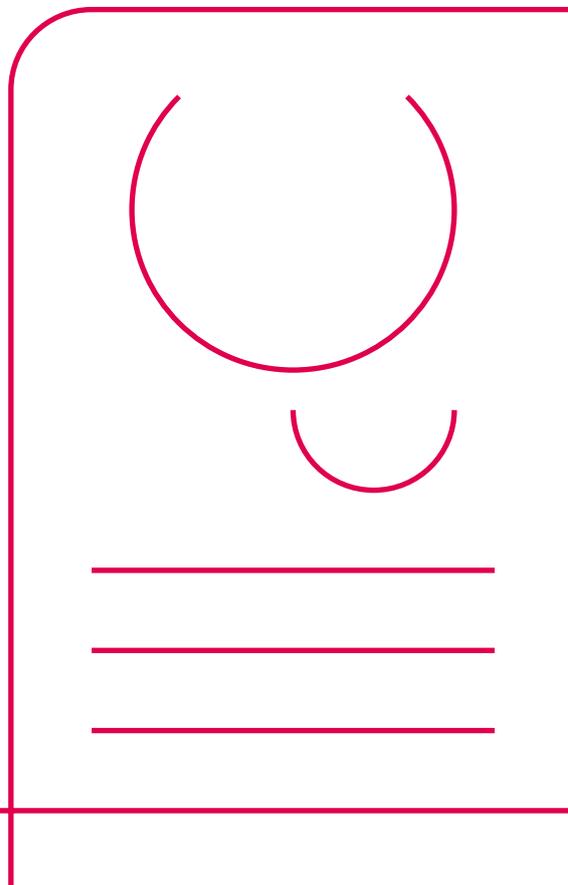


September 2016

AoMRC
Trainee
Doctors'
Group

Creating supportive environments

Tackling behaviours that undermine a culture of safety



Executive summary

This interim report by the Academy of Medical Royal Colleges' Trainee Doctors' Group (ATDG) explores bullying and undermining within the medical workforce in the UK. It looks at current efforts to tackle problems and what further work is required.

The ATDG wants to tackle this behaviour at a systems level by leading initiatives that will create supportive environments and bring about a change in medical culture for doctors in training.

There is increasing evidence that bullying and undermining is bad for patient safety. Sir Robert Francis QC's report following the Mid Staffordshire NHS Foundation Trust Public Inquiry and Dr Bill Kirkup's report into failures of care at Morecambe Bay NHS Foundation Trust in 2015 found the extent of bullying and undermining cultures in tandem with unusually poor patient outcomes.

Bullying and undermining also damages the wellbeing of those involved. It is not conducive to high quality training and does not help recruitment and retention of staff. In addition, it can affect the patient's experience of care and increase costs. It damages the reputation of medical specialties and the wider NHS.

In many countries, undermining and bullying in medical education and training is endemic. Some senior doctors think humiliation is not only acceptable, but helpful to the learning process. In fact, those who feel bullied have less confidence in their clinical skills. In the 2015 General Medical Council (GMC) National Training Survey, 7% of doctors in training felt they had been bullied or harassed themselves 13% reported having witnessed such behaviour, while 17% felt significantly undermined by a senior colleague.

The Academy of Medical Royal Colleges Trainee Doctors' Group (ATDG) organised a one-day seminar in collaboration with the General Medical Council to share examples of good practice and inspire new initiatives. Held on 28 September 2015, delegates included representatives from medical royal colleges and faculties, Deaneries, Local Education and Training Boards, NHS Employers, patient and lay representatives, trainers, and doctors in training. This report summarises the discussion from the seminar.

A number of themes emerged during the event. It was recognised that there has been substantial cultural change within medicine over recent decades. However, to promote a culture of safety and good quality of care, the health system must act to address behaviours that threaten the performance of the healthcare team. Factors identified as predisposing to bullying and undermining were dysfunctional leadership, division within teams and steep hierarchies.

Recommendations

- **Medical royal colleges, faculties and Local Education and Training Boards must work together to share good practice across clinical specialties and geographical areas.** This will include educating doctors in training and trainers to raise awareness of unacceptable behaviour and supporting both groups to enhance the training environment.
- **Creating effective clinical teams.** This should be an aspiration for all clinical environments. A shift towards activities that 'normalise' proactive attempts to promote good workplace behaviour must be an active process, and employers must support time for such work.
- **The ATDG propose to pool experience, skills and funding to work towards common goals.** A group set up within the Academy, drawing on the experience of senior healthcare professionals, patient and lay representatives, and led by the ATDG, should work with organisations to stimulate change.

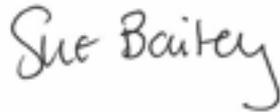
Foreword

Undermining and bullying in any form and in any working environment is wrong and should not be tolerated. That it is so self-evidently prevalent in healthcare, where lives are at stake and the quality of care can be so influenced by the way doctors, nurses and allied healthcare professionals are treated by their colleagues must be of great concern to us all.

For this reason I have been wholly supportive of the work carried out so commendably by the Academy of Medical Royal Colleges Trainee Doctors' Group. The progress outlined in this update makes an unarguable case for more to be done. Understanding the scale of the problem is only the beginning. We must do far more to tackle the phenomenon itself and the root causes that lead to undermining and bullying being in some way normalised or viewed as acceptable.

I would particularly like to thank Dr Jude Harrison and Dr Vicki Mason for leading on this work for the Academy Trainee Doctors' Group as well as Dr Jon Bailey, Chair of the ATDG for stewarding the work so effectively and indeed to his predecessor Dr Gethin Pugh who was in many ways responsible for its inception.

The Academy of Medical Royal Colleges (the Academy) should now play its part in facilitating further work to ensure the recommendations are acted upon.



Professor Dame Sue Bailey OBE
Chair, Academy of Medical Royal Colleges

An old problem

Undermining and bullying behaviours are ‘traditional’¹ in medical education and training.

They pervade the practice of medicine in many countries.^{2,3,4,5,6,7} In the UK, most senior clinicians and medical educators provide excellent training and work hard to ensure that all those they work with feel supported and valued. However, it seems that less helpful attitudes persist in some quarters. Medical students and doctors in training report that some seniors think humiliation is not only acceptable, but helpful to the learning process.^{8,9,10,11} The evidence does not support this. In fact, students who feel bullied have lower confidence in their clinical skills.⁹ Students can, and have reported being subjected to bullying and undermining in their first experience of clinical settings.¹²

Why is this important?

Teamwork, communication, and a co-operative work environment are essential for the delivery of safe, good quality patient care.¹³ Equally, bullying and undermining within medical teams is bad for patient safety.^{10,14,15,16} It is damaging to the health and wellbeing of those involved¹⁷ and it is not conducive to high quality training^{10,18} or staff retention.^{2,19} It can also negatively affect the patient's experience of care¹⁴ and increase the cost of treatment.^{20,15} It damages the reputation of the profession and of the NHS as a whole.

The Francis' report 2013 highlighted the extent of bullying in the Mid Staffordshire NHS Foundation Trust.²¹ Similarly, the Kirkup report²² of the Morecambe Bay investigation in 2015 identified significant tribalism within inter-professional groups and undermining of individuals. Therefore, to promote a culture of safety and good quality of care, the health service must act to address behaviours that threaten the performance of the healthcare team.

What is meant by bullying and undermining?

Bullying and undermining behaviours are complex. They range from subtle to overt, and can present in many different ways. Definitions of undermining and bullying vary, different terms are used in the literature and behaviours are often difficult to measure objectively. Moreover, they are often defined in terms of the feelings of those on the receiving end, and so understanding different people's perceptions of behaviour is very important.

In the GMC National Training Survey, undermining and bullying are defined as follows:

- *‘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’¹⁰*

This interim report uses the definitions as described above by the GMC.

How common is it?

In the GMC 2015 National Training Survey, seven per cent of doctors in training felt they had been bullied or harassed themselves. Thirteen per cent reported having witnessed someone else experiencing these behaviours²³ and 17% had experienced undermining. Previous surveys reported even higher rates of bullying.^{18,24}

Why focus on doctors in training?

Workplace bullying affects staff of all professional backgrounds throughout the healthcare system according to the 2014 NHS staff survey.²⁵ Bullying is commonly reported within nursing,²⁶ particularly by junior nurses or nursing students.²⁷ Other healthcare professions, such as midwifery,²⁸ report similar problems. Staff from different professional backgrounds often feel victimised or undermined by each other.²⁰

The Value of the Doctor in Training: A Charter for Postgraduate Medical Training,²⁹ affirms that high quality training is essential to produce doctors capable of practicing autonomously and providing high quality care. Cultures of bullying and undermining impede this learning process.^{8,9,10}

Leadership is inherent to the doctor's role, as outlined in the 2008 Consensus Statement on the Role of the Doctor:

'Doctors...must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty'.³⁰

Therefore it is important that all doctors in training learn the constituent parts of supportive environments. As doctors in training move regularly, they are ideally placed to reflect on departmental and organisational cultures. They can be supported to raise concerns about clinical care and training, and empowered to work to ameliorate them. On the other hand, doctors training in an unsupportive environment can become habituated to poor workplace behaviour. Worse still, they can engender unhelpful attitudes among future generations of medical professionals. Thus, understanding how doctors in training perceive such perverse behaviours is an important issue for medical training and the wider working environment.

Beyond healthcare

Sectors which require team-working and high-stakes decisions commonly report problems with bullying and undermining. For example, a report from the UK College of Policing in 2015³¹ has warned of a '*bullying, arrogant, macho*' culture within British police forces, where whistleblowing is frowned upon and cases of racism and sexism are rife. It described the '*wrong kinds*' of values that stemmed historically from a command-and-control style of management and the toleration of bullying within a '*boys' club*' culture. Interpersonal misconduct cases involving senior officers frequently involve bullying. A quote from the report describes how officers become habituated to bullying:

'I formed the view over many years of close involvement with police... that you emerge from training school and all your way up to chief superintendent by degree, which is largely down to what posts you have and your character and who else is around, you are bullied. You then go on the [Strategic] Command Course. You succeed on the Command Course. You get your first chief officer appointment and you suddenly wake up and think, 'I can be the bully'... The bullying still continues because, of course, the chief will be bullying the ACCs, but it's lesser at that level than it is back down the chain. So one of the underlying factors for me about what happens specifically with chief officers is this sudden new dawn, 'Oh I can do this, I can do that in a way I couldn't when I was a ranked officer'. [Stakeholder and S/IO]³¹

The British Armed Forces has had similar problems with cultures of bullying and undermining. It considers it highly damaging to the operational effectiveness of teams, and the reputation of the Armed Forces and Ministry of Defence (MoD). They have produced some of the most unequivocal guidance in the area:

'1.4. It is MoD policy that all Service and civilian personnel, regardless of rank or grade, have a right to be treated with dignity, and a responsibility to do all they can to ensure that the working environment is free from all forms of harassment and that the dignity of others is respected.'

All personnel must therefore:

- a. ensure that their own conduct does not amount to harassment;
- b. have the moral courage to challenge inappropriate behaviour;
- c. be prepared to support those who experience or witness harassment; and,
- d. report harassment against themselves or others.³²

The report also spells out that 'having a bullying and/or harassment complaint made within their command is not a sign of failure; the failure is not taking appropriate and timely action.' However, in the police, armed forces and in medicine there is evidence of underreporting and a preparedness to overlook such behaviour.

A culture of silence

The GMC produced a report on undermining and bullying in 2015.¹⁰ It identified various barriers to reporting undermining and bullying, including the belief that nothing will be done about the problem, or fear of the consequences of raising it. Anecdotally, junior doctors worry that it will inhibit their career. It could either become harder to attain evidence needed to progress in training, or more difficult to get a consultant job when deemed to be a 'trouble maker'. Also, doctors may fear they will be perceived as weak for complaining that the training environment is unsupportive. Doctors often report being unsure who to report bullying to, and generally have a little awareness of employment law.

A BMA report on bullying found that a culture of secrecy within the NHS may prevent people from speaking out, and that under-reporting might mask the real extent of the problem.¹⁹

“Don’t ever say anything because it’ll never work out well for you – ever. You say to yourself: ‘It might be the right thing to do, but it’s not the right thing to do for me’”

A trainee representative at the Creating Supportive Environments event

There is evidence that medical students are less likely to report feeling bullied and undermined than nursing students.¹² Doctors who feel bullied and undermined at work may be less likely to voice concerns about patient safety, for fear of the consequences they may suffer. This was addressed by the *Freedom to Speak Up* review³³ which looked at whistleblowing in the NHS. It supported the findings of other high profile reports. It clearly identified the need for cultural change around bullying and undermining and inter-professional working in the interests of patient safety.

What did the ATDG do?

The ATDG arranged a one-day seminar, developed in collaboration with the GMC.

It aimed to gather people with experience in this area from different perspectives to participate in the seminar and to take part in focused discussion workshops. Delegates included representatives from Colleges, Faculties, Deaneries & Local Education and Training Boards, NHS Employers, lay representatives, trainers and doctors in training. A wide spectrum of medical professionals were present, including foundation doctors, speciality trainees and senior consultants with specific educational responsibilities. The format of the day comprised a number of relevant presentations followed by small group discussions.

The key objectives were:

- To share examples of good practice
- To inspire innovative new approaches in tackling such problems.

What follows are the findings of the discussions of a highly complex set of issues around bullying and undermining in medicine. It presents the attendees' perceptions of poor workplace behaviour, rather than an objective assessment. However, the delegates were well-placed to inform the debate and provide a qualitative snapshot of unsupportive environments. The scale and nature of problems described were commensurate with reports in the GMC National Training Survey.

Current initiatives

All major healthcare organisations have operational policies on bullying and harassment. Many bodies are going further, developing novel initiatives designed to engender supportive environments and encourage those who feel bullied and undermined, or who witness problems, to speak up. The ATDG asked organisations to submit details of any relevant initiatives/activities that are on-going or planned in advance of the meeting, and many were discussed during the event.

Dealing with Problems

Addressing allegations of bullying and undermining is difficult. There is more than one side to every story. The perceptions of all parties must be explored sensitively. There are some specific challenges. For example, feedback given to a struggling doctor may be perceived as bullying and undermining. Also, international medical graduates may experience more problems with bullying: as a result, some Colleges are addressing the specific needs of this group.³⁴ Those required to conduct such investigations, usually the hospital Directors of Medical Education, need advice and support.

Individual departments approached bullying and undermining in different ways. Examples of departmental interventions were discussed, including:

- Internal anonymous internal surveys to capture details of behaviour on the ground
- Departmental away days: perceptions can be explored in an informal and anonymous way away from the clinical environment



- STOPIT and TrACE³⁵ style courses: these externally led courses are designed to increase awareness of perverse behaviours and encourage more positive interactions
- Additional 'Train the Trainers' workshops: extra training for educational and clinical supervisors, particularly in how to give feedback
- Engagement with Deanery/LETB and GMC processes
- Mediation between staff in conflict
- Mentors: mentorship programmes can help to guide and support individuals. (This can be particularly useful at times of transition in roles and responsibilities)
- Refer those affected to professional support bodies
- Schwartz rounds: meetings which encourage all healthcare staff across an organisation to reflect on the emotional aspects of their work
- Regular meetings between senior management and junior staff to allow issues to be addressed in both directions
- Employing a consultant with one programmed activity for medical education, to focus on improving teaching and training, and with a pastoral role
- Encouraging engagement in management and leadership.

Efforts to promote good workplace behaviour, and employers' supporting time for such work, tend to be reactive and restricted to areas where there have already been problems with bullying and undermining. Proactive efforts to create supportive environments and effective clinical teams are less common. The table below summarises the reactive and proactive interventions currently used as identified by the delegates at the Creating Supportive Environments event.

Reactive Interventions	Proactive Interventions
GMC National Training Survey follow-up	Trainee forums and regular surveys
Quality panels	Regular senior management & junior staff meetings
Monitoring visits	Mentoring
Referral to professional support bodies	Schwartz rounds & safety huddles
Human Resources procedures	GMC, College & Faculty guidance
Mediation between those in conflict	Departmental away days, 'Trainer/Manager of the month'
STOPIT and TrACE style courses	Resilience training

Discussion around case vignettes

Case vignettes based on real-life trainees' reports were used in the seminar to focus discussions to what interventions could make a difference. The case vignettes can be found in the appendix.

What predisposes to unsupportive environments?

Dysfunctional leadership

Leadership at all levels is crucial to creating supportive environments. Transformational, exemplary leaders who create a sense of shared purpose and engage staff were identified as protective. Pace-setting, coercive leaders and frequent leadership changes were felt to be detrimental. It was recognised that leaders at all levels had to be able to model the care and compassion they wished staff to show to patients and to each other. Leaders were also required to demonstrate sensitive and effective methods for addressing poor performance.

"Most of the undermining behaviour that I've come across is unintentional. No one gets out of bed saying to themselves: 'I'm going to make some people feel bullied and undermined today'"

A delegate at the Creating Supportive Environments event

Steep hierarchies

Steep hierarchies can give rise to feelings of intimidation which can impair communication, especially on difficult matters, such as raising concerns about patient safety. It was acknowledged that most behaviours that made people feel undermined were unintentional. Marked hierarchies may magnify the impact of relatively slight behaviours or comments if those affected are less able to voice how it made them feel. Certain specialities appear to have steeper hierarchies than others. Some delegates felt that there was a relationship between steeper hierarchies and greater reported problems with bullying and undermining. On the other hand, it was recognised that hierarchies have both generational and cultural dimensions. Those who are older may have different expectations of their relationship with junior colleagues. People from other cultural backgrounds may place a greater or lesser emphasis on showing deference to elders, for example, in use of formal or informal modes of address. These considerations should be balanced alongside the need to for all healthcare professionals be approachable and to treat all their colleagues with respect.

Divided teams and strained working relationships

Cohesive teams enable supportive environments, whereas bullying and undermining are associated with divisions and tribalism. There was discussion of the effect of modern rotas and working patterns which may involve significant time away from the team. Combined with staff shortages and high staff turn-over, it presents a challenge to developing team dynamics. However, it was noted that using deliberate 'teaming' interventions, such as Schwartz rounds and safety huddles, the ethos of team can be created more quickly. In any team activity, knowing the names of fellow team members is a huge advantage. Anonymity is universally associated with poor behaviour. The social media campaign #hellomynameis, developed by the late Dr Kate Granger, highlighted how staff often forgot or did not feel the need to introduce themselves to patients and colleagues.

Strong working relationships, characterised by good communication and mutual understanding, are protective. The relationship between the doctor in training and the supervisor was felt to be of crucial importance for learning. A strong supervisory relationship is supportive, and can provide a safe space for reflection and advice. It allows the supervisor to model behaviour and facilitates feedback in both directions. Antagonistic supervisory relationships can lead both parties to feel isolated.

Organisational pressures

Pressures within the organisation, such as large, top-down service changes, merges and closures, restructuring, high demand for services and staff shortages can cause stress on teams. This could lead to a sense of disempowerment and learned helplessness, making perverse behaviour more likely. However, effective leadership can ameliorate the effect of these pressures.

Organisational cultures

Organisational culture is a unifying theme. It was discussed at length during the event with respect to clinical teams, hospitals and professional groups. It was recognised that there has been gradual but substantial cultural change within medicine over recent decades. However, action is required, not only to address bullying and undermining, but to promote good workplace behaviours, create effective clinical teams and supportive environments that can enhance the safety and effectiveness of the healthcare team.

Individual characteristics

The strengths and weakness of a person determine their experience of the environment. Factors such as level of experience, personality traits, resilience, private life stresses and professional and social support networks all play a part. An individual's awareness of what behaviours may make others feel undermined and bullied is important. Mentoring, counselling, coaching, resilience training and awareness courses could all be helpful to individuals. From the perspective of the doctor in training, a good understanding of the educational landscape, including sources of advice and support, is also helpful.

The way forward

Bullying and undermining in medicine reflect a highly complex set of issues. Leadership, hierarchies and teams have a large impact on the supportiveness of the environment.

Organisational pressures can magnify cultural problems, which often do not bring out the best in people. At the event it emerged that individuals, teams and organisations are able to identify where there are problems, but do not always feel equipped to address them. It also became apparent that activities aimed at creating supportive environments are largely reactive to problems, rather than proactive, preventative strategies. However, there are a number of different organisations who have an interest in creating supportive environments. A multi-faceted approach from all agencies is required to tackle behaviours which undermine a culture of safety. Willingness to work toward such cultural change has never been greater.

Recommendations

The discussions of the seminar produced many strategies and suggestions of areas for improvement. The recommendations are made alongside potential initiatives that could be developed for each. The ATDG wish to take these recommendations forward in a second phase of work, engaging with stakeholders to further define specific initiatives to be taken forward.

1.

Medical Royal Colleges, Faculties and Local Education and Training Boards must work together to spread good practice across clinical specialities and geographical areas.

This will include educating doctors in training and trainers to raise awareness of unacceptable behaviour and supporting both groups to enhance the training environment. For example, the Royal College of Obstetricians and Gynaecologists are attempting to tackle unsupportive environments through a 'Workplace Behaviour Champions' programme. **Similar initiatives should be rolled out across all Colleges and Faculties.**

The Conference of Postgraduate Medical Deans (CoPMED), Health Education England and the Deaneries deal with problems arising from unsupportive environments. In some areas, there is trainee representation and opportunities for trainee-led projects within local training organisations. These raise awareness of the educational landscape and sources of support amongst doctors in training. **All LETBs and Deaneries should have this representative structure.** Some LETBs and Deaneries operate regular surveys that enhance communication with doctors in training. These must be expanded into all specialties and all areas. To have maximal benefit they should be trainee-led, regional and specialty-specific.

2.

Creating effective clinical teams should be an aspiration for all clinical environments.

A shift towards activities that 'normalise' proactive attempts to promote good workplace behaviour must be an active process, and employers must support time for such work.

The GMC Generic Professional Capabilities framework, currently in development, looks at the broader human qualities required to provide excellent patient care, such as being able to communicate effectively, to work as part of or lead a team. **The ATDG would like to work with the GMC to promote these new standards.**

During the event, the issue of training in giving and eliciting feedback arose. The Academy is already working on improving feedback. The GMC's *Recognition and Approval of Trainers* programme seeks to ensure that all medical trainers are valued. Feedback from trainees could be used in the approval process of trainers to demonstrate their suitability for the role, helping to 'normalise' feedback in all directions.

NHS Trusts and Health Boards, represented by NHS Employers, have a pivotal role in creating supportive environments. The ATDG would like to use these networks to promote strategies which proactively develop the ethos clinical teams and good workplace behaviour, for example Schwartz rounds, safety huddles and team/individual prizes for behaviour and attitudes. The aim is to make promotion of good behaviour and team spirit normal.

As demonstrated by the #hellomynameis campaign, using names is important for relationships with patients and colleagues. **The ATDG would like to work with NHS Employers to encourage NHS organisations to develop minimum standards for easily readable and conspicuous name badges.**

3. The ATDG propose to pool experience, skills and funding to work towards a common goal.

The Academy represents all medical royal colleges and faculties and has relationships with the other organisations who have an interest in creating supportive environments. A group set up within the Academy, drawing on the experience of senior healthcare professionals, patient and lay representatives, and led by the ATDG, should work with organisations to stimulate change.

Conclusion

By any measure, behaviour that undermines a culture of safety is a serious issue in medicine.

Bullying and undermining of any member of the workforce, whether overt or covert, risks jeopardising patient safety in the first instance, but more than this, can lead to lower staff morale and create a more general climate of staff feeling undervalued. As this interim report shows, this is already too prevalent among trainee doctors. If we are to avoid the systemic and long-term problems that follow cultures where undermining and bullying are tolerated, we must take a proactive approach to prevention. Put simply, we cannot look the other way if we witness poor behaviour or tolerate it if we are the victim of it. What is needed is a whole systems approach to promoting effective clinical teams and supportive behaviour, whilst introducing zero-tolerance for undermining and bullying. The detail of that approach and the process of implementation were beyond the scope of the work outlined here. The next steps must surely be to set out a clear templates for fostering positive workplace behaviour and best practice in eradicating bullying and undermining. Institutions and individuals who do not stick to those principles or uphold those values must then be called to account.

Acknowledgements

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With thanks and acknowledgement to all members serving on the ATDG
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Appendix

Case vignettes

Case 1

'The post involved many radiology requests and on several occasions the juniors were afraid to attend the radiology department to discuss a request with the radiology consultant depending who was on as they have experienced being shouted at, insulted or told to 'go away', so they asked me to go, and I often experienced undermining from one particular radiology consultant – on one occasion the consultant refused my request for an urgent CT scan as he was in the middle of a conversation. I find it concerning when juniors feel afraid to conduct their duties and have to screen which consultant is on before arranging vital patient tests and delaying their management.'

Case 2

'I have approached my clinical supervisor about this matter who said explicitly that 'this is not bullying because she does it to everyone'. However, I do feel the need to mention it because I have felt an adverse effect upon my training. With one consultant in my placement I experienced a lot of negative commentary on my work and got 'told off' for things that were completely out with my control and even occurred when I wasn't at work. There has been a lot of low level undermining and criticism of every decision that I tried to make whether it had sound clinical grounds or not. She would ask me for an update on her patients, interrupt and stop me before I had finished and then be annoyed that I hadn't given her enough information. My confidence has been affected, and I dreaded going into work when she was doing a ward round that day. I felt like the only reason I was joining her on ward round was so that she had someone to vent her frustrations at when things had not happened the way she wanted them to. This may not be bullying but it has affected my ability to progress and learn in this post and I am mentioning it because it has been significant in my development. I feel like her behaviour towards me was unnecessarily negative and not encouraging for a young doctor in training.'

Case 3

'Sometimes other senior healthcare professionals, nurses for example, can be very pushy in their approach when they want something done, which the junior doctor does not feel comfortable with or agree with e.g. discharges. Even if you express a thought-out opinion they will bypass you and continue with their own agenda without taking into consideration your view point. It can feel as if your voice doesn't matter even though you have more responsibility for the patient than they do and it is not within their job specification to make such decisions. I witnessed a trainee being reduced to tears after being shouted at by a senior nurse after they didn't feel able to discharge someone. This occurred in front of medical and nursing staff, patients and relatives during a busy day shift in the department.'

Case 4

'I emailed a consultant concerned about changes to registrar working patterns which had not followed the appropriate channels. I never received a reply from the consultant in question. The consultant did not approach me and talk to me about my concerns. I heard through colleagues that said consultant did not like the e-mail I'd sent. The consultant has given me strange looks in the department and tried not to make eye contact with me for over three months. This made me feel uncomfortable in the department and led to me avoiding them. The consultant became the College Tutor at my training site. I did not feel that I could approach this consultant with any concerns in their new capacity as College Tutor given how said consultant was behaving towards me. I felt isolated and ostracised. I heard from colleagues the consultant was 'disappointed' in me because of the email I had sent raising concerns. As a trainee with little power, it is easy to be made to feel helpless and victimised by those who are in positions of power.'

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