills in the training curriculum, and mentoring [18]. Institutional interventions enhance reporting mechanisms to facilitate reporting of bullying [19] and greater support for whistle blowers [15]. Such interventions are often supported by "Informational or media campaigns to change policy [and] incentives to change/adhere to policies"[15, 19]. Two things are evident however. Firstly the majority of these interventions focus on the victim, or the organisation, rather than the perpetrator. Secondly, it is assumed, or inferred from the literature, that the victim needs such support because they have less standing in the organisation than the perpetrator. Thus, while studies of bullying and undermining of nurses by nurse managers and clinicians, and of trainee doctors bullied by consultants and managers are common, consultants themselves are seldom considered as victims. This paper seeks to fill this important gap in our understanding of bullying and undermining in the health sector.

The Consultant as Victim

Consultant medical staff are often identified in studies as the main source of bullying and undermining, particularly towards trainees, but no published comprehensive study has examined UK consultants as victims. Consequently the full extent of the problem and the impact on the personal

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and professional life of consultants is not known. This research aimed to reveal the extent, nature and consequences of bullying and undermining of O&G consultants to enable a more holistic understanding.

Methodology

The research framework was created from a review of the literature, particularly The NHS Scotland Staff Survey [21] and Unison[22], the RCOG Trainee Evaluation Form feedback (personal communication), and the a cross sectional survey of the undergraduates, trainees and consultants in Obstetrics and Gynaecology in the West Midlands [23.] Structured interviews, based on these finding, were carried out with RCOG consultants to refine questions.

The sampling frame was the roll of 2404 consultants within the UK generated by the RCOG Membership department. Consultants were contacted via email and provided with a short summary of the research project and Rayner & Hoel's taxonomy of bullying and undermining behaviours to ensure commonality[24]. The RCOG reviewed the survey and deemed that further ethical approval was not required. In addition to some personal details (although the survey was anonymous), respondents were asked about their experiences as a victim (if any), the nature and duration of bullying and undermining behaviours and the standing of the perpetrator. The effects on personal and professional life were explored, together with the experiences of using formal reporting and disciplinary processes.

Results

There was a 28% (664) response rate. Of those that responded, 47% (314) were male and 53% (350) were female, over half were age 45-54 years (52%), followed by 55-64 (22%), 35-44 (22%) and 65-74 (3%). All deaneries / Local Education and Training Boards (LETBs) were represented by at least 20 respondents. Those completing their postgraduate training in the UK accounted for 98% of respondents and 78% were working full time. Some fifth (22%) of respondents were in Trust management roles[1].

Since the questionnaire concerned bullying and undermining behaviour it is likely that victims are over represented as a proportion of the sample. That said, some 290 consultants (44%) responded that they had been persistently bullied or undermined. These 290 constitute more than 10% of the total RCOG consultant body working in the UK[2]. Between 19% and 45% of all respondents believed there to be a general bullying and undermining problem in their unit, depending upon their location as defined by deanery / LETB. Non-UK males and females figured prominently in the sample of those reporting bullying and undermining behaviours, even though they were a relatively small proportion of the overall response. UK qualified females were more likely to report such behaviours than male UK qualified consultants.

[1] Small numbers of respondents did not give details of location or age – these have been omitted from the summary here

[2] This figure is not dissimilar from that reported by Illing for levels of bullying elsewhere if one assumes that all victims have completed the survey

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Types of bullying and undermining behaviours

The types of behaviours most reported were persistent attempts to belittle and undermine an individual's work; undermining an individual's integrity; persistent and unjustified criticism and monitoring of work; freezing out, ignoring or excluding and continual undervaluing of an individual's effort. The sharing of emails with others seemed to be a subtle and effective strategy used by perpetrators to bully and undermine. Physical and sexual abuse was reported by only a very small number of consultants.

Who are the Perpetrators?

Some 2/3 of respondents indicated that the bullying and undermining was perpetrated by one or more individuals rather than a specified group. The 1/3 that identified groups as the source of the behaviours reported managers, senior consultants and medical directors as culprits. Unprompted responses included lead clinicians, clinical directors, clinical secretaries, career grade doctors, patients, administration managers, GPs and board level executives. Most bullying and undermining is carried out by those senior or at least close in the hierarchy. Bully from juniors accounts for some 12% of those claiming to be victims of bullying and undermining, (generally consistent with concerns reported by participants around feedback and training of challenging trainees)

Both males and females were reported as perpetrators, with 37% reporting predominantly males, 28% reporting predominately females, with the remainder citing both equally.

Duration and Frequency

Alarmingly, two thirds of victims report that the behaviour had been occurring for longer than 3 years (see Fig 1).

Figure 1: Duration of Bullying and Undermining Experience

Not only are these behaviours longstanding, but they are also frequent. Of the 278 consultants who answered the question, 50% stated that bullying and undermining occurs on half, or more, of all encounters with perpetrators, with 13% reporting that **all** encounters lead to such behaviours.

Impact on professional and personal life

Participants used free text boxes to comment on their experiences of bullying and undermining, and were asked how such behaviour impacted on their professional and personal life. The 236 comments considered were put into four categories, namely *major, moderate, minor and coping* (see Fig 2). The comments were categorised using key words mentioned in the survey responses. These are as follow:

1. Major – Suicide, illness, sick leave, early retirement, moving or moved posts, depression requiring medication or therapy.

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2. Moderate – Struggle to work, fear, resigned from positions in the Trust, considering moving, stress requiring help, significant sleep disturbance, relationship and home life problems, reduced confidence.
3. Minor – Demoralised, sleep loss, isolation, stress but not affecting patient care, feel resigned, putting up, come to work to pay bills
4. Coping – Stand up to it, avoid certain individuals, getting on, head down, no effect.

Fig 2. Effects of Bullying and Undermining on Consultants.

As Figure 2 shows, 2/3rd of consultants identifying themselves as victims of bullying and undermining suffer major or moderate effects. The significance for patient safety is clear. At least 8% of consultants registered with the RCOG have indicated that bullying and undermining behaviour causes them such problems as significant sleep loss, reduced confidence, depression and illness for example.

Management of bullying and undermining/outcome of reported cases

When asked if the problem was being addressed, 73% of those who answered this question stated that it was not. Only 140 had reported the behaviour to the relevant individuals in their Trusts. Of these, 110 indicated the consequence; as shown in Figure 3 below. Out of the 57% who reported that the issues had not been addressed, 48% reported that the behaviour continued, while 9% reported that the behaviour had stopped (for example after the perpetrator(s) had moved on to another role). In one typical example, the victim was told "this is how the [perpetrator] speaks" and no further action was taken. Rather than address the way the perpetrator "speaks" through some intervention, the onus was placed on the victim to accept behaviour that should be considered unacceptable. Only 4% of cases were resolved.

Figure 3: Impact on Personal and Professional Life

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Exhibit 1: Quotes from Consultants using Formal Processes of Redress

1. I reported only the tip of the iceberg. Unfortunately in those few situations the matter remained unabated.
2. Initially on two occasions the behaviour was stopped but eventually persisted and resulted in me having to leave the post.
3. The issue was not addressed and the issue with management and the senior consultant was brushed under the carpet.
4. The chief investigator was the friend of the medical director and the investigation was a white-wash.
5. The supposed investigation was an absolute disgrace, with the perpetrator eventually getting senior management roles.
6. Attempts made to facilitate change. This was just a tick box exercise. Behaviour continues and situation stays unresolved.
7. It was half-heartedly addressed and is either resolved or is further under the radar at present.
8. Investigation process is not very fair and is very stressful.
9. Action will not be taken against certain individuals because of who they are

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Conclusion

A substantial proportion of the consultant members of RCOG working in the UK indicate that they have experienced bullying and undermining behaviour. In many cases the behaviour has persisted for years. In addition to their own distress, patient safety is compromised by the effects identified in the taxonomy. Those that report such behaviours are rarely satisfied that the issues have been addressed.

The situation is clearly unacceptable from every point of view. Such recent initiatives as the RCOG/RCM joint statement regarding zero tolerance[3] and new RCOG initiatives such as the bullying and undermining toolkit, eLearning module, and the establishment of National Workplace Behaviours Advisory Network & Workplace Behaviours Champions are to be welcomed.

Yet this research shows emphatically that the immediate situation is disturbing and unacceptable. Without wishing to diminishing steps already taken, much more needs to be done by institutions on designing interventions that tackle bullying and undermining behaviours directly rather that those that seek to minimise consequences. Such interventions need to be both local, through health care providers, and national through Colleges. Such interventions must include an overhaul of the current inadequate reporting and investigation processes. What is more, all such interventions require effective evaluation and thought should be given to effective monitoring of the feedback through both established mechanisms such as the NHS staff survey but also more widely, potentially through the collaboration of Colleges. The RCOG has developed an action plan for ongoing work to help tackle bullying and undermining behaviour at all levels. Finally we would call for regulators such as the Care Quality Commission, via its leadership domain, to consider this agenda more explicitly given the impact on both staff and patients.

KEY FINDINGS:

Who is bullied?

- The majority of the sample of consultants are not, and have not, been bullied or undermined
- Of the sample that did report bullying, those qualified outside the UK, both male and female, are more likely to report bulling and undermining behaviour than those trained in the UK - consistent with the 2013 GMC Training Survey
- Bullying and undermining is reported across all Deaneries
- Consultants in Trust Management roles report similar behaviours to those in clinical roles

Impact on personal and professional life

[3] https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with undermining/development/

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- Some two thirds of the sample report that such behaviours have lasted more than three years
- Impact spans from suicidal thoughts, depression and sleep disturbance, to resignation/retirement, a lack of confidence and simply coming to work to pay the bills
- More than two thirds of the sample report major or moderate impact on working and personal life.

Who are the reported perpetrators of bullying and/or undermining?

- Reported perpetrators occupied various positions, however Managers, Senior Consultants and Medical Directors are reported to be the main perpetrators.
- The sample suggests that the perpetrator is often one person (38.7%)
- Upward bullying had been experienced by 12% of those claiming to have been bullied
- For most of the sample, bullying occurs in more than half of all encounters with the perpetrator

Types of reported bullying and undermining behaviour

- The types of reported behaviours most prevalent were more associated with isolation and demoralisation of individuals rather than frank harassment.
- The main reported types of behaviour were persistent attempts to undermined and belittle work; persistent and unjustified criticism and monitoring of work; constant undervaluing of an individual's efforts; undermining of personal integrity; freezing out, ignoring or excluding.
- Sharing of emails via global email addresses was reported to be a subtle and insidious method used to bully and undermine.

Outcome of cases reported to relevant individuals within hospital Trusts (outcome based on alleged victim's perception)

- In 57% of reported cases the issue/s raised was not addressed
- In 32% of reported cases the issue/s raised was addressed but not resolved and the behaviour continued
- In 4% of reported cases the issue was resolved and the behaviour stopped.

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	• Substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data.	Drafting the work or revising it critically for important intellectual content	• Final approval of the version published.	• Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.
TS	Original design of methodology and method, application of research method. Extensive literature review. Collation, presentation and analysis of data	Production of complete first draft Substantial redrafting	Agreed by all authors	Extensively reviewed and agreed by all authors
WPS	Design of research method, analysis of data	Critical review all drafts Drafting of significant amendments		
SO	Design of research method, analysis of data			
SJM	Project lead Design of methodology, interpretation of data			
SJH	Second analysis	Extensive editing		

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	and re Interpretation of data,	and review of first and subsequent drafts		

Transparency declaration: The guarantors affirm that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

Competing interest: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare:

TS was employed by the RCOG and received some financial support for the submitted work.

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No authors have any financial relationships with any organisations that might have an interest in the submitted work

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Data sharing: Additional data from the survey of RCOG consultants are available from Joanna Mountfield at Joanna.mountfield@uhs.nhs.uk

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Figure 1: Duration of Bullying and Undermining Behaviour

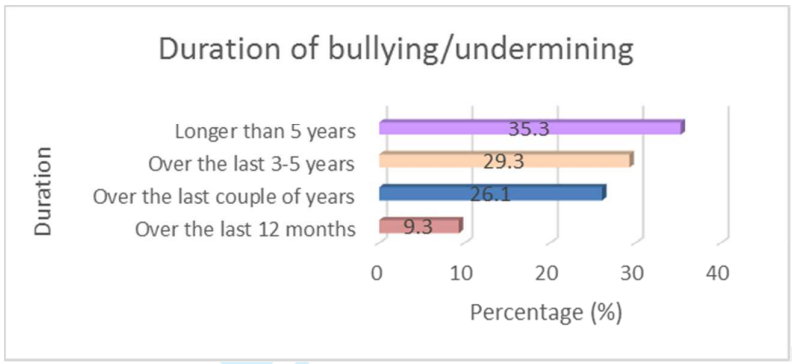

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Figure 2 Impact on Personal and Professional Life

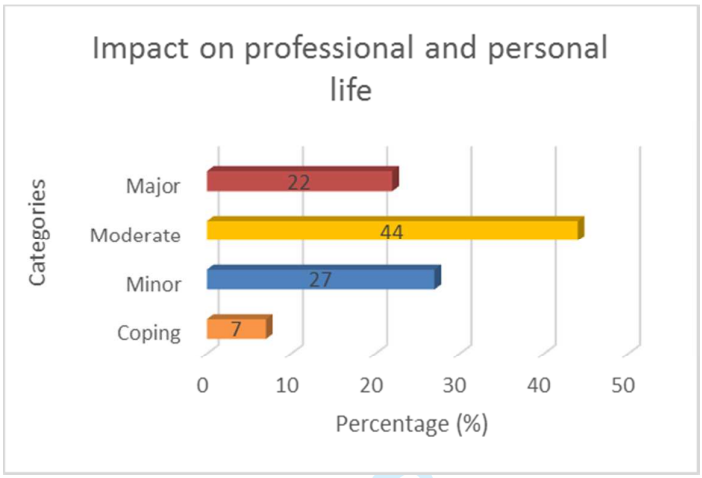

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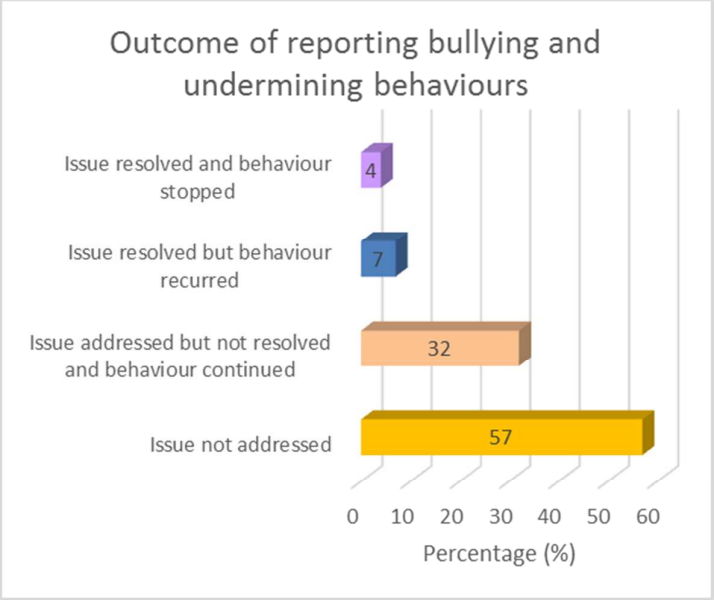
Figure 3: Outcome When Reporting Bullying and Undermining Behaviour



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CONSULTANTS AS VICTIMS OF BULLYING AND UNDERMINING: A SURVEY OF ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS CONSULTANT EXPERIENCES

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Abstract

Objective: To explore incidents of bullying and undermining among Obstetric and Gynaecology (O&G) consultants in the United Kingdom, to add another dimension to previous research and assist in providing a more holistic understanding of the problem in medicine.

Design: Questionnaire survey

Setting: Royal College of Obstetricians and Gynaecologists (RCOG).

Subjects: Obstetrics and Gynaecology consultant members/fellows of the RCOG working in the UK.

Main outcome measures: Measures included a typology of four bullying and undermining consequences from major to coping.

Results: There was a 28% (664) response rate of whom 44% (229) responded that they had been persistently bullied or undermined. Victims responded that bullying and undermining is carried out by those senior or at least close in the hierarchy. Of the 278 consultants who answered the question on 'frequency of occurrence', 50% stated that bullying and undermining occurs on half, or more, of all encounters with perpetrators and two thirds reported that it had lasted more than three years.

The reported impact on professional and personal life spans a wide spectrum from suicidal ideation, depression and sleep disturbance and a loss of confidence. Over half reported problems that could compromise patient care. When victims were asked if the problem was being addressed, 73% of those that responded stated that it was not.

Conclusion: Significant numbers of consultants in Obstetric s and Gynaecology in the UK are victims of bullying and undermining behaviour that puts their own health and patient care at risk. New interventions to tackle the problem, rather than its consequences, are required urgently, together with greater commitment to supporting such interventions.

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Strengths of the Study

The study is the first College level investigation into bullying and undermining at level of senior physicians. It reveals a hitherto unknown incidence of consultants as victims rather than perpetrators, and the scale of the suffering that seniors cause each other.

Weaknesses

The large number of variables implicated: male/ female, UK/ overseas trained, location, perpetrator etc. made detailed statistical analysis problematic. Hence there are no speculations on what might be the general case.

It is probable that victims are over represented in the sample. Hence the study does not infer relationships applying to the wider population

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Introduction

Research on bullying and undermining in medicine concludes that the problem is widespread and pernicious in nature and under-reported in NHS units and embedded as an experience from the earliest days of a trainee's career [1-6]. The impact on a victim's personal and professional life may range from a loss of confidence/depression, which subsequently impacts on a doctor's competence and the level of patient care provided, to destruction of health and family life, serious psychological damage, and suicidal ideation. It can distract clinicians' attention from vital information which could in-turn lead to serious or fatal errors, not only confined to operating theatres [6-13] Consequences for organisations include absences from work, low job satisfaction, high staff turnover, unnecessary additional financial costs [8-15]

Individuals who raise concerns about problems in their organisation are often treated negatively and subjected to processes described as 'harrowing and isolating' [1,7]. Instances where individuals who raised concerns were treated positively, were found to be within organisations that promote "…a culture of openness, [had] a good knowledge of whistleblowing policies and procedures, [provided support for whistle blowers] during the process, and [maintained] good working relationships with colleagues"[7]. Management and leadership styles are known to influence bullying and undermining in the workplace and play a central role in increasing or decreasing such behaviour [13]. Yet the continued omnipresence of bullying and undermining in the health sector suggests that these best practices are not universal.

A number of interventions to control or stop bullying and undermining behaviour have been described in the literature, [14-18] although as Illing points out trenchantly, few such interventions have been evaluated adequately in healthcare [13]. Some interventions focus on the resilience of the victim, offering "cognitive rehearsal of responses to common bullying behaviour"[15]. Assertiveness and aggression training programmes have been used to assist individuals to deal with difficult situations in the workplace [16]. Others include social and behavioural skills group training, inclusion of interpersonal skills in the training curriculum, and mentoring [17]. Institutional interventions enhance reporting mechanisms to facilitate reporting of bullying [18] and greater support for whistle blowers [15]. Such interventions are often supported by "Informational or media campaigns to change policy [and] incentives to change/adhere to policies"[14, 18]. Two things are evident however. Firstly the majority of these interventions focus on the victim, or the organisation, rather than the perpetrator. Secondly, it is assumed, or inferred from the literature, that the victim needs such support because they have less standing in the organisation than the perpetrator. Thus, while studies of bullying and undermining of nurses by nurse managers and clinicians, and of trainee doctors bullied by consultants and managers are common, consultants themselves are seldom considered as victims. This paper seeks to fill this important gap in our understanding of bullying and undermining in the health sector.

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The Consultant as Victim

A UK medical consultant is a senior medical practitioner who has completed their training and is registered on the General Medical council specialty register (usually requiring more than eight years postgraduate experience in their specialty). They would have been appointed to their NHS consultant post in open competition. Consultant medical staff are often identified in studies as the main source of bullying and undermining, particularly towards trainees, but no published comprehensive study has examined UK consultants as victims. Consequently the full extent of the problem and the impact on the personal and professional life of consultants is not known. This research aimed to reveal the extent, nature and consequences of bullying and undermining of O&G consultants to enable a more holistic understanding.

Methodology

The research framework was created from a review of the literature, particularly The NHS Staff Survey [19-20]and Unison[21], the RCOG Trainee Evaluation Form feedback (personal communication), and a cross sectional survey of the undergraduates, trainees and consultants in Obstetrics and Gynaecology in the West Midlands [22.] Structured interviews, based on these finding, were carried out with RCOG consultants to develop and refine questions (see appendix).

Consequently, most of the questions were closed answer questions - such as those asking those reporting that they had been bullied or undermined to indicate the status of perpetrator, types of offensive behaviour and age range. Other questions requested straight-forward data such as region or job title. The exception concerned the part of the survey examining the effects of bullying and undermining behaviours that included free text boxes. Participants used free text boxes to comment on their experiences of bullying and undermining, and were asked how such behaviour impacted on their professional and personal life. The 236 comments considered were put into four categories, namely *major, moderate, minor and coping*. The comments were categorised by using key words mentioned in the survey responses. These are as follow:

1. Major – Suicide, illness, sick leave, early retirement, moving or moved posts, depression requiring medication or therapy.
2. Moderate – Struggle to work, fear, resigned from positions in the Trust, considering moving, stress requiring help, significant sleep disturbance requiring medical attention, relationship and home life problems, reduced confidence.
3. Minor – Demoralised, sleep loss that has not been treated, isolation, stress but not affecting patient care, feel resigned, putting up, come to work to pay bills
4 Coping – Stand up to it, avoid certain individuals, getting on, head down, no effect

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Individual consultants reporting bullying and undermining behaviours were classified according to their most significant impact.

Those that had tried to seek resolution through formal processes were also given the opportunity to write of their experiences in free text boxes. A selection of the quotes has been chosen to illustrate the general dissatisfaction with process and outcome implied by the survey data.

The RCOG reviewed the survey before it went live and deemed that further ethical approval was not required. In addition to some personal details (although the survey was anonymous), respondents were asked about their experiences as a victim (if any), the nature and duration of bullying and undermining behaviours and the standing of the perpetrator. The effects on personal and professional life were explored, together with the experiences of using formal reporting and disciplinary processes.

The sampling frame was the roll of 2404 consultants within the UK generated by the RCOG Membership department. Consultants were contacted via email and provided with a short summary of the research project and Rayner & Hoel's taxonomy of bullying and undermining behaviours to ensure commonality[23]. The email also contained assurances of anonymity and a web link to the survey that remained live for three weeks.

Results

There was a 28% (664) response rate. Of those that responded, 47% (314) were male and 53% (350) female, over half were age 45-54 years (52%), followed by 55-64 (22%), 35-44 (22%) and 65-74 (3%). All deaneries / Local Education and Training Boards (LETBs) were represented by at least 20 respondents. Those completing their postgraduate training in the UK accounted for 98% of respondents and 78% were working full time. Some fifth (22%) of respondents were in Trust management roles (small numbers of respondents did not give details of location or age – these have been omitted from the summary here).

Since the questionnaire concerned bullying and undermining behaviour it is likely that victims are over represented as a proportion of the sample since they may be more motivated to complete the online questionnaire. That said, some 290 consultants (44% of sample) responded that they had been persistently bullied or undermined. Between 19% and 45% of all respondents believed there to be a general bullying and undermining problem in their unit, depending upon their location as defined by deanery / LETB. Non-UK males and females figured prominently in the sample of those reporting bullying and undermining behaviours, even though they were a relatively small proportion of the overall response. More UK qualified females report such behaviours than male UK qualified consultants.

These 290 that reported themselves victims of bullying and undermining behaviour constitute more than 14% of the total RCOG consultant body working in the UK. This figure is not dissimilar from that reported by Illing for levels of bullying elsewhere if one assumes that all victims have completed the survey. That is to say that even if response bias is accepted and the sample over represents the proportion of victims in the wider population, the data presented below nonetheless captures the experience of a segment of the RCOG membership usually thought of as perpetrators rather than

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victims. The data does not claim to be representative of a wider population of victims since the sample is self selecting. Indeed the diversity of experience reported here undermines the notion of a central tendency of victimhood.

Types of bullying and undermining behaviours

The types of behaviours most reported were persistent attempts to belittle and undermine an individual's work; undermining an individual's integrity; persistent and unjustified criticism and monitoring of work; freezing out, ignoring or excluding and continual undervaluing of an individual's effort. The sharing of emails (copied in or blind copied in), containing criticism or alluding to poor performance that should have been dealt with person to person seemed to be a subtle and effective strategy used by perpetrators to bully and undermine. Physical and sexual abuse was reported by only a very small number of consultants (0.4% and 1.8% respectively).

Who are the Perpetrators?

The survey sought to uncover whether perpetrators were individuals acting maliciously but alone, or whether they were bullying as a coordinated group. Some 2/3 of respondents indicated that the bullying and undermining was perpetrated by one or more individuals acting independently (112 reporting a sole bully, 92 citing more than one individual). When asked for the role of perpetrators, unprompted responses included lead clinicians, clinical directors, clinical secretaries, career grade doctors, patients, administration managers, GPs and board level executives. The remaining 1/3 (86 respondents) who reported individuals acting maliciously together identified managers, senior consultants and medical directors as culprits. Victims report that most bullying and undermining is carried out by those senior or at least close in the hierarchy. Such colleagues as nurses, midwives, consultants from other specialties and managers are more likely to be involved where there are multiple sources of bullying than the sole perpetrator. Bullying from juniors, often called upward bullying, accounts for some 12% of those claiming to be victims of bullying and undermining, (generally consistent with concerns reported by participants around feedback and training of challenging trainees)

Both males and females were reported as perpetrators, with 37% reporting predominantly males, 28% reporting predominately females, with the remainder citing both equally. It is clear that although this paper focuses on the consultant as victim, the key perpetrators are other consultants and many junior consultants have already learned these behaviours (see table 1).

Table 1: Individual Perpetrators of Bullying and Undermining Behaviour

Perpetrator	Frequency
Senior Consultant	57
Junior Consultant	25

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Manager	2
Medical Director	5
Others	20
Undeclared	3
Total	112

Duration and Frequency

Alarmingly, two thirds of victims report that the behaviour had been occurring for longer than 3 years (see Table 2).

Table 2: Duration of Bullying and Undermining Experience

Duration	Percentage (%)
Over the last 12 months	9.3
Over the last couple of years	26.1
Over the last 3-5 years	29.3
Longer than 5 years	35.3

Not only are these behaviours longstanding, but they are also frequent. Of the 278 consultants who answered the question, 50% stated that bullying and undermining occurs on half, or more, of all encounters with perpetrators, with 13% reporting that **all** encounters lead to such behaviours. The impact on consultants' professional and personal lives are illustrated (see table 3).

Table 3: Effects of Bullying and Undermining on Consultants

Impact on professional and personal life	
Category	Percentage (%)

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Major	22
Moderate	44
Minor	27
Coping	7

As Table 3 shows, 2/3rd of consultants identifying themselves as victims of bullying and undermining suffer major or moderate effects as defined in the methodology section above. The significance for patient safety is clear. At least 8% of consultants registered with the RCOG have indicated that bullying and undermining behaviour causes them such problems as significant sleep loss, reduced confidence, depression and illness for example. This alone should raise anxieties for patient safety and add to similar conclusions drawn by Francis [3] and Illing[18] among others.

Management of bullying and undermining/outcome of reported cases

When asked if the problem was being addressed, 73% of those who answered this question stated that it was not. Only 140 had reported the behaviour to the relevant individuals in their Trusts. Of these, 110 indicated the consequence; as shown in Table 4 below. Out of the 57% who reported that the issues had not been addressed, 48% reported that the behaviour continued, while 9% reported that the behaviour had stopped (for example after the perpetrator(s) had moved on to another role). In one typical example, the victim was told "this is how the [perpetrator] speaks" and no further action was taken. Rather than address the way the perpetrator "speaks" through some intervention, the onus was placed on the victim to accept behaviour that should be considered unacceptable. Only 4% of cases were resolved. A selection of direct quotes from those believing that they had been let down by the formal reporting and disciplinary procedures are illustrated (see table 5).

Table 4: Outcome of reporting bullying and undermining behaviour

Outcome	Percentage (%)
Issue resolved and behaviour stopped	4%
Issues resolved but behaviour recurred	7%
Issue addressed but not resolved and behaviour	32%

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continued	
Issue not resolved	57%

Table 5: Quotes from Consultants using Formal Processes of Redress

1. **I reported only the tip of the iceberg. Unfortunately in those few situations the matter remained unabated.**
2. **Initially on two occasions the behaviour was stopped but eventually persisted and resulted in me having to leave the post.**
3. **The issue was not addressed and the issue with management and the senior consultant was brushed under the carpet.**
4. **The chief investigator was the friend of the medical director and the investigation was a white-wash.**
5. **The supposed investigation was an absolute disgrace, with the perpetrator eventually getting senior management roles.**
6. **Attempts made to facilitate change. This was just a tick box exercise. Behaviour continues and situation stays unresolved.**
7. **It was half-heartedly addressed and is either resolved or is further under the radar at present.**
8. **Investigation process is not very fair and is very stressful.**
9. **Action will not be taken against certain individuals because of who they are**

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Conclusion

A substantial proportion of the consultant members of RCOG working in the UK indicate that they have experienced bullying and undermining behaviour. In many cases the behaviour has persisted for years. In addition to their own distress, patient safety is compromised by the effects identified in the taxonomy. Those that report such behaviours are rarely satisfied that the issues have been addressed.

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The situation is clearly unacceptable from every point of view. Such recent initiatives as the RCOG/RCM joint statement regarding zero tolerance[14] and new RCOG initiatives such as the bullying and undermining toolkit, eLearning module, and the establishment of National Workplace Behaviours Advisory Network & Workplace Behaviours Champions are to be welcomed.[24]

Yet this research shows emphatically that the immediate situation is disturbing and unacceptable. Without wishing to diminish the importance of steps already taken, much more needs to be done by institutions on designing interventions that tackle bullying and undermining behaviours directly rather that those that seek to minimise consequences. Such interventions need to be both local, through health care providers, and national through Colleges. Such interventions must include an overhaul of the current inadequate reporting and investigation processes that not only leaves those who complain stressed by the process and unsatisfied at the outcome, but also deters others from complaining. What is more, both preventive and disciplinary interventions require effective evaluation and thought should be given to effective monitoring of the feedback through both established mechanisms such as the NHS staff survey but also more widely, potentially through the collaboration of Colleges. The RCOG has developed an action plan for ongoing work to help tackle bullying and undermining behaviour at all levels. Finally we would call for regulators such as the Care Quality Commission, via its leadership domain, to consider this agenda more explicitly given the impact on both staff and patients.

KEY FINDINGS:

Who is bullied?

- The majority of the sample of consultants are not, and have not, been bullied or undermined
- Of the sample that did report bullying, those qualified outside the UK report more bulling and undermining behaviour than those trained in the UK - consistent with the 2013 GMC Training Survey
- Bullying and undermining is reported across all LETBs/Deaneries
- Consultants in Trust Management roles report similar behaviours to those in clinical roles

Impact on personal and professional life

- Some two thirds of the sample report that such behaviours have lasted more than three years
- Impact spans from suicidal thoughts, depression and sleep disturbance, to resignation/retirement, a lack of confidence and simply coming to work to pay the bills
- More than two thirds of the sample report major or moderate impact on working and personal life.

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Who are the reported perpetrators of bullying and/or undermining?

- Reported perpetrators occupied various positions, however Managers, Senior Consultants and Medical Directors are reported to be the main perpetrators.
- The sample suggests that the perpetrator is often one person (38.7%)
- 12% of those claiming to have been bullied identified a junior colleague as the perpetrator
- For most of the sample, bullying occurs in more than half of all encounters with the perpetrator

Types of reported bullying and undermining behaviour

- The types of reported behaviours most prevalent associated with isolation and demoralisation of individuals.
- The main reported types of behaviour were persistent attempts to undermined and belittle work; persistent and unjustified criticism and monitoring of work; constant undervaluing of an individual's efforts; undermining of personal integrity; freezing out, ignoring or excluding.
- Sharing of threatening, undermining and damaging emails via global email addresses was reported to be a subtle and insidious method used to bully and undermine.

Outcome of cases reported to relevant individuals within hospital Trusts (outcome based on alleged victim's perception)

- In 57% of reported cases the issue/s raised was not addressed
- In 32% of reported cases the issue/s raised was addressed but not resolved and the behaviour continued
- In 4% of reported cases the issue was resolved and the behaviour stopped.

Footnote

The strong assumption is that the sample proportions are close to the population proportions. Using a two sample z test to compare sample proportions, the null hypothesis that men and women consultants are equally likely to report themselves as victims of bullying is rejected at $p<0.001$, as are the null hypotheses that UK trained consultants are equally likely to report themselves as victims as those trained abroad and UK trained women report these behaviours equally with non UK trained women. The null hypothesis is accepted at $p<.05$ when comparing the sample of consultants who have management positions with those who do not, and UK trained males with those trained abroad. That said the authors find no reasons, compelling or slight, to accept the strong assumption.

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	• **Substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data.**	**Drafting the work or revising it critically for important intellectual content**	• **Final approval of the version published.**	• **Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.**
TS	Original design of methodology and method, application of research method. Extensive literature review. Collation, presentation and analysis of data	Production of complete first draft Substantial redrafting	Agreed by all authors	Extensively reviewed and agreed by all authors
WPS	Design of research method, analysis of data	Critical review all drafts Drafting of significant		
SO	Design of			

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	research method, analysis of data	amendments		
SJM	Project lead Design of methodology, interpretation of data			
SJH	Second analysis and re Interpretation of data,	Extensive editing and review of first and subsequent drafts		

Transparency declaration: The guarantors affirm that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

Competing interest: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare two potential conflicting interests:

TS was employed by the RCOG and received some financial support for the submitted work.

JM is the unpaid RCOG Workplace Behaviours Advisor and is reimbursed for travel and accommodation expenses where appropriate when on RCOG business

No authors have any financial relationships with any organisations that might have an interest in the submitted work

No authors have any other relationships or activities that could appear to have influenced the submitted work.

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Data sharing: Additional data from the survey of RCOG consultants are available from Joanna Mountfield at Joanna.mountfield@uhs.nhs.uk

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BULLYING AND UNDERMINING QUESTIONAIRE

Q1 – Please record your gender
Male
Female

Q2 – What is your age group?
34 years or under
35 - 44 years old
45 - 54 years old
55 - 64 years old
65 - 74 years old
75 or older

Q3 – Please indicate the Deanery/LETB for your Trust

Health Education East Midlands (formerly East Midlands)
Health Education East of England (formerly East of England)
Health Education Kent, Surrey & Sussex (formerly Kent, Surrey & Sussex)
Health Education London (formerly London)
Health Education North West (formerly Mersey)
Health Education North East (formerly Northern)
Health Education North West (formerly North Western)
Health Education South West (formerly South West Peninsula)
Health Education South West (formerly Severn)
Health Education Thames Valley (formerly Oxford Deanery)
Health Education Wessex (formerly Wessex)
Health Education West Midlands (formerly West Midlands deanery)
Health Education Yorkshire & the Humber (formerly Yorkshire and the Humber)
Northern Ireland Medical & Dental Training Agency
NHS Education for Scotland
Wales Deanery.

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Q4 – Did you originally qualify from medical school in the UK?
Yes
No

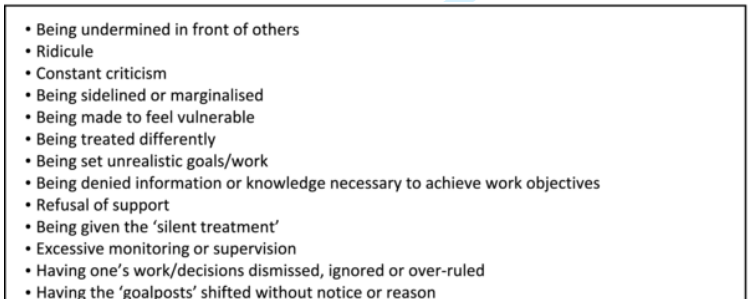
Q5 - Did you complete your postgraduate training in the U.K?
Yes
No

Q6 – For approximately how many years have you been working as an O&G consultant in the UK?
1-5 years
6-10 years
11-15 years
16 -20 years
21-25 years
26+ years

Q7 – Are you working full time or less than full time?

Q8 - Do you have a Trust Management role? (eg. Clinical Director, Medical Director)
Yes
No

This survey deals with bullying or undermining behaviour in the workplace. By bullying and undermining behaviour we mean the following behaviours, generally but not exclusively.



Q9 – Looking at the list above, do you feel that you have personally been subjected to **persistent episodes** of bullying or undermining behaviour by other staff while working in the NHS in the UK?
Yes
No – Skip to Q24

Q10 – Approximately for how long has this behaviour been occurring?
Over the last 12 months
Over the last couple of years
Over the last 3 to 5 years
Longer than 5 years

Q11 – Where does this behaviour usually occur? (Tick all that apply)
In theatre
In the maternity assessment unit
In the early pregnancy unit
In the midwife birth unit
In the delivery suite
In the ward/Trust generally
During teaching/training sessions
In the community
Other (please specify)

Q12 – In the main, is this behaviour being carried out by one specific person, by more than one person or by specific groups of people generally?
By one specific person skip to q13
By more than one person skip to Q14
By one or more specific group of people generally Skip to Q15

Q13 – And is this person…?
A senior consultant (i.e. with over 10 yrs practice)
A junior consultant
A consultant from another specialty
A manager
A medical director
A trainee
A nurse
A midwife
Theatre staff
Other (please specify)

Q14 – And are these people…? (Tick all that apply)
A senior consultant (i.e. with over 10 yrs practice)
A junior consultant
A consultant from another specialty
A manager
A medical director
A trainee
A nurse
A midwife
Theatre staff
Other (please specify)

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Q15 – And is/are this group of people…?(Tick all that apply)
Senior consultants (i.e. with over 10 yrs practice)
Junior consultants
Consultants from other specialties
Managers
Medical directors
Trainees
Nurses
Midwifes
Theatre staff
Other (please specify)

Q16 – And out of 10 times you come into contact with this person(s)/group(s), how often does the behaviour occur approximately?
Every time (10 times)
9 times
8 times
7 times
6 times
5 times
4 times
3 times
2 times
Once

Q17 – And are the people carrying out the behaviour mostly…?
Male
Female
Equally male and female

Q18 - In hierarchical terms, are the perpetrators of this behaviour…?
Above your grade/level
At a comparable grade/level
Below your grade/level
Not applicable/Don't know

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Q19 – Please identify the type(s) of behaviour that you have been subjected to. (Tick all 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 or sarcasm
Verbal and non-verbal threats
Making inappropriate jokes about you
Persistent teasing
Physical violence
Withholding necessary information from you
Freezing out, ignoring or excluding
Unreasonable refusals of applications for leave or training
Undue pressure to produce work
Setting of impossible deadlines
Shifting goalposts without telling you
Constant undervaluing of your efforts
Persistent attempts to demoralise you
Removal of areas of responsibility without consultation
Discrimination on racial, gender or sexual grounds or other protected characteristics
Unwelcome sexual advances
Other (please specify)

Q20 – How has such behaviour impacted on your professional and personal life? Please comment.

Q21 – Have you reported this behaviour?
Yes – go to Q22
No – go to Q23

Q22 – what was the outcome?
The issue was resolved and the behaviour stopped
The issue was resolved but the behaviour recurred
The issue was addressed but not resolved and the behaviour continued
The issue was not addressed however the behaviour stopped
The issue was not addressed and the behaviour continued
Other (please specify)

Q23 - Why did you not report it?
I was concerned that reporting the issue would make the situation worse
I did not know who to report the issue to
I felt I would not be supported if I reported the issue
I was concerned about the impact that reporting the issue would have on my career
The behaviour stopped and has not recurred
The person I would normally report the issue to is the perpetrator
Other (please specify)

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Q24 - Have you witnessed other colleagues or staff being subjected to persistent behaviours by others which has eroded their professional confidence or self esteem?
Yes
No – skip to Q28

Q25 – Have you reported this behaviour?
Yes – go to Q26
No – go to Q27

Q26 – what was the outcome?
The issue was resolved and the behaviour stopped
The issue was resolved but the behaviour recurred
The issue was addressed but not resolved and the behaviour continued
The issue was not addressed however the behaviour stopped
The issue was not addressed and the behaviour continued
Other (please specify)

Q27 - Why did you not report it?
I was concerned that reporting the issue would make the situation worse
I did not know who to report the issue to
I felt I would not be supported if I reported the issue
I was concerned about the impact that reporting the issue would have on my career
The behaviour stopped and has not recurred
The person I would normally report the issue to is the perpetrator
Other (please specify)

Q28 – Do you feel that there is a general problem with undermining in your unit?
Yes – go to Q29
No - go to Q30

Q29 – Is this being addressed?
Yes
No

Q29a – Please give details

Q 30 - Have you attended any training on how to address undermining/bullying?
Yes
No

Q31 – Finally, do you have any comment on any issues relating to bullying and undermining?

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