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### A survey of workplace bullying of psychiatric trainees in the West Midlands

#### AIMS AND METHOD

A postal survey was conducted to ascertain the prevalence of bullying behaviour experienced by psychiatric trainees in the West Midlands. Questionnaires were sent to 232 junior doctors, 76% of whom responded.

#### RESULTS

In the preceding year, 47% of trainees had experienced one or more bullying behaviours. Only 46% reported that they knew whom to contact if they were bullied. Foreign doctors were significantly less likely to take action when bullied than local doctors.

#### CLINICAL IMPLICATIONS

Workplace bullying is commonly experienced by psychiatric trainees and other junior doctors in the National Health Service. This behaviour could have adverse effects for both the individual and the employer. To tackle this problem, awareness needs to be raised, and action is required at a number of levels.

Bullying behaviour is widespread within the National Health Service (NHS) and can have serious consequences. It can significantly decrease job satisfaction and increase job-induced stress; it also leads to low self-confidence, depression, anxiety and a desire to leave employment (Bjoerkqvist, 2001; Quine, 2001; Field, 2002). Bullying contributes to high rates of staff turnover, high rates of sickness absence, impaired performance, lower productivity, poor team spirit and loss of trained staff (Field, 2002). This clearly has implications for the recruitment and retention of medical staff within the NHS.

Quine (1999) found that 38% of employees within an NHS Trust had experienced bullying in the workplace in the previous year. Bullying was most likely to be perpetrated by a manager, and attempts by the person bullied to take action invariably led to disappointment. In a survey of workplace bullying of junior doctors, 37% of respondents reported being bullied and 84% had experienced at least one bullying behaviour within the last year (Quine, 2002). Black and Asian doctors and female doctors were more likely to be bullied.

Historically, workplace bullying of doctors has generated little interest or research, and no study has looked at this issue among psychiatric trainees. Our study aimed to ascertain the prevalence of bullying experienced by psychiatric trainees in the preceding year, to consider whether certain subgroups of doctors were particularly vulnerable, and in the event of bullying, whether trainees sought help and what the outcome was likely to be.

#### Method

We contacted the relevant medical personnel departments of the various trusts that make up the West Midlands psychiatric rotation, to enquire if they had an anti-bullying policy.

Postal questionnaires were also sent to all psychiatric trainees on all the basic and higher psychiatric training schemes in the West Midlands. Trainees who did not respond were sent a second copy of the questionnaire after 8 weeks and prompted by telephone to reply. The questionnaire consisted of two parts. The first collected demographic details including age, gender, ethnicity, residential status in the UK ('local' or 'foreign'), and current position: senior house officer (SHO) or specialist registrar (SpR). There was also a statement that required a 'yes', 'no' or 'unsure' response: 'Do you know where to obtain help or whom to contact if you are bullied?' The second part consisted of a questionnaire previously validated by Quine (1999, 2002) to assess bullying behaviour. Behaviours were grouped into six categories: threats to professional status; threats to personal standing; isolation; overwork; destabilisation; and discrimination on the grounds of race or gender.

Only psychiatric SHOs and SpRs were included in the survey. All other trainees and non-training-grade doctors were excluded. Forty doctors were excluded from the original list of 272 junior doctors, obtained from the regional clinical tutors. Of the 232 doctors eligible for inclusion, 177 (76%) returned completed questionnaires.



## Results

Of the 177 participants, 93 were male (53%); 115 (65%) were SHOs and 62 (35%) were SpRs; 69 were White (39%) and 91 (51%) were Asian; 100 (56%) were foreign doctors training in the UK. Overall, 84 (47%) respondents had experienced one or more bullying behaviours in the preceding year. There was no statistically significant difference in the numbers of male and female doctors (48 v. 36%), White and Asian doctors (27 v. 47%) or local and foreign doctors (33 v. 51%) who had experienced bullying. Those doing the bullying were non-medical staff (in 28% of cases), senior medical staff (27%), patients (20%), managers (16%) and peers (9%). Eighty-two respondents (46%) replied that they knew whom to contact in the event of bullying.

A total of 401 individual episodes of bullying behaviour were reported in the preceding year. On 92 occasions action was taken: 31 had a positive outcome and 61 had a negative outcome. Foreign doctors were significantly less likely to take action about the bullying than local doctors (on 32 v. 60 occasions;  $\chi^2=24.292$ , d.f.=1,  $P<0.001$ ). There was no significant difference between local and foreign doctors in the outcome, when action was taken.

## Discussion

There is increasing interest in the idea of organisational or cultural bullying – norms of behaviour and practices in the workplace that regularly undermine those who work in it (Houghton, 2003). Medical training usually takes place in institutions that have a highly-structured hierarchical system, and has traditionally involved teaching by intimidation and humiliation. Such practices may foster a culture of bullying and the setting up of a cycle of bullying, analogous to other cycles of abuse in which those who experience it go on to abuse others when they become more senior. Doctors are increasingly reporting to the British Medical Association that they are being bullied, often by older and more senior colleagues, many of whom were badly treated themselves when more junior (Williams, 1998). These behaviours can ruin the careers of those accused of bullying, as well as those at the receiving end.

Intuitively, the psychiatric profession might be expected to be particularly sensitive to bullying and its consequences. However, this survey confirms that bullying of junior doctors is prevalent in the NHS and shows that psychiatric trainees are in no way exempt. Moreover, we found that those who are bullied are often unsure how to access help, and when they attempt to do so the results are often unsatisfactory.

Foreign doctors training in the UK may be particularly vulnerable. Our survey found that they were significantly less likely to take action when bullied than local doctors. This finding suggests that the incentives to keeping quiet and colluding outweigh the incentives to challenge bullying behaviour. Foreign trainees may have a great deal invested in completing their training in the UK. They may be particularly reluctant to 'rock the boat' and

risk alienating those on whom they depend for references. They may find it particularly difficult to challenge bullying behaviours, which can be an isolating and alienating experience, especially for those who are already working in an unfamiliar environment and who may be geographically remote from their sources of support.

Studies of workplace bullying rely on self-report questionnaires. This may introduce selection bias, as those who experience bullying may be more likely to complete and return questionnaires. However, the high response rate achieved in this study (76%) would have minimised this bias. Despite limiting our survey to the West Midlands, our sample consisted of a large, mixed group of junior doctors working in a variety of clinical settings, and is likely to be representative of psychiatric trainees elsewhere in the UK.

Bullying is a subjective experience. No single definition of bullying is universally accepted and thresholds for labelling behaviours as bullying vary. The Stephen Lawrence inquiry stated that if a person feels bullied then he or she is being bullied (MacPherson, 1999); others rely on more stringent criteria (Houghton, 2003). Individuals may interpret and attribute behaviours in different ways and may have different levels of tolerance. This makes it difficult to standardise or quantify bullying behaviours. Discrimination on the grounds of race or gender could be classified as racism or sexism rather than bullying. Similarly, it may be contentious to include patients' actions under the heading of bullying when no account was taken of whether or not these actions were taken in the context of mental illness. However, it was considered important to use an inclusive definition of bullying that had previously been well validated (Quine, 1999, 2002).

All the West Midlands trusts contacted had anti-bullying policies. However, it is not clear how these policies are being implemented and how information regarding these policies is disseminated to those they are designed to protect. Indeed, it is unclear whether doctors are even aware that such policies exist. Anecdotal evidence suggests that these policies may be perceived as being 'only for show' and that they offer little or no practical value to those who are bullied (Paterson, 2002). It may be unrealistic to assume that victims of bullying will always actively seek help, so trusts need to be more proactive in preventing bullying and offering dedicated support to victims. At an individual level, unacceptable behaviour should be challenged and those in senior positions and involved in teaching should be mindful of the powerful effects of role modelling on those who are impressionable (McAvoy & Murtagh, 2003). There is evidence that support at work can protect against the damaging effects of bullying (Quine, 2001). One of the strengths of psychiatric training in the UK is the regular supervision afforded to trainees, and this may represent an opportunity for addressing bullying behaviour and providing such support.

Sweden and Norway are the only European countries with specific anti-bullying legislation (McAvoy & Murtagh, 2003). The UK has no specific law to protect those who are bullied, and legislation is urgently needed



to address this. Significant changes are needed at a national, organisational and individual level to tackle this problem. Action is needed to raise awareness of this problem, to provide support and assistance to those who report bullying, and to foster bully-free working environments.

## Declaration of interest

None.

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