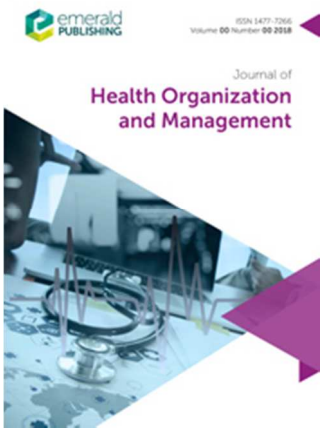

The Stopit! Programme to Reduce Bullying and Undermining Behaviour in Hospitals: Contexts, Mechanisms and Outcomes

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ABSTRACT

Purpose

The impact of bullying and undermining behaviours on the National Health Service (NHS) on costs, patient safety and retention of staff was well understood even before the Illing Report, published in 2013, that reviewed the efficacy of training interventions designed to reduce bullying and harassment in the outputs. This paper provides an example of a good programme well evaluated.

Design

The methodology follows a broad realist approach, by specifying the underling programme assumptions and intention of the designers. Three months after the event, Q sort methodology was employed to group participants into one of three contexts – mechanism – output groups. Interviews were then undertaken with members of two of these groups, to evaluate how the programme had influenced each.

Findings

Q Sort identified a typology of 3 beneficiaries from the Stopit! workshops, characterised as Professionals, Colleagues and Victims. Each group had acted upon different parts of the programme, depending chiefly upon their current and past experiences of bullying in hospitals.

Research Implications

The paper demonstrates the effectiveness of using Q sort method in a realist evaluation framework.

Practical Implications

The paper considers the effectiveness of the programme to reduce bullying, rather than teach victims to cope, and how it may be strengthened based upon the research findings and Illing recommendations.

Social Implications

Work place bullying is invariably implicated in scandals concerning poor hospital practice, poor patient outcomes and staff illness. All too frequently, the sector respondents by offering training in resilience, which though helpful, places the onus on the victim to cope rather than the employer to reduce or eliminate the practice. This paper documents and evaluates an attempt to change workplace practices to directly address bullying and undermining.

Originality / Value

The paper describes a new programme broadly consistent with Illing Report endorsements. Secondly, it illustrates a novel evaluation method that highlights rigorously the contexts, mechanisms and outcomes at the pilot stage of an intervention identifies contexts and mechanisms via factor analysis using Q Sort methodology.

Introduction

This paper is an evaluation of a small-scale intervention designed to reduce bullying and harassment in an NHS setting. The paper has two aims, firstly to bring the Stopit! programme to a wider audience. Secondly, there is novelty in that the evaluation combines realistic evaluation with Q sort method to demonstrate the effect of the programme with greater specificity that is normally the case.

The problems generated by bullying in contemporary organizations have received increasing attention in recent years (Illing et al, 2013, Buttigieg et al, Georgakopoulous, 2011). Additionally research has also been conducted into the associated issue of incivility in the workplace (Sayers et al, 2011,Porath and Pearson, 2013); often a precursor to more 'heavyweight' bullying behavior, Andersson and Pearson,1999). In addition to the harm bullying causes to individuals (Giga et al 2008, Samnani 2013) there are also wider financial costs (Indivik and Johnson, 2012,) and social costs) entailed (Gumbus and Lyons, 2011.

There is long standing research into bullying within UK hospitals. An early large scale survey showing high levels of bullying was reported by Quine et al.(1999, 2001). McAvoy and Murtagh (2003) drew attention to the danger of the role modelling of negative behaviours in medical education whilst Field (2002), the founder of the UK national workplace bullying helpline, argued that bullies were attracted to the caring professions by the opportunities available to exercise power over employees who may have a vulnerability rooted in their commitment to protect their patients. High rates of bullying have been found to have been inflicted upon junior doctors (Paice et al) psychiatric trainees Hoosen and Callaghan, (2004) and nursing students

(Ferns and Meerabeau, 2009) and even consultants who are members of the Royal College of Obstetricians and Gynecologists (Shabazz et al,2016).

Bullying behaviours have been associated with several negative outcomes for employees and their patients: such as absence; (Kivimaki et al, 2000) stress and depression; and intention to leave (Djurkovic, 2004). In a realist synthesis and consultation, Illing et al (2013) reported widespread concerns over bullying behavior and its consequences, consistent with a Chartered Institute of Personnel Development survey of over 1000 healthcare employees which found that 25 per cent of the doctors, and 33 per cent of nurses surveyed, believed that they had been bullied into acting contrary to patients' interests in the previous two years (CIPD,2013) At worse, such activities may become an accepted part of the organisational culture, contributing to atrocious standards of patient care(Francis, 2013). These findings are congruent with similar overseas research conducted in hospital environments generally, highlighting the damaging consequences of workplace bullying, for example Cashmore et al (2012) and Askew et al (2012) in Australia; Ozturk et al (2008) in the US; Malik &Farooqi (2011) in Pakistan; Matthiesen&Einarsen (2007) in Norway; and Fujishiro (2011) in the Philippines.

There is relatively little information in relation to successful anti-bullying campaigns but the zero-tolerance approach adopted in an ACT hospital in Australia, and reported by Meloni & Austin (2011) is a notable example. Additionally, Hills et al (2011) have discussed the relative effectiveness of a number of alternative workplace aggression prevention actions, once again in Australian hospital settings. That said, in spite of many initiatives throughout the sector in the UK particularly, Illing et al (2013) found only a handful of programmes that had been evaluated. What is more, many of the better evaluations relate to programmes aimed at supporting the

victim (see Stagg, 2011 for a good example) rather than addressing the bullying problem or directly deterring the perpetrator.

The Stopit! Programme

Of particular concern to a multidisciplinary team at Health Education Wessex (formerly Wessex Deanery) was the impact of bullying behaviours on trainee doctors – particularly in obstetrics. The team devised "StopIt!" a half day workshop to improve working relationships by reducing undermining; bullying and harassment behaviours and so improve the clinical and learning environment in three areas:

- Relational: improvements in the way staff interact and interpret the behaviours of others
- Institutional: improvements in policies and procedures
- Individual: improvements in self-reflection

Tools such as transactional analysis, role play, video dramas and educational games were used in the workshops to stimulate discussion and maximize participation. The various sessions within the programme as described in Table 1, included the identification of inappropriate and damaging behaviours from short video cases; the exploration of cultural differences which inform alternative behaviours; demonstrations of how to give constructive feedback; and the opportunities for participants to identify positive changes to make in their own behavior in the future.

*Table 1

These interventions were based upon a literature review and the long standing professional experience of the programme designers, and are consistent with the desirable elements of such a programme identified in the realist synthesis undertaken by Illing et al (2013) as shown in Table 2.

*Table 2

Three pilot sessions of some twelve participants each were carried out in maternity/gynecology departments since these were seen as "high risk". The programmes were run in three different trusts and offered to consultants, junior doctors, staff, various clinicians and administrators. Immediate feedback after the sessions was very positive, indicating that the various interventions had been successful in making the programme messages clear. However, the crucial test was the impact on *behaviour* months after the intervention.

Evaluation Method

The research problem was to assess the impact of the three pilot workshops on the thirty-six attendees - from diverse health backgrounds – three months after the event. Clearly with such small numbers it would be difficult to measure the central tendency of anything with confidence; even if such were desirable. Moreover, continuing the pilots until statistically significant data had been produced would run the risk of funding an expensive intervention for longer than would be justified if the evaluation were to suggest limited longer-term impact

The methodological thinking which informed the research design for this project was largely derived from Pawson & Tilley's (1997) realistic evaluation. So the focus was very clearly fixed upon how alternative workplace contexts would mediate the impact of the intervention (workshop series) to create different outcomes for different groups of healthcare professionals.

A realist evaluation seeks to answer what works, for whom and why. To do this, the evaluators identify the resources offered to a participant by an intervention or programme such as Stopit!, and construct a theory that explains the behaviour changes that this is likely to create. This theory consists in the main of three elements, the context, mechanism and outcome (CMO).

Contexts, in this instance, might be the department or section in which a participant works, whether or not they are or have been a bully, victim or neither, their own tolerance of uncivil behaviour around them and most likely, age, gender, culture, medical specialism, rank in the medical hierarchy and across hierarchies (between managers, nurses and doctors) and so on. The resources presented at the workshop sought to cover as many contexts as possible, although the potential list of such things is vast. The evaluation team captured as many of these as possible with its research instruments, but the premise of the programme focused upon the degree to which particpants face bullying, undermining and uncivil behavior in their day to day work.

Mechanisms are most easily considered as the responses to the resource in context, and in this kind of project chiefly consist of changes to reasoning and emotions of the participants. As Westhorp puts it, the mechanism is “the interaction between what the programme provides and the reasoning of its intended target population” (Westhorp, 2014 p.5). Outcomes are the behaviour changes themselves. When these mechanisms fire, that is the resource provided leads to sufficient changes to reasoning and emotions, the participant changes behaviour and it is this behavior change that is identified as the programme outcome.

Consider, for example, a resource consisting of the Human Resources director presenting an explanation of the process of making a formal complaint of bullying and undermining, and the

support available for those making such a complaint. For a participant that is not a victim, nor in an environment where such behaviour is apparent, the resource is redundant, and even if a mechanism such as greater awareness is fired, it is not obvious that there would be discernible changes to behaviour. However, perpetrator of bullying behaviours may respond by becoming more fearful that victims will complain, giving reasons to cease or reduce such actions. A victim may learn about processes and support and feel more confident about making a complaint and trust their own standing would not be undermined by instigating formal disciplinary processes again a bully. These mechanisms might lead to such outcomes as standing against a bully, in both situ and though the disciplinary procedures. Yet another victim may have already tried such a process, finding it very stressful and unproductive (Shabazz, 2016) in which case the mechanisms of confidence and trust will not fire, no complaint will be made, and it is even possible that the participant may become more embittered.

The CMO configurations for the three aims are given in Tables 3-5 below. It should be stated that this formulation was constructed by the evaluators after discussion with the programme designers. As in many such cases, there was not unanimity and these configurations consist of testable theories rather than agreed premises.

*Tables 3

* Table 4

* Table 5

The delivery of the programme was evaluated by structured and semi structured questionnaire immediately after each workshop. This questionnaire examined whether or not participants had understood the purposes of each element and sought to establish which had been most beneficial.

It was clear that the interventions succeeded in making their point, and that no single part of the programme was more beneficial than any other across the full range of participants.

The outcomes, contexts and mechanisms were evaluated by Q methodology, a technique for exploring subjective viewpoints on a participant in a controlled, rigorous way. In Q sort, participants are given a number of statements and are usually asked to sort these on the basis of how much they agree or disagree with each statement. These statements are derived from the intentions, and beliefs of programme designers. This is supported and embellished by a literature review, to both ground the views of designers in academic literature and also to identify other possible elements that might inform a participant's subjective reasoning or their emotions. As literature review was focused upon candidate reasons and emotions the review encompassed not only formal academic studies, but also publications in the grey literature, magazine and newspaper articles and other sources that are seldom captured in scholarly databases nor subject to critical peer review. The literature review, in this case, continued until no new candidate statements were derived from additional sources. The point is that the statements do not, in themselves, carry any truth claim, and hence the normal systematic and critical imperatives of a scholarly review do not apply in the creation of statements. It is the positioning of all such statements by the participant that enables the evaluator to make truth claims about the efficacy of a programme and thus each statement must capture something that might be part of the viewpoint of a respondent and does not have to be true by any external criteria of correspondence or veracity. For example, the source of statement 10, which refers to success as leading to victimization, came from a letter in a magazine with little attendant detail, but it is clear from Table 6 that it resonates somewhat with one of the three factors.

The sorting process requires the respondent to choose between alternatives rather than, say, marking each statement on a Likert scale. The usual Q convention of sorting the statements into a pseudo-normal distribution, requiring participants to place fewer statements at the extremes and more statements towards the centre was employed. Factor analysis was then applied to the resulting hierarchy of responses (Watts and Stenner, 2005). This technique correlates the data and allows statistically distinct shared perspectives to be identified. As such, Q methodology allows subjectivity (viewpoints) to be captured reliably, scientifically and experimentally.

Twelve participants completed the Q Sort that entailed sorting 34 statements. The Q sort procedure was conducted online using FlashQ.(Hacket et al, 2007).

Factor analysis was used to summarise the unique viewpoints of each individual into a smaller number of factors, which represent common or shared viewpoints. Analysis of the data was performed using PQ Method,(Schmolch and Atkinson, 2002), the software widely recommended and used by other Q practitioners. Once the scores against each statement were entered, on a participant by participant basis, correlations were calculated between sorts.

After distinctive groups of respondents were identified by the factor analysis, narratives were constructed to help describe the uniqueness of each factor (or distinctive group of participants). Post-sorting Interviews sought to confirm the legitimacy of these narratives and provide richer insights into the various viewpoints.

Results

Centroid factor analysis, followed by varimax rotation led to the emergence of three key factors, each of which loaded at least two participants and which together, accounted for eleven of the twelve in the whole group. The impact of one third of participants was thus identified, and the

solution covered 91.7% of respondents – suggesting that further respondents would load into existing groups.

This table shows the factor analysis scores for the three extracted factors against each of the sorts completed. Bold numbers indicate sorts that significantly load onto the respective factor (defining sorts).

*Table 6

Three distinctive groups of participants are derived from the factor analysis, shown in Diagram 1 below. We have named these groups 'professionals', 'colleagues' and 'victims' and plotted these in relation to the objectives of the programme.

*Diagram 1

The interpretation of each viewpoint is based on the statements with which participants most agree (+5 & +4), most disagree (-5 & -4) and those statements that distinguish the factor from other factors (based on statistical significance) which are indicated by (D). The initial interpretation is then enriched by comments that the respondent had included on their post workshop questionnaire and, where possible, interviews. Throughout each interpretation the relevant Q-sort statement and its rank are provided in parentheses and quotations from interviews are followed by the interviewee number. In the case of distinguishing statements the rank for all three factors is stated following the statement number with the rank for the current factor in bold.

The Colleagues (Factor 1)

Five participants load onto factor 1, which explains 17% of the variance.

Participants loading onto this factor were able to think of examples where bullying or inconsiderate behaviour has significantly reduced their own job satisfaction (S20; +5) reflecting their personal experience. A post-sorting interview indicated that this is not seen as an isolated, individual issue as interviewee 3 reveals:

> *I think, you know, bulling or intimidation is indigenous within the National Health and particularly, you know historically …. I trained by intimidation. That was considered the norm, particularly within the medical profession, but certainly to quite a large degree within the nursing profession.*

Members of this group also expressed concerns regarding the effectiveness of the policies and procedures to address inappropriate behavior:

> *Well my view is we are told that there is zero tolerance within the Trust …I know for a fact that bullying takes place and not an awful lot sometimes is done about it. And I have not just medical colleagues, but other colleagues that have been in a bullying situation and have not known where to go and felt that if they do report anything there will be consequences that they might not be able to deal with.*(Interviewee 1)

Following the Stopit! workshop they were less likely to accept bullying and inconsiderate behaviour as a rite of passage (S19; +5) and interviewee 3 describes how important it is for programmes such as Stopit! to raise awareness about behaviour towards others:

> *I think that it is something that we all have to be very mindful of because although most of us would be absolutely horrified to think anybody thought we were bullying them … it's a fact that your behaviour might be seen by somebody else as inappropriate*. (Interviewee 3*)*

Since the workshop they are more likely to offer support to a colleague who is a victim of bullying (S32; +4)and they are more likely to discriminate between a colleague under pressure and a bully (S16; **+4**, -3, -1(D)) which distinguishes this group from the others.

They have not considered the possibility that they are inadvertently perpetuating bullying relationships normally accepted at work (S9; -4). When reflecting on their own actions, they do not find themselves imitating roles, relationships or behaviours that could be thought of as bullying (S8; -4).The colleagues do not believe that the degree of work place bullying is overstated at the Trust (S27; **-5**, -2, -1 (D)) a view that distinguishes this factor from the other two and they do not suspect that their team is more likely to tolerate bullying and inconsiderate behaviour than other teams (S30; -5).

The Victims / Bullies (Factor 2)

Two participants load onto factor 2, which explains 10% of the variance. The two participants loading on this factor had identified themselves as both bully and victim in the sessions observed by evaluators.

This factor can identify examples where bullying or inconsiderate behaviour has significantly reduced their job satisfaction and their effectiveness at work in the past (S20; +5; S25; +4). They also suspect that their team is more likely to tolerate bullying and inconsiderate behaviour than other teams (S30; -5,+**4**, -5 (D)), which strongly distinguishes this perspective from the two others.

As a result of theStopIt! workshop they are less likely to accept bullying and inconsiderate behaviour as a rite of passage (S19; +5). However, the victims are strongly distinguished from the other factors in that the workshop did not influence the way they think about their work place

relationships and did not make them more likely to offer support to a colleague who is a victim of bullying (S26; +2, **-4**, +4 (D); S32; +4 **-5**, +3 (D)).

The workshop did not cause them to begin to reflect on how work systems and routines may inadvertently facilitate bullying (which distinguishes them from the other factors)and they do not consider themselves more aware of the misuse of systems and procedures to cause problems for a particular individual(S7; -2, **-5**, 0 (D);(S12; -4).

It is also revealing to consider the positioning of a number of reflective statements that are distinguishing statements for this factor and emphatically rejected by the two other factors. The victims moderately agree that after the workshop they recognise that some of their behaviours could be thought inconsiderate or bullying by someone with a different cultural background (S14; -2, +**3**, -1 (D)). When they reflect on their own actions, they find that they are imitating roles, relationships and behaviours that could be thought of as bullying (S8; -4, +**3**, -5 (D)) and since the workshop they have considered the possibility that they may be inadvertently perpetrating bullying relationships normally accepted at work (S9; -4, +**2**, -3 (D)).

Unfortunately, neither participant from the Victim/Bullying group consented to a follow up interview.

The Professionals (Factor 3)

Four participants load onto factor 3, which explains 13% of the variance.

The professionals felt that the StopIt! workshop had influenced the way they think about many work place relationships (S26; +4) and as a result they are more likely to take the time to repair

relationships that may have suffered during intensive or pressurized periods at work (S18; +5). Following the workshop, they are more conscious of the need to give difficult feedback without undermining a colleague (S21; +2, +1, **+5** (D), which distinguishes this perspective. When they reflect on their own actions, they do not find themselves imitating roles, relationships or behaviours that could be thought of as bullying (S8; -5) and they are distinguished from the other factors in that they are not more conscious of incidents where others might see their own style and methods as inconsiderate or bullying (S2; 0, 0, **-4**, (D)).

They reject the idea that their team is more likely to tolerate bullying and inconsiderate behaviour than other teams (S30; -5). They haven't seen colleagues subjected to systematic bullying at work (S28; -1, 0, **-4**, (D)), which is distinguishing, and think that the Trust has appropriate procedures for supporting a victim who cannot resolve their bullying problem alone (S34; +4). This was confirmed during the post-sorting interviews where one participant stated:

> *I think we have all the things in the right place. We have a policy; we have harassment and bullying advisors, so if a member of staff doesn't feel able to follow the formal route with a complaint they can seek advice from our independent people within the organisation. So I think the mechanisms are there and when complaints come to our attention we act upon them.* (Interviewee 2)

Hence, bullying is seen as an individual problem with the employer's role as being the development and maintenance of effective procedures. However recent events have led to reappraisal of this view as interviewee 4 describes:

> *The emphasis (within the NHS) is on the process rather than the person and I think that sort of thing, that sort of way of thinking can inadvertently lead to bullying. Now there may be opportunities for changes in leadership style within the NHS that could reduce the chances of bullying happening and I'm hopeful that maybe*

with the Francis Report they may actually identify that as something that caused problems in the NHS in Mid-Staffs and probably elsewhere. (Interviewee 4)

Discussion

In terms of the objectives of the Stopit! Workshops it is clear from both post workshop evaluation and Q sort that all groups took some benefit, and changed their behaviours, following the workshop. This is a somewhat unusual finding in any evaluation exercise and suggests that the StopIt! programme has considerable merit despite its relatively small scale.

Whether these changes are significant in terms of reducing the volume or impact of bullying behavior is more problematic to judge. There are clear indications that relational and personal objectives have been met. Although the aims of the programme include institutional changes, it was somewhat optimistic to hope that a small intervention delivered to disparate groups would lead to structural changes. However, feedback indicates that the issue is raised at meetings more frequently than it was previously.

What Works for Whom and Why?

A summary of the key CMO configurations of the Stopit! programme overall in shown in Table 7, In general it is not possible to isolate particular resources to particular outcomes, with the expectation of the Gross Misconduct video that provoked a strong public reaction from those in the Victim/Bullying factor.

*Table 7

The impact would seem to be deeply contextual. The key contextual features are indicated in Table 7. Programme theories outlined in Tables 3-5 show conjecture based around current levels of bullying and undermining and this is evident where levels are high (Victims / Bullies, factor 2) and low (Professionals, factor 3) but in the case of both colleagues (factor 1) and Victims / Bullies the key context past rather than current experiences of working in a bullying and undermining environment. This was particularly evident from interviews held with participants from factor 1. Perhaps this explains, in large part, the reasons why obvious structural contexts such department, medical specialty, position in and across the hierarchy etc. did not correlate with the factor that a participant loaded on to.

In the case of the Professionals group, the feeling seems to be that there is relatively little such behavior and only minor changes are thus necessary to bring about improvements. However, the prediction that raised awareness would not trigger mechanisms in this context is not born out. This awareness has lead reviews of such processes as feedback are given and the need to maintain good relationships. Members of this group would, but do not anticipate, assisting a bullied colleague, believing that institutional arrangements are satisfactory as they stand.

The Colleagues group believes that bullying and antisocial behaviours do occur, but less frequently in their departments than others. Consequently, they now pay more attention to their relationships with others and indicate a willingness to intervene should such behaviors occur.

The Victims / Bullies group see themselves as working in a department more prone to such behaviours, but their response is ambiguous. Intervention on behalf of another is rejected, perhaps it is simply the absurdity of a bully offering assistance to a victim? That said, the

mechanism of an introspective review of their own behavior may turn out to have the greatest impact of all.

Clearly the institution objectives needed greater attention. Although there is much merit in running the workshops with a mix of participants from different specialties and functions and also at different stages in their career, it carries the problem that participants are neither a critical mass in their own contexts nor, necessarily of sufficient standing to bring about change. The programme designers have made some changes to the delivery of the programme in line with general hospital strategy.

In short, the Q sort method opened up context, mechanism and output for three sub groups of participant that attended the same programme. At this point it is possible to return to the original programme design and review programme effectiveness against Illing (Table 2). Illing mechanisms- participants thinking about their behaviour and its impact on other and creating a shared understanding were achieved, but in starkly different ways. Colleagues and Professionals reject any notion that they behave in the unacceptable ways discussed in the workshop, they have acted upon their relationships and processes. The Victims / Bullies seem to have taken it personally. Mechanisms relating to interpersonal relationships are clear in , Colleagues and Professionals less so Victims / Bullies. However, all three factors reject statements concerning the structural changes implied bythe fourth mechanism. In truth, the failure to meet this objective did not surprise the programme team, who were well aware that neither the context (participants were selected from different departments and locations), duration of programme nor timescale of evaluation (3 months) were consistent with structural improvements identified elsewhere in the literature.

Conclusion

The Q-sort technique worked effectively despite the relatively small number of respondents (however there were sufficient to enable the technique to be statistically significant). Where available, interview data, corroborated and enriched the Q sort results. The relative ease of the technique suggests that it is a useful way to evaluate expensive interventions and provides an extremely robust method for identifying statistically distinct, yet holistic viewpoints.

Our two data sets enabled us to identify and confirm three distinctive groups of workshop participants each of which purported to benefit in some way from the intervention. Such benefits seemed to operate at individual, team or process level, depending upon the individual participant. Interestingly, and rather unusually, all twelve participants expressed the view that the workshop had provided some benefit. This is consistent with the immediate questionnaire feedback, completed by all attendees, which contained no suggestion that the event was not a good use of time. The Q sort results imply that these benefits were still present some three months after the event.

There is little evidence to suggest that the workshops have led to significant institutional change, perhaps unsurprising given that its pilot status and diversified trainees fall short of the "critical mass" and "seniority" mechanisms summarised by Illing et al (2013). What is more, the Professional group would have explicitly denied that such change was necessary, while the Colleagues group may well doubt that it should be such a priority given the large number of institutional changes reverberating through the NHS. The existing programme continues with

modified interventions designed to reach those better positioned to tackle the more institutional objectives.

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Resources	Deployment
Presentation from HR Director/Senior Representative	The presence of such a senior figure signified the importance of the event. Content covered legal distinctions between bullying, undermining, incivility and the Trust's position on such behaviours, the complaints procedure, and support for those making a complaint.
Cultural Role Play	Each participant was given a role that could cause communication problems for others – always answering slowly, never giving a direct answer, constant handshaking, speaking too loudly, always answering with another question etc. Participants were required to obtain specific information from a other participants playing these roles. Observation by evaluators and follow up discussion identified that many participants registered and focused on these obstructive behavioural routines. Feedback discussed the cultural underpinnings that might lead to such behaviours, and the issues that arise from misunderstandings.
Cultural Misunderstandings Case Study	A south Asian General Practitioner explained how he became isolated and vulnerable in his first post in the UK by retaining the mores and norms expected in his home country and failing to recognise when these were ineffective or created barriers. The presentation was witty but made its point extremely well. Extensive discussion led to a wider review of culture, and its impact in the multicultural NHS. Participants were assured that it was permitted to be "politically incorrect" in the discussion and the resulting perspectives were discussed. Participants also raised issues concerning cultural differences prevailing in different departments of the Trust.
Video Dramas	The Stopit team commissioned a number of dramas, performed by professional actors, to highlight key incidents. These were shown then discussed during the session. Key scenes included: *Doctor's bad day*: where a doctor behaves poorly following a series of unconnected events, but his display of ill temper is interpreted as bullying by a colleague. The colleague begins a formal complaint, but shortly afterwards the doctor apologises and explains his incivility to his colleague.

	Discussion centred around distinctions between isolated acts and systematic undermining and bullying. *Subtle Undermining*: A senior doctor undermines a junior doctor by body language, questioning all decisions and referring to alternatives practice that she claims to be normally undertaken by senior colleagues. Many participants recognised the tactics used from their own training. *Gross misconduct*: A scene depicting gross misconduct as a consultant threatens to end the career of a junior doctor. The observing evaluators saw two occasions where a participant identified themselves with both parties (victim and bully) at different stages in their careers.
Departmental Discussion	A discussion of steps that could and should be taken after the workshop in the participants section at work. Observe evaluators saw that this activity was generally lively, but that groups did not always consist of those from the same department.
Difficult Feedback Video drama: Two scenes contrasting ways of giving feedback to a junior doctor that has performed poorly. Participants discussed both the style and efficacy of the techniques. Role Play "Sticky Situations	The video scenarios were used to explain transactional analysis with participants and encourage "adult to adult" dialogue with such feedback." Participants in pairs played the roles and applied the techniques discussed.
Trainers	The workshop was delivered by the programme designers, who were respected senior figures medical and midwifery in the Trust. Participants valued this and the experience that they brought to the workshop.

Table 1 The Structure of the Stopit! Workshop

Illing mechanisms	Elements in Stopit!
Developing trainee insight into their own behaviour and its impact on others	Discussion of video dramas, exploration of cultural differences
Creating a shared understanding of acceptable / unacceptable behaviour	Discussion of video dramas, discussion of hospital policy
Developing interpersonal and conflict management skills	Role play, discussion of feedback skills, transactional analysis
Identifying local problems and causes of conflict and generating solutions	Exploration of cultural differences, review of departmental issues and first steps to change

Table 2: Illing Mechanisms and Stopit! Strategies

Institutional Objectives	Context	Mechanism	Outcome
Presentation by HR director /senior representative concerning legal and Trust definitions, and formal processes Group discussion on supporting victims based around video drama Group discussion of department level changes that could be made	No perceived bullying and undermining behaviours experienced by discussion group	Increased awareness of issue	No changes
	Isolated instances of bullying in the section or department	Shared understanding of unacceptable behaviour Common understanding of tactics and strategies to isolate bullies Commitment to support a victim formalising a complaint Ownership of agenda to review systems and processes that appear oppressive	Formidable obstacle to persistent bullying behaviour Collective responses to incidents agreed in advance Greater use of formal disciplinary processes when appropriate Section process (induction, feedback, review etc) handled in a more sensitive way
	High levels of bullying in the section	Fearfulness that supporting a victim may draw similar behaviour from bullies Bullies undermine and ridicule reforms during section discussions	No barriers raised to persistent bullying Little of no collective support for victims Little change in patterns or volume of bullying and undermining behaviour.

Table 3 CMO for Institutional Objectives

Individual Objectives	Context of participant	Mechanism	Outcome
Role plays with difficult partner Video dramas; particularly a scene of humiliation of a junior doctor by a consultant Cultural misunderstandings case study	No experience of bullying and undermining at work	Increase awareness of issue	No changes
	Working in a context where bullying occurs	Reflection on how own culture, habits and behaviours might be seen by others Recognition of patterns of bullying behaviour and victimisation Strengthening of resolve to act	Greater sensitivity in dealing with others Greater resolve in facing bullying conditions
	A bully	Revaluation of self as seem by others Shame Reflection on past bullying experiences now transferred to others	Greater circumspection

Table 4 CMO for Individual Objectives

Relational Objectives	Context for Participant	Mechanism	Outcome
Role plays Cultural misunderstandings presentation Video dramas: Difficult Feedback Role play "Sticky Situation"	Low or no levels of uncivil or bullying behaviours	Learning to distinguish between cultural discontinuities and uncooperative behaviours Consideration of own behaviours on others Seeing uncivil episodes within a longer-term relationship Greater patience in difficult relationships Disputes resolved within relationships	Difficult relationships do not escalate into bullying and undermining Disputes resolved without formal processes A more civil work environment
	Working in a context where bullying occurs	As above	Mechanisms not strong enough to change bullying environment

Table 5 CMO for Relational Objectives

		FACTOR	
STATEMENT	**1**	**2**	**3**
1. Since the StopIt workshop I am more aware of the distinction between bullying and inconsiderate behaviour at work	**1**	**-3**	**-2**
2. Since the StopIt workshop I have been more conscious of incidents when others might see my own style and methods as inconsiderate or bullying by others	**0**	**0**	**-4**
3. I am much more conscious of bullying and inconsiderate behaviours around me than I was before the StopIt. Workshop	**-1**	**-1**	**2**
4. Bullying and inconsiderate behaviour are commonplace at any workplace	**-2**	**0**	**-2**
5. The StopIt workshop has helped sensitise me to the psychological damage caused by bullying	**2**	**-4**	**0**
6. Following the StopIt, workshop I can see that some standing jokes, banter, nicknames etc. could be interpreted as bullying	**1**	**1**	**3**
7. Since the StopIt workshop I have begun to reflect on how work systems and routines may inadvertently facilitate bullying	**-2**	**-5**	**0**
8. When I reflect on my own actions, I find I am imitating roles, relationships or behaviours that could be thought of as bullying	**-4**	**3**	**-5**
9. Since the StopIt workshop , I have considered the possibility that I am inadvertently perpetuating bullying relationships normally accepted at work	**-4**	**2**	**-3**
10. Following the StopIt workshop , I can think of examples of a victim attracting bullying behaviour by being too successful	**-3**	**2**	**-3**
11. Following the StopIt , workshop I can think of examples of a victim attracting bullying behaviour because of weak social skills	**-3**	**-2**	**1**
12. Following the StopIt workshop I am more aware of the misuse of systems and procedures to cause problems for a particular individual	**0**	**-4**	**-3**
13. Since the StopIt workshop I am more sensitive to the possibility that a difficult work relationship I have might be due to different cultural backgrounds and expectations	**0**	**0**	**0**
14. Since the StopIt workshop I see that some of my behaviours could be thought inconsiderate or bullying by someone from a different cultural background	**-2**	**3**	**-1**
15. Since the StopIt workshop I have made a greater effort to empathise with colleagues carrying different cultural	**-1**	**2**	**1**

expectations			
16. After the StopIt workshop , I am more likely to discriminate between a colleague under pressure and a bully	**4**	**-3**	**-1**
17. The StopIt workshop signals that the Trust is not prepared to accept the damage caused by bullying	**3**	**-1**	**1**
18. After the StopIt workshop I am more likely to take the time to repair relationships that may have suffered during intensive periods or episodes at work	**3**	**0**	**5**
19. After the StopIt workshop I am less likely to accept bullying and inconsiderate behaviour as a rite of passage	**5**	**5**	**-2**
20. I can think of examples where bullying or inconsiderate behaviour has significantly reduced my job satisfaction	**5**	**5**	**-1**
21. Since the StopIt workshop I am more conscious of the need to give difficult feedback without undermining a colleague	**2**	**1**	**5**
22. Since the StopIt workshop I am more mindful of techniques that enable me to give difficult feedback without bullying or undermining behaviours	**1**	**-1**	**1**
23. Since the StopIt workshop I have made significant improvements to the way I give difficult feedback	**0**	**0**	**0**
24. Since the StopIt workshop I am more likely to receive constructive but critical feedback more professionally	**-1**	**-1**	**0**
25. My effectiveness at work has been reduced by bullying or inconsiderate behaviour in the past	**3**	**4**	**0**
26. The StopIt workshop has influenced the way I think about many work place relationships	**2**	**-4**	**4**
27. The degree of work place bullying is overstated at the Trust	**-5**	**-2**	**-1**
28. I have seen colleagues subjected to systematic bullying at work	**-1**	**0**	**-4**
29. I can think of current examples where inconsiderate or bullying behaviour reduces the effectiveness of the team	**-3**	**1**	**3**
30. I suspect that my team is more likely to tolerate bullying and inconsiderate behaviour than other teams	**-5**	**4**	**-5**
31. After the StopIt workshop I am less likely to accept being bullied	**0**	**-2**	**2**
32. After the StopIt workshop I am more likely to offer support to a colleague who is a victim of bullying	**4**	**-5**	**3**
33. After the StopIt workshop I am confident that the Trust	**0**	**1**	**2**

would take a sympathetic approach to someone alleging bullying behaviour			
34. I think that the Trust has appropriate procedures for supporting a victim who cannot resolve their bullying problem alone	**1**	**2**	**4**

Table 6 Statements and Factor Distributions, Colleagues (Factor 1), Victims / Bullies (Factor 2) and Professionals (Factor 3)

	Colleague	Victim/ Bully	Professional
Organisational Context	Little bullying in own department but exists elsewhere (statement 30). Rejects the notion that the incidence of bullying is overstated in the Trust (statement 27)	More than "average" bullying in own department (statement 30)	Limited experience of bullying at work (statements 28, 30) but some inconsiderate behaviour (statements 6,29)
Individual Context	Job satisfaction and effectiveness undermined by bullying behaviour in the past (statements 5,20)	Job satisfaction and effectiveness undermined by bullying behaviour in the past (statements 5,20)	Neutral on effects of being bullied at work. Have not seen colleagues systematically bullied (statement 28)
Locus of behaviour change	Team	Individual	Process
Key mechanisms	Resolution about tackling bullying and undermining (statements 16, 17, 19, 27, 32)	Reflects upon own behaviours and accepts the possibility that they may be perpetuating abusive relationships (statements 8,9,10,14)	Raised awareness of bullying and undermining (statements 3,6, 26)
Key Outcomes	Will support bullied colleagues (statement 32), and more conscious of need to maintain good relationships after stressful events (statement 18). Will stand against bullying as rite of passage (statement 19)	Will stand against bullying as rite of passage (statement 19)	Reflection on key relationships and feedback processes (statements 4,21) Would support a bullied colleague if this were necessary (statements 32,34)

Table 7 What Works for Whom and Why

Diagram 1 Particpants by Programme Obectives