



# Building a supportive environment:

a review to tackle undermining and bullying in medical education and training

Working with doctors Working for patients

General  
Medical  
Council



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# Summary of our findings:

## factors contributing to positive workplace behaviours and a supportive learning environment

### Valuing doctors in training

All members of departments,\* especially trainers, should try to understand the needs and priorities of doctors in training. Effective departments challenge themselves to consider how these doctors may perceive their comments and behaviours.

Departments, deaneries and local education and training boards (LETBs) should be alert for signs of undermining and bullying, and should acknowledge and take ownership of any issues that arise. Meeting to discuss problems as a group, and obtaining external support, can help departments facilitate this.

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\* We use the term departments because we visited departments of surgery and obstetrics and gynaecology. This term may not be appropriate to all the learning environments where we expect this report may be useful – for example, general practice placements.

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## Departmental cohesion and leadership

Departments need to be cohesive to provide a good training environment and departmental leaders need to be able to gain the support of their colleagues when making changes. Formal and regular departmental meetings to discuss training and other issues, and transparency in job planning, can help promote cohesion.

## Workload and stress for doctors in training and for consultants\*

Departments need to make sure the model for service delivery can provide appropriate time and resources for training. Employing more consultants, more staff and associate specialist doctors, and other professionals – such as advanced nurse or midwifery practitioners and physician’s associates – can help reduce the reliance on doctors in training, reduce the stress levels of consultants and doctors in training, and give time for consultants to teach.

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\* We heard mainly from consultants, but we expect that this would also apply to general practitioners (GPs) and other doctors not in training.

## Communication with doctors in training and recognising undermining and bullying

Departments should have open discussions with doctors in training about training issues. Encouraging less hierarchical relationships within departments and introducing focus groups can promote good communication. Learning activities such as workshops or electronic learning packages can help build understanding of what constitutes undermining and bullying behaviour.

## The need for effective senior leadership

Senior management and subsequently clinical departmental leaders should set strong policies on undermining and bullying and back these up with robust action that is seen to address poor training performance or behaviour. Senior management should support departments to take the necessary action in response to poor workplace behaviour, which may include reallocation of leadership or educational roles.

Senior management and the board should take an active interest in medical education and training – for example, by having a standing agenda item for board-level discussion.

# Why are we interested in undermining and bullying?

Undermining and bullying are unacceptable behaviours and have no place in modern medical education and training. Undermining and bullying in the workplace is bad for patient safety, bad for the health of those involved and bad for the quality of training.

Doctors in training who report having been bullied are more likely to have made mistakes at work.<sup>1</sup> Those who are bullied are also less likely to work well in a team, and yet good teamwork is one of the most important factors in achieving good outcomes for patients.<sup>2,3</sup>

Perhaps most importantly, doctors who are bullied at work may be less likely to raise concerns they have about patient safety, for fear of the consequences they may suffer.

## These behaviours have serious consequences

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“Some medical students and doctors in training say they believe their seniors think humiliation is an acceptable part of medical education.”

Undermining and bullying can have serious consequences for both the mental and physical health of those who experience it. It can also lead to absenteeism, which increases the workload for other members of the healthcare team.

Undermining and bullying behaviours unfortunately have a long history in medical education and training, and are known to be a persistent problem in many countries. Some medical students and doctors in training say they believe their seniors think humiliation is an acceptable part of medical education.<sup>4,5,6</sup> Yet students who report having been abused or mistreated have lower confidence in their mastery of clinical skills and rate their medical education as being of lower quality.<sup>7</sup>

In our 2014 national training survey,<sup>8</sup> 8% of doctors in training reported experiencing bullying or harassment themselves, and nearly 14% reported having witnessed someone else suffering these behaviours. 18% had experienced undermining. There are many definitions of undermining and bullying, and we discuss this later in the section *What behaviours did we hear about?* on pages 14–17.

# We take action on undermining and bullying

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As well as asking questions about whether doctors in training have experienced these behaviours, the national training survey gives doctors in training the chance to tell us specific details through free-text comments.

When doctors in training tell us about specific undermining and bullying concerns, we make sure that deaneries and LETBs investigate these as soon as possible and take appropriate action where it is needed. Deaneries and LETBs also investigate and take action, and inform us of this, when such concerns are raised directly with them.

A large number of doctors in training who respond to questions about undermining and bullying in the national training survey, saying they have experienced or witnessed these behaviours, do not go on to give us details in the free-text comments. Others that do give information wish to remain anonymous. In both cases, deaneries and LETBs do try to resolve these issues, but it can be more difficult for them to do so.

We do not know why doctors in training do not tell us about what they have experienced or witnessed. It might be because their concerns have been resolved locally to their satisfaction. From what we know about reporting of patient safety concerns,<sup>9</sup> barriers to reporting undermining and bullying may include a sense that nothing will be done about the problem, or, worse, fear of the consequences of raising an issue.

# We monitor issues until they have been resolved

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When we know about issues related to undermining and bullying, we keep track of deaneries' and LETBs' progress to resolve them through the annual deans' reports that they submit to us.

If the situation doesn't improve, they tell us. We then work with all the organisations involved to improve the quality of training through what we refer to as our enhanced monitoring process. In rare cases, where no progress is made despite this, we may have to work with the deanery or LETB to withdraw doctors in training from posts.

As of February 2015, we list on our website seven sites across the UK under enhanced monitoring for issues related to undermining and bullying. We also list 144 issues related to undermining and bullying in the deans' reports, which involve 74 sites across the UK.

“When doctors in training tell us about specific undermining and bullying concerns, we make sure that deaneries and LETBs investigate these as soon as possible and take appropriate action where it is needed.”

# Poor workplace behaviour in healthcare: the wider context

“Workplace bullying does not affect only doctors in training, but is unfortunately present throughout the healthcare system.”

Workplace bullying does not affect only doctors in training, but is unfortunately present throughout the healthcare system. In the National Health Service (NHS) staff survey for 2013, 23% of staff in England reported that they had been bullied, harassed or abused by other staff members in the previous 12 months.<sup>10</sup>

A number of recent reports and statements have highlighted the extent of bullying in the health service, and the impact on staff and on the care they provide. The 2013 report of the Mid Staffordshire inquiry<sup>11</sup> repeatedly mentions bullying. Although this is noted at all levels, bullying by managers, and the role this may have had in discouraging staff from raising concerns, are emphasised as important contributors to the poor care delivered at Mid Staffordshire NHS Foundation Trust.

Although the Mid Staffordshire inquiry focused on one NHS trust, it found that a bullying culture was likely to be a wider problem in the health service. In keeping with this, a 2008 report commissioned for Lord Darzi notes a 'shame and blame' culture in NHS management in England,<sup>12</sup> while the current<sup>13</sup> chairman of the Care Quality Commission and

a former<sup>14</sup> chairman of the Healthcare Commission have both warned that a culture of bullying in the NHS is of great concern. More recently, Healthcare Improvement Scotland's 2014 short-life review of quality and safety at Aberdeen Royal Infirmary also draws attention to undermining and bullying.<sup>15</sup>

The 2013 report by Illing and colleagues synthesises evidence on the occurrence, causes, consequences, prevention and management of workplace bullying and harassment.<sup>16</sup> This document demonstrates the complexity of the factors that contribute to and perpetuate these behaviours.

At the level of the clinical working environment, a report from the British Medical Association in 2006 describes a spectrum of unacceptable behaviours and calls for increased awareness and a shift from reactive to proactive management policies.<sup>5</sup>

# There are a number of initiatives to tackle undermining and bullying

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There are several initiatives that aim to improve the way health service staff members are supported to raise concerns, including the Freedom to Speak Up review.\*

This review notes that bullying is a safety issue if it deters staff from raising concerns, and recommends a systems approach to tackling this behaviour, including consideration of whether unacceptable demands or pressure are being placed on individuals.

The review also recommends honest and direct feedback to individuals about the impact of their behaviour. While in some cases the review notes that support might sometimes be more productive than admonition, it also says that failure to modify bullying behaviour should always be a matter for disciplinary action.

“ The Freedom to Speak Up review recommends honest and direct feedback to individuals about the impact of their behaviour. ”

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\* More information on the Freedom to Speak Up review is available at <https://freedomtospeakup.org.uk>.

Several organisations, including deaneries and LETBs, medical colleges and other professional bodies, have been involved in initiatives to tackle undermining and bullying.

The Royal College of Surgeons of Edinburgh is developing a programme of peer-to-peer mentoring to support surgical professionals, which will have a remit for support and advice on the issue of undermining and bullying.\*

Since 2013, the Royal College of Obstetricians and Gynaecologists has been developing a workplace behaviours project.† This has established a network of workplace behaviour champions, and the College has recently launched an undermining toolkit together with the Royal College of Midwives.

The Academy of Medical Royal Colleges is embarking on a programme of work to help share examples of initiatives that have been successful in tackling undermining and bullying.

Deanery and LETB examples include a 2013 guide on managing bullying and harassment produced by the London Deanery,‡ a charter of professional responsibilities produced by Health Education North East§ and a series of small group workshops with video scenarios run by Health Education Wessex.¶

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\* More information is available at [www.rcsed.ac.uk](http://www.rcsed.ac.uk).

† More information is available at <https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining>.

‡ More information is available at [www.faculty.londondeanery.ac.uk/educational-team-development/managing-bullying-harassment-and-undermining](http://www.faculty.londondeanery.ac.uk/educational-team-development/managing-bullying-harassment-and-undermining).

§ More information is available at [www.northerndeanery.nhs.uk](http://www.northerndeanery.nhs.uk).

¶ More information is available at [www.wessexdeanery.nhs.uk](http://www.wessexdeanery.nhs.uk).

# What did we do?

To help tackle undermining and bullying in medical education and training, we visited a number of sites to develop a deeper understanding than is possible using the national training survey. We wanted to draw out common themes that could be useful to other sites and specialties.

To do this, we identified 12 sites to visit as a programme of checks: six departments of surgery and six departments of obstetrics and gynaecology. We chose these specialties because they are among those in which undermining and bullying are most commonly reported in the national training survey.<sup>8</sup> We describe the programme in more detail on pages 36–39.

In identifying the sites and designing the programme of checks, we worked closely with the Royal College of Obstetricians and Gynaecologists, the Joint Committee for Surgical Training and other organisations. We also engaged with the Royal College of Midwives to make sure our approach to the obstetrics and gynaecology aspect of the visit was appropriate, as we were eager to speak to midwives at site visits about the training environment for doctors.

At the site visits, we interviewed doctors in training, consultants and senior managers. To better capture the multidisciplinary nature of teamworking in these specialties, and to get a more rounded view of the departments we were visiting, we also interviewed midwives on our visits to obstetrics and gynaecology departments and doctors training in anaesthesia on some of our visits to surgical departments.

## We gathered evidence through group interviews

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To protect the anonymity of individual doctors in training, we spoke only to groups of three or more, as is usual practice for our quality assurance visits. However, it is important to recognise that some interviewees may have not felt comfortable raising issues about undermining and bullying when in a group, and so we may not have identified all their concerns.

These checks formed part of our regular quality assurance process. We did not design the checks specifically to get further details from doctors whose answers to the national training survey indicated that they had experienced undermining or bullying. We wanted the checks to complement the national training survey as a different source of information on the same subject. And, above all, we wanted to identify themes that could be useful in improving practice across medical education and training at all sites in the UK.

Although we held open discussions, we concentrated on issues related to undermining and bullying of doctors in training. We did not survey undermining and bullying of other staff groups.

“Above all, we wanted to identify themes that could be useful in improving practice across medical education and training at all sites in the UK.”

# What behaviours did we hear about?

“ There are numerous definitions of undermining and bullying, reflecting the fact that these behaviours are complex and can take many different forms. ”

Undermining and bullying behaviour is not unique to medical education and training, and the ways in which it can manifest have been extensively documented.<sup>16, 17</sup> There are numerous definitions of undermining and bullying, reflecting the fact that these behaviours are complex and can take many different forms. It is important to note that these behaviours are difficult to measure in objective terms. They are often defined in terms of the recipient's perceptions, and so understanding the range of different people's perceptions is very important in understanding why people feel bullied or undermined.

In our national training survey, we define undermining and bullying as different entities.\*

- **Undermining** is behaviour that subverts, weakens or wears away confidence.
- **Bullying** is behaviour that hurts or frightens someone who is less powerful, often forcing them to do something they do not want to do.

Most doctors in training we spoke to during our visits felt well supported by their supervisors. In all cases they said that they would feel able to report patient safety concerns.

This is a thematic report, and so we have used generalised examples to protect anonymity and make sure that the lessons learnt can be used more widely. Although specific individual cases were discussed as part of the checks, we do not discuss any individual cases in this report.

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\* Definitions are available at [www.gmc-uk.org/help/NTS04.htm](http://www.gmc-uk.org/help/NTS04.htm).

# We heard mostly about undermining

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Although most doctors in training we spoke to did not report undermining or bullying behaviour to us, we did hear of some concerns. Using the definitions on page 15, these were mostly about undermining; there were very few examples of bullying.

Doctors in training told us about the following behaviours.

- Criticism that made them feel belittled or humiliated. Such comments questioned the professional abilities of doctors in training, and were sometimes made in front of other healthcare professionals or even patients.
- Reprimands made by non-medical staff members, usually higher up in the organisational hierarchy. These comments were not perceived as relevant for training or patient safety, but were more related to ensuring service delivery.
- Outright threats of consequences for the future careers of doctors in training if they did not stop 'making trouble' by raising concerns about the quality of their training.
- Criticism in workplace-based assessments that had not been discussed constructively with the doctor in training.
- Bestowing apparent favours on some doctors in training by giving them access to resources, such as study leave or training opportunities, while denying these to others, on an unpredictable and unfair basis.
- Unreasonable expectations of doctors in training in terms of workload, particularly related to staying late to ensure service delivery or provide cover for unfilled posts and rota gaps.
- Failure to demonstrate concern for the educational needs of doctors in training, such as not engaging with doctors in training or not completing workplace-based assessments, and consistently prioritising clinical efficiency over training.
- Failure to acknowledge the importance of doctors in training having a personal life or to consider their stress levels and workload.

# Most of the behaviours were unintentional

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We heard from consultants that behaviours perceived by doctors in training to be undermining had almost invariably not been intended to have this effect. The vast majority of consultants had reflected on these behaviours and tried to change them.

Where doctors in training held an individual responsible for these behaviours, this was most often a consultant in their own specialty, but consultants in other specialties and other healthcare professionals were also identified.

We heard that some groups of doctors were more reluctant than others to raise concerns about training, and particularly about undermining or bullying. In part, this reflected the general quality of communication between doctors in training and their trainers at different sites. But we did note that doctors in training in small, close-knit specialties and within more isolated geographical training areas stated that it was hard to raise concerns for fear of jeopardising their future careers.

“The vast majority of consultants had reflected on these behaviours and tried to change them.”

# Which groups of doctors in training report undermining and bullying?

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Through published research and surveys, such as the national training survey, we already know that some groups of doctors are more likely to report having experienced undermining and bullying during training. Groups at higher risk include recent graduates, female doctors, disabled doctors, or those from an ethnic minority.<sup>1</sup> There is some evidence that doctors in less than full-time training also experience more undermining and bullying.<sup>18</sup> These at-risk groups are similar to those identified in studies of workplace bullying outside of medicine.

In the 2014 national training survey, black and minority ethnic doctors in training reported experiencing bullying and harassment more commonly than white doctors (9.3% vs 6.8%), and this was also true when only UK graduates were considered (9.2% vs 6.6%). Doctors in training with a primary medical qualification from either the European Economic Area or elsewhere in the world reported bullying more commonly than those with a UK qualification (10.0%, 9.9% and 7.6% respectively).

Disabled doctors reported both undermining and bullying more commonly than those without a disability (28.1% vs 18.2% for undermining, 15.4% vs 7.8% for bullying). Reporting rates for both undermining and bullying were not very different between male and female doctors, or between doctors training full time and less than full time. The reason for these differences is unclear. It is important to note that there are many possible confounding factors, and that these associations may not be causal.

# Some doctors reported dismissive attitudes

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In our checks we heard of several examples where doctors in training felt undermined by other staff members' apparent dismissive attitudes towards their specific needs. In some cases these needs related to protected characteristics, such as childcare commitments for doctors in less than full-time training, or to specific religious requirements.

We heard that doctors in training with particular needs sometimes felt unwelcome, or perceived that some of their trainers felt they should be grateful for the efforts made to accommodate them.

We encountered a wide variety of perceptions among doctors in training on what constituted undermining or bullying behaviour. In our checks we did not hear that this was related to protected characteristics.

“ We heard that doctors in training with particular needs sometimes felt unwelcome... ”

# Doctors training in some specialties report more undermining and bullying

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It is well known that reporting of undermining and bullying varies widely between specialties. Our checks were not designed to investigate why doctors training in surgery and in obstetrics and gynaecology are more likely to report undermining and bullying than those in other specialties. This has been done in more detail elsewhere.\* We did, however, hear of several factors implicated in undermining and bullying that may relate to these specialties, and potentially also to other specialties that we did not visit. These included:

- the acute nature of the specialty
- the significant on-call commitments, often with distant supervision
- the perfectionist characteristics exhibited by many consultants (especially in surgery and in operative gynaecology)
- the high risk of being involved in clinical incidents and the need to ensure patient safety (especially in obstetrics and gynaecology).

However, we are not able to say that these factors have a causal association with why undermining and bullying are more common in surgery and in obstetrics and gynaecology.

Considering again that undermining and bullying are defined by the perceptions of the person exposed to these behaviours, it may be that not all groups of doctors in training will have the same perceptions.

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\* More information is available at <https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining>.

# Factors contributing to undermining and bullying and how these can be tackled

Undermining and bullying are complex phenomena with multiple causes and contributing factors. During our checks we heard of factors related to individuals, but also of factors related to team interactions and to the training environment.

We have tried to condense these findings into a few broad themes that we hope will be of benefit to other sites trying to tackle poor workplace behaviours. We have summarised the factors that contribute to positive workplace behaviours and a supportive learning environment on pages 2–3.

# Valuing doctors in training

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We heard that some consultants and other staff members appeared to have little respect for colleagues, including the doctors in training working with them. For the most part, we did not hear that these individuals were malicious. But they were often described as 'perfectionists', with exacting standards for both clinical performance and dedication to work, which doctors in training felt they could not live up to. This manifested in different ways:

- rebukes or criticism related to clinical knowledge or performance
- bypassing the doctor in training, ignoring them or not allowing them to perform their expected duties
- expecting doctors in training to prioritise work commitments above all else, at the expense of their personal lives.

In other cases, consultants or other staff members gave doctors in training the impression that they had little or no interest in them either as doctors in training, or as people.

- Some anaesthetists, surgeons and other operating theatre staff prevented doctors in training from being able to operate so they could finish cases more quickly.

- Some doctors in training felt their educational and clinical supervisors made little or no effort to meet programme requirements – eg through holding useful educational meetings – or made no effort to familiarise themselves with their curricula.
- Some consultants did not respond to concerns about training that were raised by doctors in training.

Behaviours like these reflect a lack of consideration and respect for doctors in training – attitudes that are no longer acceptable in medical education. Although many doctors in training recognised this, others were more hesitant and said that such behaviour was normal and to be expected.

This lack of consideration was shown at several sites through the use of the term 'senior house officer', or 'SHO', to refer to the first tier of doctors in on-call rotas. Doctors in this position could be in core training in the specialty concerned, in the second year of foundation training or in GP training. Treating these different groups of doctors as the same fails to recognise their wide range of experience and training needs, and may pose a risk to patient safety.

“Several sites had found external support helpful in tackling problems with undermining and bullying.”

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### Acknowledging the problem openly helps to tackle these behaviours

Although creating a culture of consideration and respect was not easy, we heard that departments particularly struggled to make progress when they did not acknowledge the problem openly, take ownership of it at a departmental level, and make a strong statement that undermining and bullying behaviours are not acceptable.

Consultants at several sites described how they had come to realise that they hadn't been appreciating the needs of doctors in training. We heard that many had realised that they had either participated in some of these undermining and bullying behaviours, or had permitted them to go on unchallenged. Consultants at some sites had gathered in a group to discuss their behaviour towards doctors in training. This seemed to have been more effective in promoting change than a series of individual realisations.

Several sites had found external support helpful in tackling problems with undermining and bullying. This external support had ranged from quality assurance visits by the deanery, LETB or GMC through to occupational psychologists and teamwork consultants. Facilitators from outside the organisation had helped formalise knowledge that had previously been informal.

Sites that had made progress had usually been helped to do so by an engaged deanery or LETB that had been alert to undermining and bullying concerns.

All the sites we visited had made strong statements at a senior management level that undermining and bullying were not acceptable and would not be tolerated. Doctors in training told us that these statements sometimes had little practical impact, and that the attitudes held by members of a department, and its leaders, were the main factor in determining behaviour. But, at some sites, a senior member of a department had openly discussed previous undermining and bullying problems, and the steps that had been taken to tackle these, with doctors in training – this was seen as helpful.

“ Sites that had made efforts to promote open conversations...were making progress towards resolving problems of understanding. ”

### Trainers need to appreciate the needs and priorities of doctors in training

We heard of instances where undermining and bullying problems appeared to have originated in an individual trainer's lack of understanding of the needs and priorities of doctors in training. Sites that had made efforts to promote open conversations about how the specific needs and priorities of doctors in training could be accommodated were making progress towards resolving problems of understanding.

Departments that were making progress had also challenged themselves to consider how doctors in training perceived their comments and behaviours, and especially their interactions with specific groups of doctors in training, such as those in less than full-time training or black and minority ethnic doctors. At several sites, discussing these issues with doctors in training had enabled departments to redesign teaching sessions, handovers and other educational activities so that doctors in training found them more constructive and informative and less intimidating or humiliating.

### Ipswich Hospital: improving how doctors in training are given feedback

We heard that doctors training in obstetrics and gynaecology at Ipswich Hospital had sometimes felt belittled and undermined by the way they were given feedback at a meeting held each morning to discuss events from the previous night shift. The meeting had been introduced with the best intentions: the maternity service had wanted to make sure lessons were learned from any clinical incidents that occurred. Leaders in the department were shocked and saddened to find that these meetings had become a source of anxiety for doctors in training.

The meeting format was changed following the feedback from doctors in training – for example, the doctors involved in particular cases were not named. During our visit, we heard that these changes had made the meeting much more constructive, and that doctors in training viewed it much more positively.

# Departmental cohesion and leadership

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We heard that doctors in training felt less well supported in departments where consultants did not get along well as a group, appeared to be divided into factions, or did not appear to have agreed a common direction for the way they delivered clinical care and training. For example, doctors in training reported being caught in the middle of consultant disagreements about clinical management, and feeling undermined by this.

“Departments where consultants had improved the way they worked together were more effective in creating a positive environment for training.”

## Increasing departmental cohesion creates a positive environment for training

Departments where consultants had improved the way they worked together were more effective in creating a positive environment for training. We heard, for example, that starting to hold regular departmental meetings that all consultants attended enabled training issues to be aired and resolved more effectively.

We heard that confusion or secrecy about consultants' job plans contributed to a lack of cohesiveness in some departments and, in particular, that real or perceived inequalities in job planning generated tension and bad feeling between individuals. We also heard that bringing departments together for more robust job planning was challenging, and possible only through good leadership.

Where it had taken place, collective and transparent job planning as a whole department had allowed the consultants who were most interested and able in training to take on the majority of training roles, and had promoted group cohesion.

“Departments with effective leadership were able to acknowledge the impact that service pressures make on training, take responsibility for resolving this and act effectively...”

### Forward-looking leadership improves the learning environment

Leadership style is known to be an important factor in workplace bullying.<sup>19</sup> For example, both unpredictable and autocratic or authoritarian leadership styles have been associated with perceived bullying.

There were problems with undermining and bullying in several departments where power or responsibility for decision making was concentrated with one individual, and other consultant colleagues felt isolated or uninvolved in departmental decisions. But we saw several sites where a recent change in leadership had been accompanied by significant positive changes in how doctors in training felt about their posts. It was clear that departments with good, forward-looking leadership were planning more effectively for the future, were better able to prioritise training needs, and were more successful in fostering a supportive learning environment.

Sites where leaders were able to gain the support of their colleagues in implementing changes were more effective in tackling undermining and bullying issues. Departments with effective leadership were able to acknowledge the impact that service pressures make on training, take responsibility for resolving this and act effectively, but those without good leadership had struggled to do this.

# Workload and stress for doctors in training and for consultants

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It is widely acknowledged that the demands placed on health service care providers are increasing.

## Doctors in training are under high workload pressures

We heard that increasing demands on services led to many doctors in training feeling overworked. In some cases this was exacerbated by posts not being filled. Many sites were still using models for delivering clinical services that had not been updated to reflect the reduced total number of doctors training in surgery and in obstetrics and gynaecology.

Many doctors in training said they had felt pressured to work beyond their rostered hours, both to cover the required amount of work and to fill gaps in shift rotas left empty by unfilled posts. Some doctors in training said they had also felt pressured not to log and monitor these extra hours to comply with the Working Time Regulations. Our research on the impact of the Working Time Regulations on medical education and training also found this.<sup>20</sup>

Workload pressures due to the demands of the service were aggravated by continued reliance in many departments on junior medical staff to carry out tasks that could be performed by other healthcare professionals, such as phlebotomy.

## Demands on consultants reduce time for training

We also heard that demands on consultants had increased, in part due to an increased expectation for both closer supervision of doctors in training and for consultant-delivered care. Spending more time on delivering services meant consultants had less time for training and education, and found it more difficult to engage with individual doctors in training.

Perhaps more importantly, consultants told us they were more likely to speak sharply to doctors in training when they themselves were stressed. They reported that they were less able to prioritise the training needs of their juniors, and less likely to treat them with respect at all times.

We also heard that newly appointed consultants were sometimes less established in their own practice and felt less able to delegate tasks, particularly operating work, to doctors in training. We heard that this improved once these consultants had been in post for longer.

Unless a department is able to reform an overstretched service delivery model so that it can provide appropriate time and resources for training, other interventions to tackle undermining and bullying will struggle to succeed.

“Consultants told us they were more likely to speak sharply to doctors in training when they themselves were stressed.”

### Innovative approaches can improve doctors' workload and experience during training

We heard of several examples where investment and innovative service planning had helped struggling departments to evolve to an environment where doctors in training felt valued and supported. This had enhanced the general satisfaction of staff at all levels and made the department a more attractive place to work.

Examples included initiatives to coordinate bleeps to on-call doctors, and to train other healthcare professionals to relieve doctors in training from the burden of tasks such as taking blood and siting intravenous access. Several sites had made significant improvements to the workload and experience of doctors in training and consultants by employing more consultants and staff and associate specialist doctors. Sites had also improved conditions by introducing new roles, such as nurse practitioners and physician's associates.

### Birmingham Children's Hospital: improving doctors' experience while on call

Responding to the concerns of doctors in training, Birmingham Children's Hospital looked into their workload through a workforce analysis. This led the site to adapt their staffing model: they supported more junior doctors with site practitioners and physician's associates, and increased the number of doctors available to provide emergency surgical care by employing additional non-consultant doctors in fellowship posts. This allowed the site to draw up a much less onerous on-call rota for more senior doctors in training, with protected sleep overnight and better opportunities to gain practical operating experience.

The site also monitored calls made to doctors out of hours and found that many were unnecessary. To tackle this, it introduced a system to coordinate and prioritise these calls through a single point of contact, which we heard had been helpful.

### **West Middlesex University Hospital: recruiting more consultants to allow time for education and training**

At West Middlesex University Hospital, the department of obstetrics and gynaecology identified that many of the difficulties faced by their doctors in training related to workload. The site tackled this directly by appointing new consultants, which allowed them to redesign their supervision arrangements to provide overnight cover by a resident consultant for most of the week. We heard that the workload had improved for both consultants and doctors in training, and this in turn had made the training environment much more constructive.

### **Sites and LETBs need to communicate for good workforce planning**

We heard that sites had very different approaches to planning their workforce and service delivery for the future. It is clear that, in the short term at least, there will be no increase in the number of doctors training in surgery and in obstetrics and gynaecology. Some deaneries and LETBs reported that this had already led to gaps in the rota and this situation would continue.

Sites need to communicate effectively with deaneries and LETBs to make sure departments know how many doctors in training they can expect, and to help them plan their workforce accordingly.

Some departments were actively trying to reduce their reliance on doctors in training to meet service delivery needs. Challenges to this included a lack of suitably trained senior nurses and other healthcare professionals to fill new roles, and a lack of good quality applicants for positions at staff and associate specialist grade. We heard that, in some cases, geographical location was a particular challenge to recruitment.

Where sites had made progress in reducing their reliance on doctors in training, education and training opportunities and the working atmosphere had improved.

# Communication with doctors in training and recognising undermining and bullying

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Most departments that had experienced problems with undermining and bullying were very surprised to discover that their doctors in training were unhappy. It was heartening to hear that consultants and senior managers at most of these sites had been saddened at the effects on doctors in training and wanted to make sure these behaviours did not take place in the future.

## Levelling the hierarchy helps doctors to raise concerns about training

Raising concerns about training can be difficult, and this difficulty is compounded by a feeling of distance between doctors in training and those responsible for their training.

We heard during our check visits that less hierarchical relationships within departments facilitated open discussions between consultants and doctors in training. This made it easier to talk about problems before they escalated to the point where doctors in training felt undermined.

Sites that had experienced problems had almost invariably lacked regular and open discussions between consultants and doctors in training about issues related to training. Although meeting with doctors in training to discuss clinical work or for teaching sessions did help establish and strengthen relationships, in many cases this was not sufficient to empower the doctors to feel able to raise concerns about their training. It was striking that many doctors had not met to discuss their training before our visit.

Regular discussions between consultants and doctors in training, specifically about education and training, helped doctors in training feel supported to talk about problems they were experiencing. We heard of a variety of ways in which this could be achieved, including formal and informal meetings, and group or one-to-one meetings with doctors in training. The important feature was that consultants made an effort to facilitate discussions and were able to demonstrate to doctors in training that they were actually interested in improving the quality of their training.

“ We heard many examples of sharp or belittling comments that were not intended as such, and that were successfully resolved with an informal conversation and an apology. ”

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### Changing work patterns increase the importance of good communication

We heard that changes in the way doctors work together have made it even more important for consultants to find new ways to communicate with doctors in training. Changes across the whole health service, which have been driven by service demands and the Working Time Regulations, mean that very few doctors in training now work in stable teams, building a relationship with a particular consultant. Most now work in shifts and so may see any individual consultant infrequently. Shift working makes it harder for consultants and other permanent staff to get to know doctors in training, who are often only in a post for a few months.

We heard many examples of sharp or belittling comments that were not intended as such, and that were successfully resolved with an informal conversation and an apology. We heard that it would be unrealistic to expect that in a highly stressful workplace, no staff member would ever speak harshly to another. However, it would be expected that these incidents be minimised and, where appropriate, be resolved through discussion and apology.

### Training about undermining and bullying can improve awareness

Several departments had introduced training for consultants and doctors in training about undermining and bullying.

We heard that consultants had found descriptions of unacceptable and desirable behaviours useful, and that training had also helped them to recognise the effects of these behaviours on doctors in training.

We also heard that doctors in training had very varied perceptions about the behaviours of other staff members – some felt undermined or even bullied by behaviour that other doctors in training did not find troubling. Some training providers and royal colleges have developed education materials focused around the concept of resilience that relate to this.

Some doctors in training reported that learning packages had helped them better understand the priorities and stressors for consultants and other members of staff, and that this had helped facilitate better relationships.

“Doctors in training had very varied perceptions about the behaviours of other staff members – some felt undermined or even bullied by behaviour that other doctors in training did not find troubling.”

### **Luton and Dunstable Hospital: facilitating group discussions to help doctors raise concerns**

Luton and Dunstable Hospital investigated concerns about undermining and bullying in obstetrics and gynaecology through a series of focus groups. A consultant, who was an expert facilitator from outside the department, ran a series of sessions with doctors in training to better identify the behaviours that were troubling them.

Doctors in training reported that these sessions were a helpful way to discuss issues that they had not had the opportunity to raise in the course of their normal educational meetings, or had not felt comfortable to do so. They also felt that the sessions demonstrated to them that the Luton and Dunstable Hospital was interested in improving the training environment.

From anonymous transcripts of these meetings, it was clear that the nature of the behaviours reported had improved over time, which was one way in which doctors in training could see that improvements were taking place.

# The need for effective senior leadership

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We heard that senior leadership had a crucial role in supporting improvements in other common themes identified, such as:

- recognising the importance of training and allocating adequate resources
- supporting investment in service reorganisation to allow better training
- ensuring good leadership to promote cohesion at the departmental level.

We heard that, at many sites, the director of medical education played an important role both in tackling undermining and bullying issues and as a champion for training and education needs at a senior management level.

Sites where progress was evident invariably had good support from an engaged senior management team that took an active interest in medical education and training, manifested, for example, in a standing agenda item for board-level discussion.

## **Policies need to be enforced to tackle unacceptable behaviour**

We heard from all the sites we visited that they had strong policies stating that undermining and bullying were not acceptable. In some sites this policy was more visible than in others, but doctors in training and consultants told us that such policies often felt distant from their working environment.

Departments that had made progress to resolve bullying issues had been able to tackle unacceptable behaviour through effective performance management or disciplinary procedures. But where these procedures were not seen to reach a satisfactory outcome for the person raising the concern, the feelings of doctors in training were much less positive. In some cases, it was clear that the lack of urgency with which senior management had addressed some individual behavioural issues had contributed to ongoing undermining and bullying. Doctors in training who had raised concerns themselves and not felt they were addressed appropriately, or who had heard of such cases, said they were much less comfortable about raising concerns in the future.

In many cases, we heard how doctors in training and permanent staff at sites had developed unofficial workarounds to avoid confrontation with other staff members whose behaviour was known to be

“Although strong policy statements on undermining and bullying are important, they must be backed up by robust action that is seen to produce results.”

confrontational or intimidating. These workarounds did not solve problems with undermining and bullying behaviours, and actually allowed these to continue.

Effective actions taken by sites we visited included reallocation of leadership roles and educational responsibility away from staff displaying unprofessional behaviours.

Although strong policy statements on undermining and bullying are important, they must be backed up by robust action that is seen to produce results. Senior management need to be involved in this, either by supporting the departmental leadership or by taking a lead role themselves.

### Using a variety sources helps gather information to support action

Doctors in training who experience undermining and bullying are often very reluctant to come forward with information about their concerns, particularly when they are asked to contribute to evidence gathering for disciplinary proceedings. We recognise that this poses a great challenge for managers trying to take action to stop these behaviours.

We heard that some sites had approached this problem by information gathering through other routes, such as informal discussions between groups of doctors in training and facilitators from outside the department, and training particular members of staff to be approachable friendly faces or workplace behaviour champions. Departments that supported a variety of pathways to gather information on undermining and bullying concerns were better informed about the experiences of their doctors in training.

Deaneries and LETBs could contribute to information gathering through their involvement in training and quality management. We heard that the presence of trainers from outside the department at annual reviews for doctors in training had helped these doctors to feel more confident to raise concerns.

We also heard that increased representation for doctors in training at the deanery or LETB – for example, through a shadow school of surgery run by doctors in training – could give them more confidence that information about undermining and bullying would be treated sensitively. Such shadow schools are designed in part to mitigate the anxiety that doctors in training have about the possible repercussions of providing negative feedback about their training.\*

\* For example, the Shadow School of Surgery in Wessex Deanery. For more information see [www.wessexdeanery.nhs.uk/specialty\\_schools/school\\_of\\_surgery/shadow\\_school\\_of\\_surgery.aspx](http://www.wessexdeanery.nhs.uk/specialty_schools/school_of_surgery/shadow_school_of_surgery.aspx).

# Information about our checks and where we visited

# What are our checks?

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A check is a short, focused visit to explore a discrete set of issues, rather than a full quality assurance visit against all our standards.

During the checks, our visit team met with doctors in training at foundation, core\* and higher specialty levels (seen as separate groups where possible), consultants, departmental leads and senior management teams (including, where possible, the chief executive, medical director, director of medical education and human resources director). Where possible, we also met midwives at visits to departments of obstetrics and gynaecology and we met doctors training in anaesthesia at departments of surgery.

Our discussions focused on safe training and the environment in which doctors in training are educated. We explored perceptions of undermining and bullying from all these groups, looking particularly for lessons that could be beneficial for other sites.

The visit team varied,<sup>†</sup> but always included a GMC associate<sup>‡</sup> from the relevant specialty (consultant surgeon or obstetrician and gynaecologist), a doctor in training, and GMC quality assurance staff. For most checks the visit team also included a lay member and a GMC associate with a background in delivering postgraduate medical education. We considered how well the training met the standards in *The Trainee Doctor*<sup>21</sup> and provided specific feedback for each site in the form of a report, published on our website.<sup>22</sup>

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\* We met doctors in GP training together with those in core training.

† The visit teams for each check are described in the individual site reports on our website.<sup>21</sup>

‡ Associates are contractors (both medical and non-medical) appointed by the GMC to undertake a number of visits, review and adjudication roles. Their purpose is to help the GMC protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

# What sites did we visit?

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To select sites for the checks, we reviewed evidence from:

- the national training surveys in 2013 and 2014
- the deans' reports to the GMC on the quality of training in deaneries and LETBs
- the Joint Committee on Surgical Training
- the Royal College of Obstetricians and Gynaecologists.

We chose a range of sites to gain a breadth of information with which to write a report that would be useful to UK medical training as a whole.

Most sites we visited had identified undermining and bullying problems in the past and were making progress in resolving these to varying degrees. Undermining and bullying is a problem across the UK, and the sites for these checks were chosen to make sure we had a good range of hospitals (from teaching hospital to district general hospital) across a variety of geographical locations. We visited the sites between September and December 2014.

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We visited the following sites.

### Obstetrics and gynaecology

- West Middlesex University Hospital NHS Trust
- Altnagelvin Area Hospital, Western Health and Social Care Trust
- Royal Victoria Infirmary, Newcastle upon Tyne Hospitals NHS Foundation Trust
- Northwick Park Hospital, North West London Hospitals NHS Trust
- The Ipswich Hospital NHS Trust
- Luton and Dunstable University Hospital NHS Foundation Trust

### Surgery

- Birmingham Children's Hospital, Birmingham Children's Hospital NHS Foundation Trust
- Belfast City Hospital, Belfast Health and Social Care Trust
- Derriford Hospital, Plymouth Hospitals NHS Trust
- Ninewells Hospital, NHS Tayside
- North Devon District Hospital, Northern Devon Healthcare NHS Trust
- Salisbury District Hospital, Salisbury NHS Foundation Trust

# Next steps

We take undermining and bullying extremely seriously and do not tolerate these behaviours in medical education and training.

### Improvements by individual sites

We have given each site we visited a report setting out what requirements they need to meet, and what further changes we recommend, to improve education and training. These reports also highlight any good practice we saw, and have been published on our website alongside this report.<sup>22</sup>

We will monitor the sites' progress to address any areas that require improvement through our usual quality assurance framework, working with the deanery or LETB.

### The wider education and training environment

We hope this report will prove useful to those trying to improve workplace behaviour and tackle undermining and bullying, particularly senior management teams, departmental leaders and those with educational responsibilities.

We will promote the report wherever we can, including through our regional liaison service. We plan to hold a number of events to promote medical professionalism over the next two years, where we will feature these findings.

### Within the GMC

This report has helped us better understand the nature of undermining and bullying in medical education and training, and some of the steps that sites can take to tackle this. We will build on this understanding by continuing to monitor undermining and bullying problems, including the equality and diversity aspects of these, through the national training survey and our quality assurance visits.

We will share the findings of this report internally with staff working in all parts of the organisation. In particular, the findings will support a number of relevant areas of our work, set out below.

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### Review of standards for medical education and training\*

We are currently consulting on new standards for managing and delivering medical education and training, as part of an overall review of our approach to quality assurance.

The review is looking at the standards for undergraduate and postgraduate medical education and training, set out in *Tomorrow's Doctors*<sup>23</sup> and *The Trainee Doctor*,<sup>22</sup> to improve consistency and coherence of standards across the continuum of education and training.

### Recognition and approval of trainers†

We view the formal recognition and approval of trainers as an important step forward in improving the quality and consistency of medical education and training. We think that formal recognition will enhance the perceived value and visibility of the trainer's role, and focus attention on the time (eg in job plans) and resources needed for training.

Having a formal process will also enhance patient safety by providing well trained doctors and establishing systems to take effective action where training is poor and remediation is not sufficient.

### Our guidance on leadership and management for all doctors

Our guidance *Leadership and management for all doctors*<sup>24</sup> sets out the wider management and leadership responsibilities of all doctors in the workplace.

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\* More information is available at [www.gmc-uk.org/education/21767.asp](http://www.gmc-uk.org/education/21767.asp).

† More information is available at [www.gmc-uk.org/education/10264.asp](http://www.gmc-uk.org/education/10264.asp).

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### Generic professional capabilities\*

We are working with the Academy of Medical Royal Colleges to explore how we can strengthen doctors' training in professional and non-technical skills. To address this we are developing a framework of generic professional capabilities that will be included in all postgraduate curricula in the future.

### Our national training survey†

This survey is an important source of information on undermining and bullying through its multiple choice questions and free-text comments. For the 2015 survey, we will also be reporting on the extent to which doctors in training think their working environment is supportive.

### Improving our quality assurance

We will use the lessons we have learned from carrying out these checks to inform our visiting processes. For these checks, we worked more closely than before with other organisations, such as the Joint Committee on Surgical Training, the Royal College of Obstetricians and Gynaecologists, the Royal College of Anaesthetists and the Royal College of Midwives. This closer collaboration made the checks more effective, and our experience of this will inform our planning for other visits in the future.

### How we interact with doctors who raise concerns

We have also commissioned an independent examination‡ looking at how we deal with doctors who raise concerns in the public interest, led by Sir Anthony Hooper, a former Lord Justice of Appeal.

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\* More information is available at [www.gmc-uk.org/education/23581.asp](http://www.gmc-uk.org/education/23581.asp).

† More information is available at [www.gmc-uk.org/education/surveys.asp](http://www.gmc-uk.org/education/surveys.asp).

‡ More information is available at [www.gmc-uk.org/news/25306.asp](http://www.gmc-uk.org/news/25306.asp).

# Annex: good practice identified during the checks

## Obstetrics and gynaecology

Site	Summary
West Middlesex University Hospital NHS Trust	<ul style="list-style-type: none"> <li>■ Senior specialty doctors have autonomy in organising their rotas. This has reduced perceptions of undermining at the unit. (<i>The Trainee Doctor</i> standard 1.5)</li> <li>■ The introduction of handover between doctors in training in the obstetrics and gynaecology unit. This contributes to effective service provision and educational support and reduces the perception of undermining at the unit. (<i>The Trainee Doctor</i> standard 1.6)</li> <li>■ The obstetrics and gynaecology unit continues annual monitoring of undermining and bullying concerns through an internal survey. (<i>The Trainee Doctor</i> standard 2.3)</li> </ul>
Altnagelvin Area Hospital, Western Health and Social Care Trust	<ul style="list-style-type: none"> <li>■ The Northern Ireland Medical and Dental Training Agency education package for doctors in training which includes building resilience, accessing support and equality and diversity. This is a recent positive intervention. The consultant body recognises that this training package is necessary and has actively requested their own training on managing relationships and delivering feedback. (<i>The Trainee Doctor</i> standard 6.35)</li> </ul>
Royal Victoria Infirmary, Newcastle upon Tyne Hospitals NHS Foundation Trust	<ul style="list-style-type: none"> <li>■ Doctors in training are well supported with good supervision and excellent educational opportunities offering broad clinical exposure and experience. This is a high performing unit with a highly effective multidisciplinary team. (<i>The Trainee Doctor</i> standards 1.2, 5.1 and 6.17)</li> <li>■ The Trust's development of a professional behaviours and leadership framework integrated into the appraisal and performance system. (<i>The Trainee Doctor</i> standard 6.32)</li> <li>■ The unit's leadership team is starting to make consultants' job planning more transparent at a departmental level. (<i>The Trainee Doctor</i> standards 6.35 and 8.4)</li> </ul>
Northwick Park Hospital, North West London Hospitals NHS Trust	<ul style="list-style-type: none"> <li>■ The vision and education focus of the chief executive, director of medical education and the senior management team. We also found a constructive working relationship between the Trust and the LETB. (<i>The Trainee Doctor</i> standard 2.2, standards for deaneries 5.1)</li> <li>■ Doctors in training are very positive about the quality of experience in the obstetrics and gynaecology unit. They are well supported and supervised by consultants, midwives and the labour ward team, with excellent educational opportunities offering broad clinical exposure and experience. (<i>The Trainee Doctor</i> standards 5.1, 6.11 and 6.17)</li> </ul>
Luton and Dunstable University Hospital NHS Foundation Trust	<ul style="list-style-type: none"> <li>■ The educational case discussion meetings and subsequent handover on the labour ward provide constructive educational and reflection opportunities for doctors in training. (<i>The Trainee Doctor</i> standard 1.6)</li> </ul>

## Surgery

Site	Summary
Birmingham Children's Hospital, Birmingham Children's Hospital NHS Foundation Trust	<ul style="list-style-type: none"> <li>■ Doctors in training reported a supportive environment with a flat rather than hierarchal structure which will encourage them to raise concerns as they occur. (<i>The Trainee Doctor</i> standard 5.4)</li> <li>■ The senior management team is committed to the continuous improvement of educational experience. Following an audit of night time working, rotas were redesigned to introduce hybrid shift patterns and to implement protected sleeping time for specialty doctors in training on call. Thus the adverse effects of sleep deprivation are minimised and educational value of training is optimised. (<i>The Trainee Doctor</i> standard 2.3)</li> <li>■ The Trust has recruited overseas fellows onto research programmes and physician's associates who, we were told, have helped with the workload of doctors in training and improved continuity of patient care. (<i>The Trainee Doctor</i> standard 1.2)</li> <li>■ The Trust implemented a highly praised outreach team, the paediatric assessment, clinical intervention and education team (referred to as the PACE team), doctors in training reported that this was a team of very experienced, supportive nurses who improve service provision and enhance their learning environment when working at night and out of hours. (<i>The Trainee Doctor</i> standard 1.2)</li> </ul>
Belfast City Hospital, Belfast Health and Social Care Trust	<ul style="list-style-type: none"> <li>■ Doctors in training told us that Belfast City Hospital has a good training environment despite heavy service pressures. They value the support from consultants. (<i>The Trainee Doctor</i> standards 5.4 and 6.2)</li> <li>■ The current senior management team is perceived as listening to the clinical voice at all levels. We recognise and encourage the efforts by the senior management team to address the pressures on the rotas and cross-site working. (<i>The Trainee Doctor</i> standards 6.18 and 7.2)</li> <li>■ We have heard a number of positive examples of excellent training and teaching at all levels of surgical training. (<i>The Trainee Doctor</i> standard 5.4)</li> </ul>
Derriford Hospital, Plymouth Hospitals NHS Trust	<ul style="list-style-type: none"> <li>■ We recognise and encourage the efforts and planned actions taken by the Trust to introduce service line education leads. This is an example of a proactive initiative to improve the learning environment. (<i>The Trainee Doctor</i> standards 6.18, 6.21 and 6.34)</li> </ul>
North Devon District Hospital, Northern Devon Healthcare NHS Trust	<ul style="list-style-type: none"> <li>■ In response to notification of this visit, the Trust was proactive in addressing issues of bullying and undermining through the arrangement of a workshop for all staff within the surgical departments. Doctors in training and Consultants greatly valued this opportunity. (<i>The Trainee Doctor</i> standard 6.18)</li> </ul>
Salisbury District Hospital, Salisbury NHS Foundation Trust	<ul style="list-style-type: none"> <li>■ There was overwhelming recognition by doctors in training, the senior management team and consultants of the role that the trauma coordinators play in supporting the clinical teams and enhancing educational experience of doctors in training in the department. (<i>The Trainee Doctor</i> standard 6.10)</li> <li>■ As a result of the outcomes from the 2010 and 2011 national training surveys, the consultant body has recognised and is addressing the issues of undermining and bullying. The education lead with the support of the LETBs have worked together well to try to improve the training and education in the department. (<i>The Trainee Doctor</i> standard 2.2)</li> <li>■ The higher specialty plastic surgery doctors in training reported that they greatly value the support from consultants and the excellent range of operative opportunities in the department. We heard that plastic surgery consultants were technically excellent and passionate about patient care. We also heard that the majority of consultants are approachable and doctors in training are able to raise concerns to their supervisors. (<i>The Trainee Doctor</i> standards 5.4, 6.2 and 8.1)</li> <li>■ Doctors in training reported that the clinical governance meetings are an excellent learning opportunity. (<i>The Trainee Doctor</i> standard 5.4)</li> </ul>

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Email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org)  
Website: [www.gmc-uk.org](http://www.gmc-uk.org)  
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then  
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