SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 51 – Volume 3

Sir Robert Francis' Response to Direction 5 Questions & Associated Documentation

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Scottish Hospitals Inquiry

SIR ROBERT FRANCIS KC – RESPONSE TO DIRECTION 5 QUESTIONS
Submitted on: 1 September 2025

1. INTRODUCTION

1.1. I am Sir Robert Francis KC. I was instructed on behalf of the Chair of the Inquiry to prepare a report advising the Inquiry on various questions posed to me concerning the standards to be expected in the treatment of whistleblowers and the concerns they raise in the context of a newly built hospital or a hospital department in Scotland. I submitted that report on 14 July 2025.[1]

1.2. I have now been asked three questions arising out of comments and requests made by core participants:

1.2.1. *With respect to the treatment of whistleblowers following the raising of a concern***:**
Would you accept that it is unfortunate that a whistle-blower may feel required to leave their job? Does this carry any implication as to whether those whose actions have prompted the whistle-blow may remain in post? In practice, what sort of support for a whistleblower to remain in post ought to be available?

1.2.2. *With respect to the issue of hierarchical relationships in a hospital setting: In a hospital setting, how should a whistle-blowing policy take account of risks arising from the presence of staff hierarchies and workplace power dynamics?*

1.2.3. *With respect to ensuring that efforts are appropriately targeted:*
Please advise on appropriate steps to keep focus on safety; is there a risk that concerns may be wrongly interpreted as matters of personal grievance, and if so, how should that be guarded against?

1.3. I have reminded myself again of the duties of an expert witness. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

1.4. I have read the substantive Core Participants Direction 5 Responses to my report[2] and note that the above questions appear to originate from the response of Drs Peter, Inkster and Redding. I also note that they requested I answer a number of other questions, but these are not within my instructions and therefore I will not offer answers to them.

[1] A53278019 – Bundle 51, Volume 1, Document 1, Page 3.
[2] A53880785 – Bundle 51, Volume 2.

1.5. That said, I perceive it is part of an expert's duty to consider whether there has been any change of circumstances or evidence which affect any opinion the expert has previously expressed. In that context I note that the doctors have drawn the Inquiry's attention to the report of Grant Thornton UK LLP for the Department of Business and Trade, *Understanding the Effectiveness of the Whistleblowing Framework in Great Britain*.[3] This was published on 14 July 2025, after the completion of my initial report. However I referred to the review, commissioned by the previous UK Government in 2023, of which the Grant Thornton report is the outcome.[4] At various points in my report I pointed to evidence that the principles supporting freedom to speak up and protection of whistleblowers were far from being effectively applied everywhere. From a necessarily brief perusal of the lengthy and detailed Grant Thorton report it appears to support the tenor of my own report for this Inquiry. It lists the many recommendations for improvement in this area which were offered in the evidence received. At the time of writing, it is not clear whether the present Government will seek to implement any of them.

2. *With respect to the treatment of whistleblowers following the raising of a concern*:

2.1. *Would you accept that it is unfortunate that a whistle-blower may feel required to leave their job?*
Without repeating the legal and cultural principles identified in my initial report, it is clearly unacceptable for any whistleblower who has raised a genuinely held concern, particularly one relevant to patient safety, to feel forced to leave their employment, if this has been caused by victimisation or other unacceptable conduct in the workplace or by the employers because they have raised the concern. In certain circumstances such conduct will amount to unlawful discrimination and/or constructive dismissal. Further, any incidence of employees feeling they have to leave their job after raising a concern is likely to deter others from raising their concerns. A culture in which staff maintain a low profile is encouraged.

2.2. *Does this carry any implication as to whether those whose actions have prompted the whistle-blow may remain in post?*
Whether there is such an implication is entirely dependent on the facts of the case and the surrounding circumstances. In my initial report I said that bullying, abuse, discrimination and oppression in the context of the treatment of whistleblowers –

cannot be tolerated at any level of the organisation and must be called out. It needs to be recognised as a safety issue and treated as potentially a serious disciplinary. matter. There should be no room in an organisation for those who persistently behave in an unacceptable manner.[5]

[3] A53783927 – Bundle 51, Volume 2, Document 1, Page 5, para 2.6.
[4] A53278019 – Bundle 51, Volume 1, Document 1, Page 43, para 4.6.2.
[5] A53278019 – Bundle 51, Volume 1, Document 1, Page 55, para 6.6.

Those observations were intended to apply to anyone in an organisation behaving in such a manner, whether in a formal leadership position or merely a colleague of the whistleblower. The implication is that where any such person has behaved in such a manner as to lead to the whistleblower feeling they have to leave their employment, disciplinary processes and their continued employment should be considered. This is an area in which the principles of accountability described in my initial report apply.[6] On the other hand if the whistleblower feels they should leave for reasons not associated with such conduct, for example through embarrassment or disagreement with an employer's response to the issue raised in the concern, this implication would not be justified.

2.3. *In practice, what sort of support for a whistleblower to remain in post ought to be available?*

In many cases raising a concern, particularly where it might be perceived as a criticism of the competence or probity of colleagues or more senior and powerful figures, will cause a whistleblower stress, anxiety and even fear, whether or not these emotions are caused or exacerbated by the conduct of others. Many whistleblowers will feel isolated because they act alone and may have no support from colleagues. Tension and stress may arise from disagreement about the merits of the concern raised or uncertainty about the procedures to be followed or the outcomes of any decision-making process. If the raising of concerns is to be genuinely valued by an employer, risks such as these need to be recognised and mitigations identified. I suggest that the following measures are ways in which the whistleblower can be supported, and if implemented sensitively will reduce the risk that they will leave the or jobs:

2.3.1. <u>Investigation of the concern:</u> I have already emphasised[7] the importance of concerns raised by staff being investigated and acted on. The investigation needs to be conducted in a way that has the confidence of the staff member raising the concern as well as the organisation and staff generally. My report addresses the requirements for an effective, fair and proportionate investigation. In the context of mitigating the risk of the whistleblower leaving their employment, the process of investigation needs to be explained to and understood by the whistleblower who should be consulted on the scope of the investigation where this is practicable. The outcome of the investigation needs to be demonstrably based on evidence and reasoned conclusions. Where there is conflicting evidence, the reasons for preferring one version need to be spelt out. Where the conclusion of the investigation is that the concern is not established the reasons for that must be also set out clearly and explained to the whistleblower. In serious cases raising patient safety issues there should be a review process if reasonably required by the whistleblower. Confidentiality should rarely be a reason for not offering a reasoned decision to the whistleblower.

[6] A53278019 – Bundle 51, Volume 1, Document 1, Page 58, para 6.12.
[7] A53278019 – Bundle 51, Volume 1, Document 1, Page 56, para 6.7.

2.3.2. A variety of sources of personal and confidential support: in addition to the availability of Speak Up Guardians or their equivalent, organisations should ensure that line managers are personally supportive of the whistleblower and recognise the sensitivity of their position. They need to be alert to and stop adverse behaviours among colleagues and to encourage the whistleblower to report any concerns about the behaviours of others. Similar support might need to be offered to staff members to whom the concern raised relates as well. The need for this should be explained to the whistleblower who will need to be assured that this does not imply any disapproval of them.

2.3.3. Counselling and occupational health: Principle 11 of the Freedom to Speak Up Review recommended that whistleblowers should be provided with ready access to mentoring, advocacy, advice and counselling.[8] While it should not be presumed that a whistleblower will require such services, they should be available, and the whistleblower made aware of them. It is important that the employer does not give the impression, whether or not intentionally, that the raising the concern suggests the whistleblower suffers from a mental or psychological issue.

2.3.4. Mediation and conciliation: in my report for the Freedom to Speak Up Review my recommended 9th principle was that[9]

Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

The recommended action was that
all NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to
a. Address unresolved disputes between staff and between staff and management as a result of or associated with a report raising a concern.
b. Repair trust and build constructive relationships.

While all the recommendations were supported by systems leaders in principle,[10] I am not aware that mediation and conciliation techniques have become recognised tools in this area. For example NHS England's Freedom to Speak Up Guidance published in 2022 makes no reference to them, apart from a brief mention of ACAS.[11] Some aspects of conciliation and mediation are perhaps inherent in the role of the Speak Up Guardians, but I suggest that more is required to resolve the sometimes deep conflicts that arise from a whistleblower's report. Mediation or other forms of conflict resolution could prevent at least some discontented or distressed whistleblowers leaving their employment.

[8] A53278019 – Bundle 51, Volume 1, Document 1, Page 203, para 11.
[9] Ibid, para 9.
[10] A53981692 – Bundle 51, Volume 3, Document 2, Page 10.
[11] A53981691– Bundle 51, Volume 3, Document 3, Page 11; A53981693 – Bundle 51, Volume 3, Document 4, Page 22.

2.3.5. Support to find alternative employment: In cases where a whistleblower has felt compelled to leave their employment because they have raised a concern in good faith, I consider that reasonable and proportionate steps should be taken by the employer to assist them in finding alternative employment. This is so whether or not that perceived need to leave is induced by discrimination or other unacceptable conduct. I expressed regret that the NHS appeared to have moved away from offering such support, while recognising the challenges inherent in its provision.[12] I suggest that the existence of such support, particularly if the system developed a track record of success, might persuade some otherwise concerned and distressed whistleblower to try to stay in their current employment.

3. ***With respect to the issue of hierarchical relationships in a hospital setting****: In a hospital setting, how should a whistle-blowing policy take account of risks arising from the presence of staff hierarchies and workplace power dynamics?*

3.1. While there are likely to be multiple barriers to speaking up, there is research evidence to support the suggestion that hierarchies of the type traditionally associated with clinical settings can inhibit the willingness of staff to challenge those senior to them. To quote a relatively recent and extensive literature review:[13]

Negative hierarchical culture features heavily in these studies. The large power discrepancies ingrained in the medicine culture may adversely affect 'low power' members' perception regarding the ease of speaking up. Consequently, this may inhibit productive communication. The characterisation of fear and intimidation perceived by junior members of the team gives insight into how a negative hierarchical culture can adversely impact patient safety, trainee learning, and team function. Without a clear and compelling reason to offer one's views in a supportive environment, the effort and risk involved with speaking gup make it unlikely to happen, even without large power differentials.

While the literature studied here appears to have mainly focussed on the relationship between nurses, trainee doctors and their clinical and professional superiors, hospital settings clearly have other hierarchies such as those involving corporate leaders, clinical directors, and other staff. Thus even consultants can find themselves at the lower end of some hierarchies or power structures.

3.2. The risks of hierarchical and power based deterrents hindering the ability or willingness of staff to speak up need to be countered. Cultural approaches to this issue were considered in my initial report including clarity of leadership, role modelling, openness and transparency, positive encouragement to raise and listen to concerns and demonstrable action taken in response to speaking up. Above all a demonstrable intolerance of oppressive behaviour is vital.

[12] A53278019 – Bundle 51, Volume 1, Document 1, Page 40, para 4.6.1.12.
[13] A53981690 – Bundle 51, Volume 3, Document 5, Page 29.

3.3. I would add one further measure – training. In my initial report I commended the value of training in how to speak up and how to receive reports of concerns. Such training should ideally be experiential. The study referred to above found suggestions in the literature that such training increased the incidence of staff speaking up, but noted that the effect seemed to fade with time. This suggests that such training needs to be repeated and refreshed. This might be considered to be particularly important where, as in most clinical contexts, the individual's place in the hierarchy will change as their career progresses, and indeed their place of employment changes.

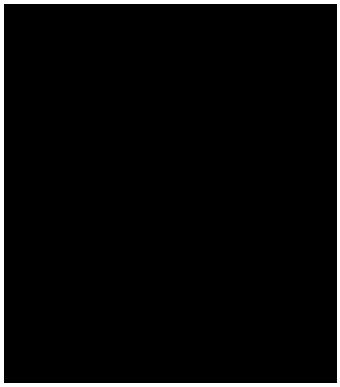
4. *With respect to ensuring that efforts are appropriately targeted: Please advise on appropriate steps to keep focus on safety; is there a risk that concerns may be wrongly interpreted as matters of personal grievance, and if so, how should that be guarded against?*

The risk here is not so much that a concern is interpreted – rightly or wrongly – as a matter of personal grievance, but that this results in a failure to investigate the reported concern. Many concerns arise in circumstances in which personal relationships between the professionals involved have broken down. Animosity or worse may motivate some reports of concerns. That does not mean that the concern is not objectively justifiable and relevant to patient safety. It is all too easy for purported disclosures to be written off as being matters of personal grievance. That is most likely to happen if the recipient of the report assumes that because of a possible ulterior motive, the concern is not real. That is one reason why it is so important to ensure concerns that appear to be relevant to patient safety – or other matters of comparable importance in the public interest – are investigated impartially, objectively and proportionately, by reference to the content of the concern rather than the personalities involved. While motivation may be relevant in assessing the credibility of conflicting accounts this should never detract from the need to establish the facts fand to search for verifiable evidence. Dismissing a concern relevant to safety on the ground of a suspected or even proven ulterior motive is never justifiable. Any leader finding that has occurred should require a review by a different – and impartial - investigator. I should add that the importance of establishing the objective facts relevant to safety does not necessarily mean that no action needs to be taken to improve negative relationships and personality issues. These themselves can, if sufficiently toxic, give rise to safety issues. There is research evidence suggesting that bullying, shouting and other symptoms of negative relationships can at least temporarily affect professionals' cognitive abilities and performance at work.[14]

5. STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.

[14] A53981694 – Bundle 51, Volume 3, Document 6, Page 41.



SIGNED [SIGNED ELECTRONICALLY]

DATE 29 AUGUST 2025

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11 February 2015

NHS Managers
NHS Foundation Trusts

Dear colleague,

As you will know, the recommendations of “Freedom to Speak Up”, the review commissioned by the Secretary of State and chaired by Sir Robert Francis QC, were published today. The purpose of the review has been to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. The review followed on from the Public Inquiry, also chaired by Sir Robert, into the Mid Staffordshire NHS Foundation Trust which exposed unacceptable levels of patient care and a staff culture that deterred staff from raising concerns.

Alongside our system partners, we at Monitor have given our support in principle to the recommendations of the review.

The importance of listening to staff cannot be over emphasised. When staff raise concerns, they very often know where things are not working well and when care is not safe, so they can help enormously in improving and ensuring acceptable levels of patient care. This is vital. It is also, of course, core to the work we do at Monitor in our mission to make the health sector work better for patients.

I am writing to you today as managers in the NHS to emphasise both the overall importance of the Freedom to Speak Up review and the importance of you as managers ensuring that all of your staff are made fully aware of the expectation that they will come forward, speak up and raise any concerns, and that they know how to do this outside their line manager relationship if necessary. If at all possible I would encourage you to speak to each of them face-to-face.

I’m sure you will join me in thanking Sir Robert for his work on this review and in hoping that it proves a cultural turning point in the NHS so that flagging up problems, risks and mistakes as they occur - and learning from them to improve patient care - becomes the norm.

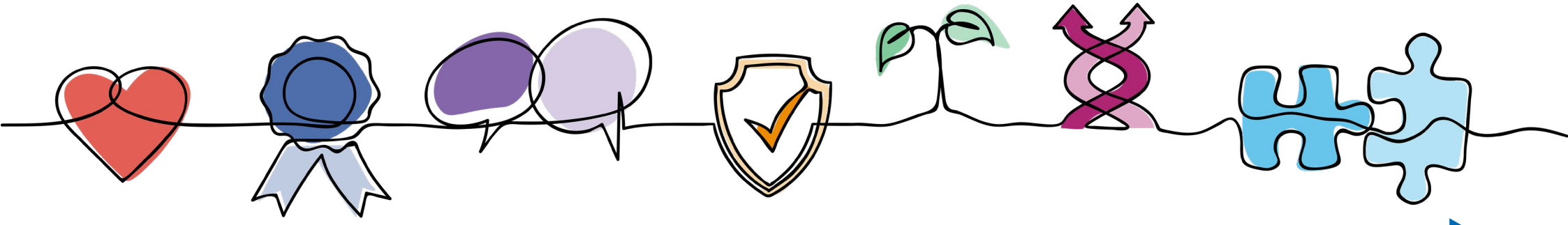
Yours sincerely

David Bennett

Chief Executive, Monitor

Freedom to Speak Up policy for the NHS

Version 2, June 2022.



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Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

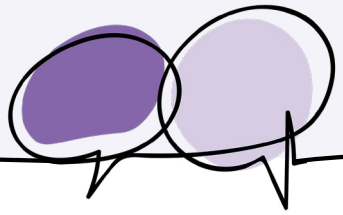
We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos



This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) [list of relevant links to local policy/process documents]. That's fine. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

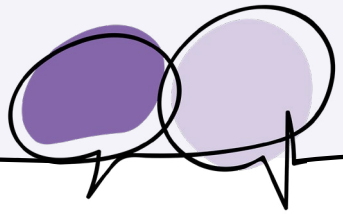
Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and depending on the size of the organisation you work in (some of the options set out below will only be available in larger organisations).

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) [include local contact details].
- Our HR team [include contact details].
- Our Freedom to Speak Up Guardian [insert name(s) and contacts details], who can support you to speak up if you feel unable to do so by other routes. [Include explanation of the status of the guardian if they sit outside your organisation and/or are shared with other organisations.] The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Local counter fraud team (where concerns relate to fraud) [include local contact details].
- Our senior lead responsible for Freedom to Speak Up [insert name and contact details] - they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up [insert name and contact details – this role is specific to organisations with boards and can provides more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed].



Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

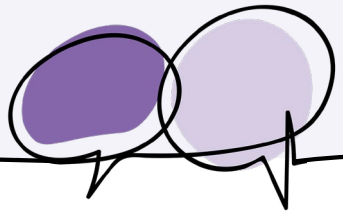
NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.



How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

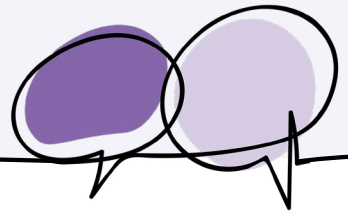
Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.



Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix A.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

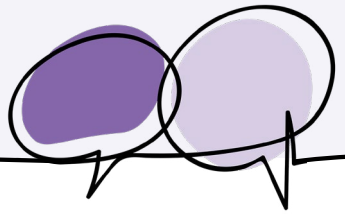
Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.



Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

•

Help you identify the options for resolution

•

Signpost you to health and wellbeing support

•

Confirm what information you have provided consent to share

•

Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

•

Referral to HR process (where approprate)

•

Referral to patient safety process (where approprate)

•

Other type of appropriate investigation, mediation, etc

Outcomes:

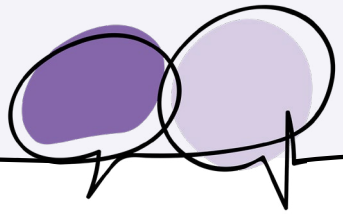
The outcomes will be shared with you wherever possible, along with learning and improvement identified

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

•

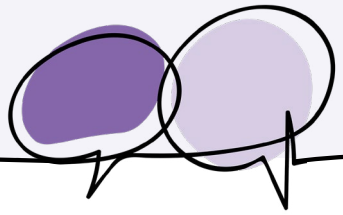
Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England



Appendix B:
Making a protected disclosure

Making a ‘protected disclosure’

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.



Transformation Directorate

This guidance has been reviewed by the Health and Care Information Governance Working Group, including the Information Commissioner's Office (ICO) and National Data Guardian (NDG).

Have we done a good job? Let us know.

Freedom to Speak Up

21 May 2025

Individual rights | Sharing with colleagues | Confidentiality

Freedom to Speak Up (FTSU) is about encouraging a positive culture where people feel they can speak up, their voices are heard, and their concerns acted upon. This guidance helps patients and staff of NHS organisations understand the FTSU process and FTSU guardians and information governance professionals (IG) to manage information raised in a safe and appropriate way.

Guidance for patients and service users

There are several ways NHS staff can raise concerns within their organisation. One of these ways is known as FTSU. The aim of speaking up is to improve patient safety and make the workplace better for NHS staff.

This is different to the way patients can raise concerns. Guidance on how to complain to the NHS is on the NHS website.

FTSU guardians

Each NHS organisation has an FTSU guardian. The guardian is someone NHS staff can speak to about any concerns they have. The guardian may be:

- a member of staff in the same NHS organisation, or
- someone from another NHS organisation, or
- someone who is paid to be a guardian but does not work in the NHS

Social care organisations do not have FTSU guardians, but these organisations should make sure there are other ways their staff can raise concerns.

Information shared with FTSU guardians

Members of staff should only share enough information to allow the guardian to look into their concern. This might include information about the way another member of staff is treating you.

In most cases, staff will not need to share personal information about you with the guardian. However, if you are at risk of serious harm, staff may need to share information such as your name or where you are receiving care, so the guardian can make sure the NHS organisation protects you.

FTSU guardians should not look at patient records as part of their role as a guardian. Their role is to pass on any concerns to the right person, or to follow the correct processes to allow them to be explored.

If your personal information needs to be used as part of an inquiry for example the UK COVID-19 inquiry, this is different. You can find out more about this by reading our guidance on inquiries, investigations and court orders.

Guidance for healthcare workers

FTSU guardians

Within NHS organisations there are several ways that staff can choose to 'speak up' or raise concerns. One way is through FTSU guardians.

The role of the FTSU guardian was created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). In England, all NHS organisations and other organisations who provide NHS healthcare services in primary or secondary care are required to appoint an FTSU guardian. This includes NHS trusts, GP practices, as well as dental surgeries, opticians and pharmacies providing NHS services.

FTSU guardians may be based within your organisation, or they may be appointed to cover a number of organisations, for example, all GPs within a local area may partner to appoint one FTSU guardian to cover them all.

Raising concerns

Your organisation will have their own procedures and processes, so you should familiarise yourself with your local arrangements. You can also find more information on speaking up in the national FTSU policy.

The most important aspect of anyone speaking up is the information they can provide, not their identity. Therefore, if you are speaking up you have the option to do so in any of the following ways:

- **openly**: the FTSU guardian knows your identity and you are happy that they can share it with anyone else involved in responding
- **confidentially**: you reveal your identity to the guardian on the condition that they will not share this further without your consent, unless there are exceptional circumstances (see guidance for **IG professionals – disclosures without consent** section below)
- **anonymously**: you do not want to reveal your identity to anyone. Organisations should provide methods for individuals to report concerns anonymously, such as through online forms

Patient confidentiality

If your concern involves a patient, you should share the minimum amount of information necessary to allow the guardian to follow up, in order to protect patient confidentiality. In most cases, this will mean providing information about the nature of your concern without sharing information that directly identifies the patient.

If patient information is required by the guardian, you should not rely on the implied consent of the patient. This is because FTSU guardians are not directly involved in the care of patients therefore a patient is unlikely to have a reasonable expectation that their information will be shared with a guardian.

In exceptional circumstances, you may share patient information without breaching confidentiality where the disclosure can be justified in the public interest, for example, to protect individuals from serious harm or crime. In these cases, you should still only provide information which is relevant to the concern.

Guardians will guide you in these conversations and let you know what information they need to take a concern forward. While it is important to keep patient confidentiality in mind, as long as you are acting in good faith and the best interest of the patient, you will not be penalised for sharing information with a guardian.

Information shared by FTSU guardians

Other parts of your organisation

Guardians may need to share information about your concern within your organisation to allow for this to be investigated or resolved.

For example:

- if the concern is about the conduct of another member of staff, the guardian may need to share information about the individual's conduct with their line manager or HR
- if the concern involves clinical or patient safety aspects, the guardian may need to escalate this and share information about your concern with a medical director, or as part of a patient safety investigation
- guardians may need to report to senior management or boards about the types of cases they are handling

Other guardians

Your organisation may have multiple guardians who share caseloads or cover each other in case of annual leave or sickness. This may include using a joint mailbox. Where information about your case is shared amongst guardians, they should inform you of this.

Sharing cases with FTSU networks

Guardians may wish to share case details among local networks of FTSU guardians for joint learning. They should only use anonymous data. If there is a risk that you can be identified (for example, due to small numbers of staff in the clinical department which the case relates to) or the unique context of the scenario, then your consent must be obtained. This is the case even if a situation is known to others (for example, a high-profile case or where there is media attention).

Where there is a safeguarding concern

In exceptional cases, information may be shared with a guardian which indicates there is an immediate risk of serious harm to another person. In these cases, the guardian may need to share the information they have about the concern with the police or other bodies to safeguard a person at risk.

If the concern has not been reported anonymously, they may need to share information about the person who reported it, in order for the appropriate body (for example, the police) to follow up and gather more information. The guardian should inform the person raising the concern if this is the case.

Where you are the subject of a concern

If someone raises a concern about you to an FTSU guardian, they would typically share information such as your name, your job role and the nature of the concern.

The guardian may share this information further within the organisation to allow the concern to be addressed, for example by sharing details of the concern with your line manager for it to be investigated.

Guardians do not need consent to share information about the subject of a concern, as this would prejudice their ability to appropriately manage concerns (see **Legal basis under UK GDPR** section below for further information).

Your organisation's Privacy Notice, or information they provide to staff about the FTSU service, should detail how your information would be used in the event of an FTSU concern being raised about you.

Guidance for IG professionals

Legal basis under UK GDPR

The lawful basis for use of personal information as part of the FTSU process is:

- Article 6 1 (e) - Public task/official authority

It may be necessary for an FTSU guardian to process special category data, for example where a concern is raised about the behaviour towards an ethnic minority colleague. In these circumstances, the lawful basis should be assessed on a case-by-case basis. The most likely to apply are:

- Article 9 2 (b) - Employment
- Article 9 2 (h) - Health and social care; or
- Article 9 2 (i) - Public health

To rely on one of these lawful bases, you must be able to demonstrate that processing the special category data is necessary. Please see ICO guidance for further information.

Confidentiality of those speaking up

The confidentiality of those who speak up should be respected, subject to the need to ensure that people are protected from serious harm (see below).

FTSU guardians should be supported to maintain the confidentiality of those reporting concerns to them, ensuring they do not share details of cases outside of the bounds of their agreements with the individuals they are supporting.

Disclosures without consent

In exceptional circumstances it may be necessary to make a disclosure without consent. For example:

- where there is an immediate risk of serious harm to a patient, worker or member of the public
- where it is required by law, for example:
  - there is a court order requiring you to release information
  - you have information that would assist police in preventing an act of terrorism or help in apprehending or prosecuting a terrorist (in line with the Terrorism Act 1989 and Terrorism Act 2000)
  - you are asked for information that might identify a driver who is alleged to have committed an offence under the Road Traffic Act 1988
  - you have information that suggests that a girl under the age of 18 has been subject to genital mutilation (in line with the Female Genital Mutilation Act 2003)

A decision to make a disclosure without consent must be taken on a case-by-case basis. Where possible, this should be discussed with the person who reported the concern and the minimum amount of information needed should be shared.

Guardians may seek support from their Caldicott Guardians, Data Protection Officers (DPO) or more senior FTSU guardians to determine whether sharing information without consent is in the public interest.

You should support guardians to ensure that they fully document any decision to disclose information without consent.

Confidentiality of patients

While it will usually be possible for staff to raise concerns with guardians without sharing information which identifies patients, this may be considered necessary in some exceptional circumstances, such as where a member of staff is putting a patient at risk.

When information about patients is shared beyond those with a legitimate relationship with the patient, explicit consent is usually required in order to satisfy confidentiality. However, staff may be supported to share patient information with guardians without breaching confidentiality where the disclosure can be justified in the public interest, for example, to protect individuals from serious harm or crime.

If a person raising a concern shares patient information with a guardian, and this does not meet the threshold for a disclosure in the public interest, guardians should be advised not to record any patient information and only share information onwards which does not identify the patient, in order to protect their confidentiality.

Transparency

Transparency is key to maintaining confidentiality and trust in the FTSU process.

In order to ensure transparency, organisations should:

- provide information about the FTSU process, including any associated information sharing and confidentiality considerations in your staff and public privacy notice, intranet or service specific material
- ensure that when an individual is sharing a concern, they are advised how their information will be used, including the exceptional circumstances that may apply to disclosing their identity where there is an expectation of privacy
- consider how FTSU guardians can best keep the people they are supporting informed of developments including any changes in plans to share information
- ensure that the use of joint or shared mailboxes is sufficiently clear to employees where it is possible that more than one guardian would access concerns reported to that mailbox
- ensure that in cases of annual leave, sickness or a change of guardian, the person who raised the concern consents to the sharing of their case with another guardian. For further guidance on handing over cases see the National Guardian's Office guidance on Starting Out and Stepping Down

Records management

IT systems should be set up to ensure that only FTSU guardians can access information relating to cases. Care should be taken when recording the details of the individual who reported the concern, and no patient details should be collected or recorded.

When recording information on FTSU cases, the guardian should only record the minimum amount of information necessary for their purposes.

The National Guardian's Office requires FTSU guardians to record details about all of the concerns that are raised with them. Organisations must ensure that they provide methods for guardians to do so securely. Consider whether concerns will be recorded on an incident management or risk management system, and what controls should be applied, for example limiting access to only the relevant FTSU guardian.

Records of FTSU cases are considered to be 'complaint records'. In line with the NHS Records Management Code of Practice, the retention period for records relating to complaints is a minimum of 10 years, at which point the records should be reviewed to see if there is a need to retain them further or not. If an FTSU guardian is leaving, records should be handed over to the new guardian and retained electronically for the appropriate retention period. If these records contain staff information, consent should be sought to share the information with the new guardian, or they should be anonymised before they are passed on.

Guardians should be encouraged to manage their emails in line with the above and not to use email systems to file complaint information, but to instead transfer appropriate information to approved systems for retention.

Reporting

FTSU guardians are required to report to the National Guardian's Office each quarter. Internal reports will be required (for example, by boards).

It may be helpful for information governance professionals to provide guardians with additional support and guidance during these

reporting periods to ensure that information is appropriately anonymised, and confidentiality is maintained.

For further advice on both recording and reporting cases, guardians should refer to the Recording Cases and Reporting Data Guidance from the National Guardian's Office.

Subject Access Requests

It is common for subjects of a concern/complaint to request copies of information about them under a Subject Access Request (SAR). It should be clear to individuals who make an SAR that only their personal information is disclosed. The identity of the individual who reported the concern will be withheld including any information likely to identify the individual. Where a statement is held but releasing it would disclose personal data, even with redactions, a summary may be provided instead. Please see our SAR guidance for further information on managing and responding to Subject Access Requests.

Further information

Freedom to Speak Up policy for the NHS

The Francis Report: 'Freedom to speak up' (2015).

National Guardian's Office Guidance

Speaking Up – General Medical Council ethical advice

BJA

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Review Article

QUALITY AND PATIENT SAFETY

Challenging authority and speaking up in the operating room environment: a narrative synthesis

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Abstract

Multidisciplinary care teams exist throughout healthcare systems. In the operating room (OR), effective communication between teams is essential, especially during crisis situations where patient safety can be in acute danger. An often-neglected skillset in educational curriculums is challenging authority. This narrative synthesis aims to explore the literature on challenging authority in the OR environment. A systematic search of Medline, EBM reviews and PsycINFO was conducted using terms related to challenging authority, speaking up, communication, patient safety, gradients and hierarchy. The initial search identified 4822 publications, out of which 31 studies were included. The data synthesis of the included studies was grouped into three distinct categories following a meta-aggregative approach: discussion and review articles, observational or qualitative studies, and studies identifying the role of specific barriers or investigating the effect of educational interventions. Themes emerging from expert beliefs, what reality tells us and what we test are consistent. Hierarchy, organisational culture and education are the most frequently observed and tested themes. Simulation research has been successful in eliciting and confirming the role of specific barriers to speaking up. Barriers and enablers are largely modifiable within institutions however, education regarding the importance of speaking up will need to accompany these modifications for any significant changes to occur.

Keywords: assertiveness; hierarchy; operating room; patient safety

Editor's key points

- The authors examined the literature on speaking up in the operating theatre environment using narrative synthesis.
- They demonstrate emerging themes from the literature consistent with our intuitive understanding – hierarchy gradients, organisational culture, and education are the most frequently observed factors affecting ability to challenge authority.
- Barriers and enablers to speaking up are largely modifiable.
- Promoting speaking up within health teams requires organisations to cultivate a culture of open, safe communication, accompanied by education regarding the importance of speaking up.

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Effective communication is an essential part of successful teamwork. Teams in the operating room (OR) are multidisciplinary and consist of perioperative nurses, surgeons, anaesthetists, and respiratory therapists of varying seniority. Effective collaboration within teams and between specialties is critical, especially during crisis situations to facilitate a safe outcome for the patient. Communication breakdown can have grave consequences on patient safety and has been described as the most important cause for patient morbidity and mortality.[1,2] Furthermore, a study examining communication in the OR categorised 30% of all communication events as failures, a third of which constituted a risk to patient safety.[3]

An often-overlooked competency in educational curriculums is the skill set required to challenge authority. The infamous case of Elaine Bromiley, a healthy young woman who died after a 'can't intubate can't oxygenate' situation illustrates the importance of effectively challenging authority. Two experienced consultant anaesthetists and an ENT (ear, nose, and throat) surgeon repeatedly tried and failed to secure her airway. During these attempts, members of the nursing team recognised the gravity of the situation and even realised that a tracheostomy was needed but were unable speak up effectively, despite bringing the required equipment into the room.[4]

Crew Resource Management originated from the observation of interactions between pilots in the cockpit. Analysis of black box recordings found repeated instances of junior pilots trying to challenge the captain in high acuity situations but doing so in an oblique way. This led to their suggestions being ignored by the senior team member, resulting in adverse events. Crew Resource Management was designed to optimise training in non-technical skills to ensure flight safety. One of these skills is the ability to effectively challenge authority.[4] These competencies are translatable to the OR environment, which resembles the flight deck in many aspects. Like aviation, it is a high acuity environment in which hierarchy is deeply engrained. The term 'crisis resource management' (CRM) was initially adopted by anaesthetic teams to refer to the non-technical skills required for effective teamwork in a crisis situation. This led to the development of full immersive simulations that we are familiar with today. Since then, many other specialties have incorporated CRM into their training.

Research on speaking up in the hierarchical environment of the OR is a relatively new concept.[5] The majority of research on the subject uses self-reporting methods and only recently has simulation been used to examine this concept.[6–8] Qualitative research using surveys and interviews offers insight into trainees' perception of hierarchy in the OR and perceived barriers and enablers.[7,9–13] Moreover, studies using simulation to explore these concepts have revealed a significant educational gap in the training given to juniors around effectively challenging authority.[14–18]

Despite the importance of challenging authority and speaking up for patient safety, it remains a difficult task for those of 'low power' in the OR environment. The barriers to challenging authority are multifactorial. Among many, these include: a hierarchical climate, a superior's interpersonal communication skill, gender differences, and a lack of adequate training in voicing concerns.[8,12,16–18] Enablers to speaking up include teaching interventions, evidence that speaking up results in meaningful changes, and anonymised reporting mechanisms.[8,16]

This narrative synthesis aims to explore the literature on challenging authority in the OR environment. Specifically, it examines the identification of modifiable barriers, the effectiveness of educational interventions on the ability to speak up, and enablers to challenging authority.

Methods

Three authors (AM, NP, SV) conducted a comprehensive search of the electronic bibliographic databases MEDLINE, EBM reviews, and Psycinfo. The search strategy aimed to identify evidence in published studies regarding challenging authority in the OR environment. The study selection considered narrative, qualitative, and quantitative studies that sought to identify barriers and enablers to speaking up in the OR environment teams including perioperative nurses, surgeons, anaesthetists, respiratory therapists, and any other member of the theatre team whether trainee or consultant. Both free-text and medical subject headings (MeSH) terms were used, including: authority; challenging authority; speaking up; communication; patient safety; gradients and hierarchy; perioperative team; advocacy–inquiry. Reference lists from identified studies and journals which appeared to be associated with the most retrieved citations were then handsearched. The flow diagram in Figure 1 illustrates the search strategy.

The search was limited to English language only, but not to place or year of publication, and all types of study design were included.[19] The included studies were assessed using a standardised critical appraisal instrument [Qualitative Assessment Review Instrument tool (QARI)].[20] It comprises 10 criteria for appraisal, and rather than exclusively relate to the validity or bias in the methods, it pursues to establish the nature and appropriateness of the methodological approach, specific methods, and the representation of the voices or meanings of study participants (Appendix 1).

In the qualitative synthesis, the data extraction from the included studies was carried out using meta-aggregation, which combines findings of individual studies in a way that is analogous to meta-analysis.[20] The meta-aggregative approach is sensitive to the practicality and usability of the authors' findings, and it does not necessarily seek to re-interpret those findings. Therefore we explored and divided the qualitative evidence into three distinct categories according to the study design and themes. These categories convey the whole and inclusive meaning of a group of similar findings. We used the 'Enhancing transparency in reporting the synthesis of qualitative research: the ENTREQ statement'[21] to guide conducting and reporting of this review, and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement to illustrate the search strategy.[19]

Results

The literature search was performed in October 2017. The search strategy found a total of 4822 citations which were screened for eligibility assessment by two authors (AM and SV). A total of 353 were selected, and after duplicates were removed and abstracts screened 132 articles were left. The remaining 132 articles were independently reviewed by two authors (AM and NP), whereas disagreements were recorded and resolved by a third independent author (ZF), leaving 37 full-text articles to be assessed for final eligibility. Six articles were excluded after full text analysis for not meeting inclusion criteria (Fig. 1). The final number of articles included in qualitative narrative synthesis was 31 (Table 1). The level of

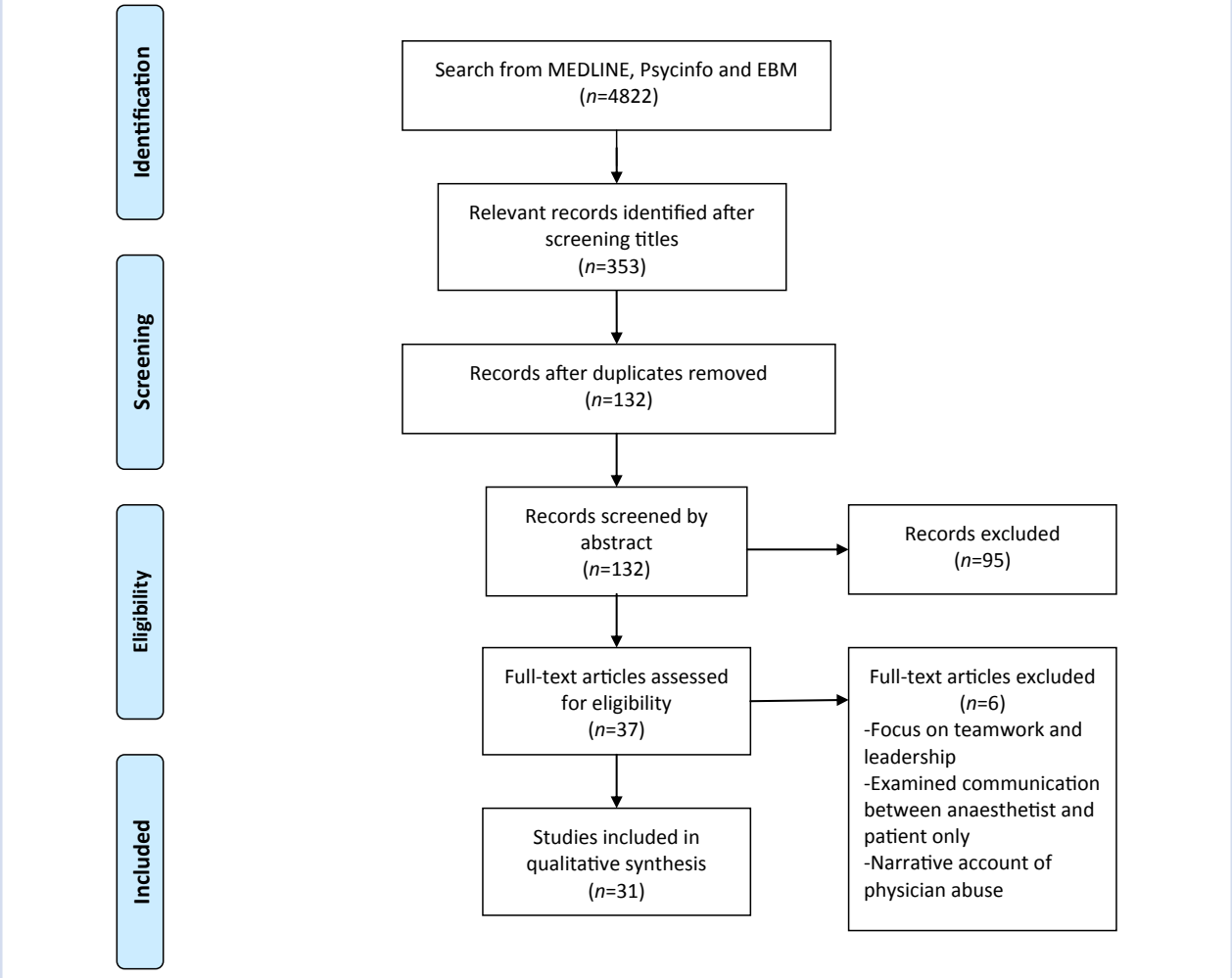

Fig 1. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram of the study selection process.

agreement between authors in this study eligibility selection yielded a kappa statistic of 0.85, considered to reflect an 'almost perfect agreement'. Included studies were published between 2003 and 2017.

The critical appraisal tool was applied to all but six of the articles, which were discussion articles around speaking up, and therefore the appraisal questions were not applicable. Similarly, there was one literature review also excluded from the tool. Regarding the critical appraisal results using QARI (Appendix 2) demonstrates that seven studies met all but one criteria, and 14 studies met all but two criteria. The main quality issues were authors not addressing the influence of the researcher on the study (Q7), and lack of a statement locating the researchers' theoretical or cultural perspective (Q6).

The data synthesis of the included studies was grouped into three distinct categories following a meta-aggregative approach:

1. Discussion and narrative articles around the subject of speaking up in the OR environment
2. Observational or qualitative studies researching the views of OR personnel regarding speaking up and challenging authority
3. Studies investigating the result of educational interventions and simulation studies identifying the role of particular barriers.

Discussion and narrative articles

Themes frequently emerging from narrative articles are similar and loosely fall into three sub-categories. The first is organisational culture, referring to the openness and transparency of an organisation and the way in which it affects the staff's ability to speak up. A number of articles make reference to this particular organisational aspect,[22–25] and in particular Reid's study[26] evidences contemporary harm data from the National Patient Safety Agency (2012). It states that speaking up is not exercised nearly enough in National Health Service (NHS) facilities in the UK. In addition, the likelihood of junior members of staff speaking up is entirely dependent on whether the voice and action of all staff are actively encouraged and valued by the organisation. Interestingly, it is a widely held belief among experts that fear of recrimination silences those who would otherwise speak up.[26] This is highlighted in the Freedom to Speak Up Report[27]; an independent review conducted in

Table 1 List of studies included. Ed Int-Simul, educational intervention or simulation to test differences between groups; MDT, multidisciplinary team; n/a, not available; Ob-Surv/Int, observational-survey/interview.

Author	Year	Type of study	Type of participants	Phenomena of interest	Context	Outcome
Berlinger and Deitz[25]	2016	Discussion	n/a	Checklists and patient safety tools	Discussion around checklists and patient safety tools limitations. The need for interpersonal collaborations to use these tools appropriately	n/a
Green and colleagues[31]	2017	Discussion	n/a	Hierarchy and tools to challenge authority	Discussion regarding hierarchy in medicine and how it affects behaviours. Summary of tools e.g. CUS and two challenge rule to help speaking up	n/a
Munday and colleagues[22]	2015	Discussion	n/a	Perioperative nurses experience of advocacy	Literature review of perioperative nurses' experience of advocacy	n/a
Reid[26]	2013	Discussion	n/a	Whistleblowing and speaking up	Discussion about whistleblowing, speaking up, and creating a patient safety culture	n/a
Spruce[24]	2014	Discussion	n/a	Strategies for perioperative nurses to protect patient safety	Discussion of strategies that perioperative nurses can use to speak up to protect patient safety	n/a
Clark and Kenski[23]	2017	Discussion	n/a	Incivility in the OR and strategies to help effective communication	Discussion around incivility in the OR and how different strategies can help effective communication	n/a
Jameson[30]	2003	Ob-Surv/Int	8 Anaesthetic nurse providers and 8 anaesthetists	Communication practices between anaesthesia providers	Results from in depth interviews examining conflict between anaesthesia providers between providers	Identification of communication practices that lead to escalation or de-escalation of conflict
Lawson and colleagues[33]	2017	Ob-Surv/Int	269 Perfusionists	Patient safety	Survey of perfusionists on patient safety culture	A positive safety environment is associated with being able to speak up without negative repercussions
Kobayashi and colleagues[32]	2006	Ob-Surv/Int	175 USA anaesthesia residents and 65 Japanese anaesthesia residents	Factors associated with willingness to speak up in different cultures	Written survey to Japanese and USA residents to assess factors associated with willingness to speak up, to highlight differences between cultures	No difference in threshold for challenging, some cross-cultural differences in importance of values and issues affecting ones decision to challenge.
Rutherford and colleagues[10]	2012	Ob-Surv/Int	22 Anaesthesia assistants and 11 consultant anaesthetists	Non-technical skills	Interview study with consultant anaesthetists and anaesthetic assistants regarding teamwork and non-technical skills	The ability to speak up did not differ with experience or age of anaesthetic assistant
Martinez and colleagues[11]	2017	Ob-Surv/Int	834 Surgical interns and residents	Speaking up and perceived barriers and enablers	Survey sent to residents regarding their experiences around speaking up and their perception of barriers and enablers	Less likely to speak up about unprofessional behaviour compared with traditional patient safety threats even if perceived to be of high potential patient harm
Sur and colleagues[12]	2016	Ob-Surv/Int	18 Surgical residents	Perceived methods of speaking up to seniors	Surgical residents interviewed about how they would approach superiors regarding their concerns for patient safety	Different factors identified regarding how surgical trainees manage concerns around superiors decision, no one method is used to address concerns

Continued

Table 1 Continued

Author	Year	Type of study	Type of participants	Phenomena of interest	Context	Outcome
Belyansky and colleagues[7]	2011	Ob-Surv/Int	38 Surgical trainees, 34 attending surgeons	Hierarchy and speaking up	Survey of surgical residents and attendings which assessed whether the surgical hierarchy interfered with the residents speaking up	Trainees do not feel able to voice their concerns to surgical attendings. Strategies to improve communication intraoperatively would increase patient safety
Sexton and colleagues[9]	2006	Ob-Surv/Int	2135 respondents –MDT	Teamwork in the OR	Questionnaire administered to OR departments to serve as a benchmark for team-working in OR	Validation of a teamwork climate tool
Edmondson[34]	2003	Ob-Surv/Int	165 Surgeons, anaesthetists, OR nurses, and perfusionists	Ease of speaking up	Analysis of qualitative and quantitative data from 16 operating room teams learning to use a new technology for cardiac surgery	Team leader coaching and ease of speaking up were associated with successful technology implementation
Hemingway and colleagues[44]	2015	Ed Int-Simul	125 Perioperative nurses	Patient safety improvement	Safety development plan implemented to improve reporting and feedback systems	Increased number of staff who would speak up if they saw something that may affect patient safety
White and colleagues[42]	2017	Ed Int-Simul	17 MDT	Uptake of a surgical safety checklist	Pilot educational course on surgical safety checklist implemented at a Congolese hospital	Pilot course for SSC implementation resulted in more than 50% of participants using the SSC at 15 months, positive changes in learning, behaviour and organisational change hierarchical culture.
Bould and colleagues[17]	2015	Ed Int-Simul	44 Anaesthesia residents	Speaking up	Residents asked to give blood to a Jehovah's witness. Qualitative study examining effect of hierarchy from structured interviews conducted with residents	Hierarchy played a dominating role in the operating room. Residents describe a negative hierarchical learning environment and describe coping strategies
Raemer and colleagues[37]	2016	Ed Int-Simul	71 Non-trainee anaesthetists	Speaking up	Implemented workshop on speaking up before a simulation scenario. Comparison between intervention and control group	An educational intervention alone was inadequate in improving speaking up behaviours
Friedman and colleagues[14]	2015	Ed Int-Simul	34 Anaesthesia trainees	Effect of positive and negative interpersonal behaviour on speaking up	Examined the effects of positive or negative interpersonal behaviour on the ability of residents to challenge authority	No significant effect of consultant behaviour on speaking up
Stewart-Parker and colleagues[36]	2016	Ed Int-Simul	68 participants - MDT	Non-technical skills	Multi-professional course on non-technical skills implemented. Feedback from self-assessments immediately and at 6 months after course analysed	Increased confidence in speaking up after course, and long-term data showed the majority of participants thought that the course directly improved patient safety
Pattni and colleagues[18]	2017	Ed Int-Simul	29 Respiratory therapists	Effect of gender on challenging authority	Examined the effects of gender on the ability to challenge authority in a CICO simulation.	Female consultants are challenged with greater frequency and with better quality of challenge than male consultants
Putnam and colleagues[38]	2016	Ed Int-Simul	51 Surgical residents	Patient safety workshop	Online curriculum regarding patient safety compared with	The additional safety workshop did not have a significant difference on

Continued

Table 1 Continued

Author	Year	Type of study	Type of participants	Phenomena of interest	Context	Outcome
					online curriculum and patient safety workshop. Comparison between two groups	patient safety perceptions, however the workshop group did show improved intraoperative patient safety behaviours
Robb and colleagues[35]	2015	Ed Int-Simul	48 Perioperative nurses	Speaking up to real or virtual humans	Comparison of speaking up behaviour between real and virtual humans in an OR environment	Speaking up to real and virtual humans is of comparable difficulty
Sydor and colleagues[15]	2013	Ed Int-Simul	60 Anaesthesia residents	Hierarchy and speaking up	Examined the effect of an OR team hierarchical structure on the ability of residents to challenge authority	No significant difference in speaking up when comparing a flat and traditional hierarchy structure
Kolbe and colleagues[43]	2012	Ed Int-Simul	31 Anaesthesia residents and 31 nurses	Speaking up and team performance	Studied the relationship between speaking up and testing team performance	Positive relationship between speaking up and technical team performance
Salazar and colleagues[41]	2014	Ed Int-Simul	55 Medical students	The effect of positive and negative behaviour on speaking up	Simulated laparoscopic surgery with resident surgeons using either an encouraging or discouraging script	A discouraging environment decreases the frequency that trainees speak up when encountering a surgical error
Beament and Mercer[13]	2016	Ed Int-Simul	12 Senior anaesthesia trainees in structured interview and 13 in simulation	Challenging authority	Examined challenging authority in the with a scripted CICO scenario also performed structured interviews with more senior trainees	Senior trainees are more likely to use non-verbal cues to encourage the consultant to change behaviour. Identified themes which were barriers to speaking up.
Friedman and colleagues[16]	2017	Ed Int-Simul	50 Anaesthesia residents	Educational intervention and speaking up	Targeted teaching intervention on speaking up compared with no teaching before simulated CICO simulation	Trainees undergoing the targeted teaching intervention significantly improved speaking up behaviour
Pian-Smith and colleagues[8]	2009	Ed Int-Simul	40 Anaesthesia trainees	Speaking up	Targeted teaching intervention on the two challenge rule after a simulated event	Significantly improved speaking up performance in a subsequent simulated scenario
Johnson and Kimsey[39]	2012	Ed Int-Simul	809 Perioperative team	Patient safety	Safety training programme designed to increase perioperative patient safety	Participants felt better able to challenge authority after the training course

response to the reporting culture in NHS organisations in the UK. It examined how organisations deal with concerns raised by NHS staff, and the subsequent treatment of those who have spoken up. The report noted two particular barriers that stood out: the fear of repercussions that speaking out would have for an individual and their career, and the futility of voicing a concern because nothing would be done about it. Furthermore, it quotes accounts of whistle-blowers raising serious concerns which were not only rejected, but met with disciplinary action against them rather than action to address the issue raised.

The second most common theme is dysfunctional interprofessional communication. Intimidating and disruptive behaviours that prevent nurses from speaking up lead to medical errors and adverse outcomes for patients. They also increase the cost of healthcare and decrease patient satisfaction scores. One study showed that 77% of healthcare professionals experienced disrespect and abuse, but only 7% spoke to the offending person and discussed their concerns.[28] The constellation of uncivil actions and intentional non-action can result in life-threatening mistakes and preventable complications. The Joint Commission's sentinel event data from 2015 show that staffing and supervision, leadership, and ineffective communication are the top three root causes for sentinel events in the perioperative period.[29]

The third theme is the effect of power differentials on the ability to speak up. This is mentioned not only in the context of hierarchy gradients between juniors and seniors of the same specialty but also between specialties.[23,25,30,31] For example, Jameson[30] states that anaesthetists do not feel afraid to ask the surgeon questions whereas nurse anaesthetists in the same position may feel more concerned about having a conflict if they ask a question. Another common opinion relates to real or perceived power differentials creating conflict between physicians and nurses, making the need for effective communication even more important.[23]

Other articles examine the methods of improving or streamlining communication by creating an environment receptive to team members speaking up.[25,31] The use of checklists has been developed to create defined safe opportunities for everyone involved in the patient's care to speak up and ask questions. In the OR, the surgical timeout is a strategy designed to support people of 'low power' in their roles to help safeguard patient safety and prevent harm. Using checklists and time-out strategies aims to offset the difficulty in speaking up and challenging superiors within a hierarchical environment. There is also an emphasis on organisational policy to enable an environment where people can speak up without fear of recrimination. Creating a culture of respect and safety implemented at leadership level, engaging frontline staff members and having a zero tolerance policy for disrespectful behaviour are all thought to help create an environment where anyone can speak up regarding their concerns.[24]

Observational or qualitative studies

Qualitative studies have predominantly focused on surveys or interview outcomes from perioperative teams. The overriding themes are again those of hierarchy and organisational culture.

Hierarchy is the most commonly cited theme.[7,9–13] Interviews with nurses in the OR[9] reveal they are less positive than physicians regarding speaking up, whereas lack of factors such as feeling supported and being a part of a culture that encourages conflict resolution are important barriers to challenging authority. This opinion is also voiced by anaesthesia assistants.[10] A survey in Scotland showed 26% of anaesthesia assistants would not speak up if they disagreed with a clinical decision in the OR, one of the reasons being the difficulty of speaking up in a hierarchical environment. Structured interviews of surgical residents yielded similar information – hierarchical culture was one of the most prominent reasons associated with a decreased willingness to speak up.[12]

Cultural conventions as modulators of speaking up behaviour have also been examined. A survey of residents in Japan and USA aimed to identify differences in barriers to speaking up between the two very different cultures. The questionnaire included statements regarding the residents' beliefs around communication and safety, and the importance of barriers to affecting a decision to question or challenge authority. Surprisingly, there was no significant difference in the threshold to challenge authority between American and Japanese residents, despite inherent cultural differences regarding hierarchy and communication. This hints at the notion that hierarchy gradients are so deeply ingrained into the medical culture that their effect supersedes even that of the national culture. In both countries, the willingness of trainees to speak up a second time was affected by the seniors' response to the first challenge. An unwelcoming response by seniors discourages subsequent questioning and challenges from juniors. This highlights that optimisation of effective communication in a crisis situation is essential.[32] Another study which indirectly compares cultures was carried out in the UK. The study itself was very similar to one carried out in Canada, which allowed some comparison of results. In these studies, a difficult airway scenario was performed as a simulation.[13] The consultant managing the airway inappropriately was a confederate and continued to try and intubate without changing anything of following a difficult airway algorithm. These scenarios were scored in a similar way using modified advocacy and inquiry scoring (mAIS). Although the studies are not directly comparable, the authors from the UK estimated that their trainees seemed to be more proactive than those in Canada. They put this down to a systematic failure of lack of conflict training in Canada, whereas in the UK, high profile cases such as Elaine Bromiley and the Clinical Human Factors Group have brought this to the forefront of communication skills training in the UK.

Organisational culture was again determined to have a major role as a barrier or enabler to speaking up. A survey of perfusionists suggested that fear of a punitive response to an error was a significant detriment to communication flow resulting in fewer cases of reporting problems.[33] Analysis of surveys from residents and interns working in different specialties in six USA hospitals found that the perception of getting someone else into trouble, fear of conflict, and concern about eliciting anger and alienation from team members were the three most commonly endorsed barriers to speaking up.[11] In contrast, they also reported that evidence of speaking up resulting in meaningful changes and anonymous reporting mechanisms were the top two facilitators to speaking up. Interviews of anaesthesia residents after a simulation asking them to give blood to a Jehovah's Witness (which they knew was considered illegal) yielded accounts of negative hierarchy characterised by fear and intimidation described poignantly by one resident ' … because the hierarchy is well established among the surgical staff, and like revered …. I think they pride themselves on sort of abusing the junior residents'.[17]

An observational study was conducted in 16 ORs across the USA studying behaviour during the implementation of a new

surgical technique. The results concluded that large power discrepancies will affect how easily 'low power' members can speak up, and this can therefore inhibit open conversation. Without a clear or compelling reason to offer one's views, the effort and risk involved in speaking up make it unlikely even without large power differentials. Team leader training and openness to speaking up were associated with successful implementation.[34]

Educational interventions and simulation research

Building on the results of these qualitative interviews and surveys, several specific barriers to speaking up have been examined in a simulated environment. These studies aimed to recreate specific barriers to challenging authority and compare the behaviour of trainees or low power participants with that of a control group.

This group of studies falls into three categories. First, the question of whether education, particularly in CRM, improves the ability to speak up. Next, testing the effect of qualitatively identified barriers to speaking up such as strict hierarchy. Lastly, examining methods that improve the ability to speak up, such as checklists.

Do educational interventions improve the ability to speak up?

The impact of educational interventions on speaking up has been studied extensively. The majority of these studies do show an increased probability of challenging authority and improved teamwork and collaboration of the perioperative team, which is known to improve patient outcomes, as a result of the intervention.[8,16,35–39] Multidisciplinary courses have been a popular way to test this hypothesis through assessment of the ability to speak up using self-assessment surveys before and after the teaching intervention. A 1 day multidisciplinary team course was used to teach, practice, and apply non-technical skills through simulation, and the effect of the course was reflected in self-assessments.[36] Thirty-seven percent of participants agreed that they felt confident in challenging a senior colleague at the beginning of the course, whereas this had increased to 92% by the end of the intervention.

An educational course designed specifically for practicing anaesthetists consisted of an educational workshop on speaking up either before or after a realistic simulated clinical scenario. Opportunities were presented to the candidate to speak up to a surgeon, a nurse, and then an anaesthesia colleague as three separate events during the scenario. The study showed that educational intervention was not effective in getting participants to speak up more frequently. The authors feel that this is powerful evidence that speaking up behaviour cannot be changed with education alone. They also found the frequency and quality of challenges was limited during the speaking up events, despite the educational intervention. Lastly, they believe uncertainty about the issue presented in the simulation was a significant barrier to speaking up. Despite an average of 15 years of experience post anaesthesia training, this shows that being uncertain is not an issue limited to trainees only. They suggest that educational interventions should be designed so that residents have the ability to speak up even if they are unsure how to manage the patient.[37]

Similarly, when evaluating behaviours and perceptions of patient safety among surgical residents in the OR before an educational course, the results did not demonstrate any difference in behaviour between the control and intervention groups.[38] More importantly, scores declined in the 6 and 12 month evaluation questionnaires. This is concerning as poor perceptions of patient safety culture in the OR are associated with an increased risk of complications.

However, the majority of studies which do show an increased likelihood of speaking up after an educational intervention suggest that formal training could be an effective use of time and resources to promote this open and transparent behaviour within OR teams to improve teamwork and collaboration, ultimately leading to a safer environment for patients.

Do qualitatively identified barriers have a significant effect on speaking up?

With respect to evaluating CRM training specifically, two studies showed that anaesthesia trainees scored better in simulations after CRM training.[8,16] The two-challenge rule originated from aviation. It allows one crew member to assume the responsibilities of another crew member who fails to respond to two consecutive challenges regarding aircraft safety.[40] Teaching the two-challenge rule paired with the advocacy and inquiry technique improved performance in simulations conducted after the teaching intervention with a better quality of challenge to senior team members.[17] Both the quality and frequency of challenging episodes have been shown to improve in simulation after a targeted teaching session on CRM.

Lastly, specific modifiers and barriers to challenging authority have been investigated to determine any difference in performance in simulated environments. These include studying encouraging and discouraging behaviours by senior surgeons to their more junior colleagues,[41] studying steep traditional hierarchy as opposed to flat hierarchy (i.e., one where the authority gradient between consultant and junior is reduced, promoting involvement in decision-making processes) for anaesthesia residents,[15] the effect of a supervisor's positive or negative interpersonal behaviour on anaesthesia residents,[14] and the effect of superior's gender on the performance of respiratory therapists.[18] Surprisingly, the effect of positive or negative interpersonal behaviour on anaesthesia residents did not influence their ability to challenge authority, and neither did flat compared with traditional hierarchy. The authors hypothesise that previous exposure to the effects of hierarchy and the professional culture they function within may have overcome the influence that the interpersonal behaviour of the superior might have had and residents performed poorly in both groups. However, in a study with surgical trainees the opposite was found. A discouraging environment was found to decrease the frequency with which trainees were willing to speak up.[41] Superiors' gender was found to have a significant effect on respiratory therapists' ability to speak up. A female staff anaesthetist was challenged with greater frequency and more aggressively than a male anaesthetist in the same tightly scripted simulated scenario.[18]

The effect of experience on a junior trainee's ability to challenge authority has also been tested. A study in the UK that conducted a crisis scenario simulation for first- and second-year trainees, found that second-year residents did significantly better, challenging the consultant more quickly and effectively and reducing the number of incorrect management interventions by the superior. A high-quality

challenge combined with non-verbal cues was performed more often by the more senior residents resulting in an improved outcome of the simulated scenario.[13]

The testing of these enablers and barriers to speaking up requires that all other factors are equal for a true comparison to take place. The studies do their utmost to try and keep all other factors in these simulations equal. However, there will always be some limitations. For example, when looking at the effect of a superior's gender on the ability to speak up, the authors acknowledge that factors such as height and build could not be standardised between the two groups for obvious reasons, although these may be significant in affecting the results.

Are there tested methods confirmed to improve the ability of speaking up?

The last studies in this group examined the methods of speaking up and their effectiveness.[35,42,43] A pilot program which taught staff at a Congolese hospital to implement the surgical safety checklist was examined. Participants reported that training had a positive effect on teamwork, organisation, and safe anaesthesia practices. However, even after the training, less than half felt able to challenge those in authority or ask questions when they saw things that they perceived as wrong.[42] This contrasts with a Massachusetts General Hospital initiative which was undertaken to improve the quality and safety program, particularly in the perioperative department.[44] A survey showed that 44% of staff did not feel able to speak up if they felt something was wrong, but felt they would do so 'knowing I have the support of management and my peers' and 'engaging in a conversation with all parties involved in the incident'. To this end, the development of an electronic safety reporting system, and formal debriefings and feedback after adverse events was initiated. It led to a major increase from 44% to 97.7% in staff reporting that they would speak up if an adverse incident occurred. A different approach to training incorporates 'Virtual humans' which were hypothesised to be easier to speak up to than real humans and their use was proposed as a means of training for effectively challenging authority. Results indicated that participants' behaviour in the scenario is not affected by whether the surgeon was real or virtual, suggesting that virtual humans with high behaviour realism can be used for speaking up training in simulated scenarios but also demonstrating how deeply ingrained hierarchy really is.[35]

Discussion

Health professionals in the OR in the majority of Western practice consist of three main professional groups: surgeons, anaesthetists, and perioperative nurses, all of varying seniority. The views and opinions of these different groups in the OR can give us insight into the barriers and facilitators encountered when speaking up and how these influence the decision to challenge authority.

Narrative articles in the literature exploring this subject focus mainly on perioperative nurses. The presence of incivility, intimidation, and bullying are mentioned frequently. Nurses are natural advocates for the patient but because of the deeply ingrained hierarchy in the OR, speaking up may put them in a vulnerable position.[1,22–24] An individual previously targeted through acts of bullying or dismissal may experience a heightened stress response. This individual may not speak up, especially if an unfriendly superior behaviour occurs, resulting in a pattern of non-challenge being repeated if a similar patient safety incident occurs. Coupled with the fear of a punitive response or fear of recrimination, this may act as a barrier to speaking up. Conversely, evidence of change after an episode of speaking up, and staff being valued by an organisation for speaking up is seen to be an enabler.

These narrative articles have subsequently been supported by results of qualitative studies, predominantly focusing on survey or qualitative interview results from perioperative teams. These demonstrate the same main themes of hierarchy and organisational culture.

Negative hierarchical culture features heavily in these studies. The large power discrepancies ingrained in the medicine culture may adversely affect 'low power' members' perception regarding the ease of speaking up. Consequently, this may inhibit productive communication. The characterisation of fear and intimidation perceived by junior members of the team gives insight into how a negative hierarchical culture can adversely impact patient safety, trainee learning, and team function. Without a clear or compelling reason to offer one's views in a supportive environment, the effort and risk involved with speaking up make it unlikely to happen, even without large power differentials.[34]

Educational courses have had a varying effect on self-reported behaviours regarding speaking up. Although most have shown a positive impact, one showed a decline in scores when followed up at 6 and 12 months. This has largely been attributed to the fact that these courses were stand-alone courses in the context of conducting this study. The authors feel that if this course were to be implemented as part of an iterative curriculum, alongside other safety initiatives such as surgical checklists and staff audit, scores may have been higher on follow-up. They also felt the course should be tailored to the experience level of the participants, as those with more experience were found to have higher scores after this course aimed at consultant anaesthetists and surgeons.[38]

Simulation studies addressing specific barriers to speaking up had some surprising results. Simulating a traditional steep hierarchical environment compared with a flat one in which the superior is open and inclusive showed no improvement in the ability of anaesthesia residents to speak up.[15] Similarly, there was no difference between an environment of positive interpersonal behaviour compared with negative and exclusive interpersonal behaviour.[14] These results seem counter-intuitive to the opinions expressed in qualitative interviews and surveys. In the latter study residents all recognised that the difficult airway scenario was being mismanaged and patient safety was at risk. Despite this risk, even those residents in the positive interpersonal behaviour group challenged infrequently and with poor quality. Other influencers such as wanting approval from their senior, and showing the appropriate respect because of the ingrained hierarchy could have also influenced behaviour.

Studies that examine speaking up necessitate some deception of the participants. The ethical dilemma of using frank deception poses a number of questions as whether it should be used as part of an educational technique. There is insufficient data on the effect of deception on learners, and there has been no research into the effect of deception on learners' performance or changes in behaviour. The use of sociological fidelity can increase the realism of the training and allow easier transfer of skills learnt in simulation. Combined with effective debriefing, this allows the learner to

explore issues regarding hierarchy, leadership, and professional identity. Local research ethics boards had approved all studies that used deception in this review.[45]

The themes regarding speaking up in terms of what experts believe, what reality shows us, and what we test are consistent. Hierarchy, organisational culture, and education are the most commonly observed and tested themes. The inconsistency of results regarding education as a means to improve speaking up shows that, although educational courses may produce short-term behavioural changes, these tools may not be retained on a long-term basis without organisational changes.

In conclusion, this review provides a summary of the published literature regarding speaking up in the OR environment. Characteristics unique to a particular person will be un-modifiable (e.g. gender), but awareness of the potential implications that these characteristics may have can go some way to promoting speaking up. Some of the barriers identified are potentially modifiable within institutions. Education around the importance of speaking up and challenging authority is essential; however, unless supported by accessible reporting systems and transparency of organisations, education on its own will not be enough.[42,44] A transformation in culture regarding hierarchy will be required, which is arguably the most important modifiable factor. Future research could consider the effect of a change in the undergraduate curriculum to try and address the lack of education around speaking up. Coupled with education in the postgraduate environment promoting open communication with trainees, this will help seniors create a culture where juniors are encouraged to speak up. All personnel in the OR have a responsibility to protect patient safety and work in an environment of dignity and respect in an often high acuity environment. It is imperative that effective inter-professional collaboration occurs to protect patient safety.

Authors' contributions

Writing the first draft of the manuscript: NP, LK.
Writing of the manuscript: NP, CA.
Literature search: NP, AM, SV.
Screening of papers: NP, AM, SV, ZF.
Data analysis: CA, ZF.
Study and protocol design: ZF.
Review of the final draft of the manuscript: ZF.

Declaration of interest

All authors have no conflicts of interest to declare.

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Appendix 1.

QARI Critical Appraisal Instrument. QARI, Qualitative Assessment and Review Instrument.

Criteria	Yes	No	Unclear
1) There is congruity between the stated philosophical perspective and the research methodology.			
2) There is congruity between the research methodology and the research question or objectives.			
3) There is congruity between the research methodology and the methods used to collect data.			
4) There is congruity between the research methodology and the representation and analysis of data.			
5) There is congruity between the research methodology and the interpretation of results.			
6) There is a statement locating the researcher culturally or theoretically.			
7) The influence of the researcher on the research, and *vice versa*, is addressed.			
8) Participants, and their voices, are adequately represented.			
9) The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.			
10) Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.			
TOTAL			

Reviewers' comments.

Appendix 2.

Critical appraisal results for included studies using the JBI-QARI critical appraisal checklist. Some references were not included as these were general discussion on the topic of speaking up: Berlinger and Dietz,[25] Green and colleagues,[31] Reid,[26] Spruce,[24] Clarke and Kenski[23]; Munday and colleagues[22]—excluded as this was a qualitative review article. JBI-QARI, Joanna Briggs Institute Qualitative Assessment and Review Instrument; N, no; U, unclear; Y, yes.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Jameson[30]	Y	Y	Y	Y	Y	N	N	Y	U	Y
Lawson and colleagues[33]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kobayashi and colleagues[32]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Rutherford and colleagues[10]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Martinez and colleagues[11]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Sur and colleagues[12]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Belyansky and colleagues[7]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Sexton and colleagues[9]	Y	Y	Y	Y	Y	N	N	Y	U	Y
Edmondson[34]	Y	Y	Y	Y	Y	N	Y	Y	U	Y
Hemingway and colleagues[44]	Y	Y	Y	Y	Y	N	N	Y	N	Y
White and colleagues[42]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Bould and colleagues[17]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Raemer and colleagues[37]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Friedman and colleagues[14]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Stewart-Parker and colleagues[36]	Y	Y	Y	Y	Y	N	N	Y	N	Y
Pattni and colleagues[18]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Putnam and colleagues[38]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Robb and colleagues[35]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Sydor and colleagues[15]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kolbe and colleagues[43]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Salazar and colleagues[41]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Beament and Mercer[13]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Friedman and colleagues[16]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Pian-Smith and colleagues[8]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Johnson and Kimsey[39]	Y	Y	Y	Y	Y	N	N	Y	N	Y

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Review

Bullying against Healthcare Professionals and Coping Strategies: A Scoping Review

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Abstract: Violence against healthcare professionals is an event that further burdens the daily lives of those who try every day to care for and assist those who need it most. In an attempt to overcome these events, there are coping strategies that can be used to reduce the stress caused. Therefore, this study aims to analyse the phenomenon of violence against healthcare professionals and the relationship between the bullying suffered by these professionals and the coping strategies they developed to overcome these moments. To this end, a scoping review was conducted in which eight articles were selected for final analysis from a total of 276 articles found in three electronic databases (EBSCO, PubMed, and Web of Science). This review concludes that the most common workplace bullying behaviours include excessive workloads, humiliation and ridicule, impossible deadlines, and verbal attacks. Professionals reported negative impacts, such as helplessness, depression, stress, insomnia, and the desire to change jobs. Victims of workplace bullying often expressed their intention to leave their current job or even abandon the profession. Problem-focused coping strategies are the most used. The studies indicated that workplace bullying negatively affects professionals in physical and mental terms, as well as in terms of quality of life at work, requiring more research and adoption of preventive measures to identify and combat the problem.

Keywords: workplace bullying; coping strategies; healthcare professionals; Negative Acts Questionnaire—Revised (NAQ-R)

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1. Introduction

Bullying understood as aggressive behaviour, intentional and repeated over time, by one or more people towards someone with the purpose of causing harm [1] is not a behaviour exclusive to the school environment and carried out only at children and young people. Bullying is a conduct that a person, of any age group, gender, or profession, may adopt in various other contexts, such as the workplace [2].

The definition of bullying in the workplace is multifaceted and complex, with several definitions and terminologies that different authors have adopted to describe this phenomenon. In the United States of America, Brodsky [3], an American psychiatrist, began to use the expression harassment, which he defined as repeated and persistent behaviour with the intention of frustrating or receiving some type of reaction from the victim. On the other hand, Leymann [4,5], a Swedish researcher, began to use the expression mobbing, as he stated that bullying was more physical and threatening violence and then defined mobbing as a more sophisticated behaviour, giving as an example isolation of the victim. Hirigoyen [6], a French psychiatrist, uses the expression "moral harassment" where she considers that behaviours can affect a person's dignity and integrity and even put their job in danger. The term incivility, although less frequent in articles that address the topic, is sometimes used to refer to acts of rudeness and discourtesy, rumours and gossip, and

disrespect for the dignity of the professional, including by colleagues [7]. The literature states that these and other actions that compromise a safety culture are extremely dangerous for both patient outcomes and the general well-being of healthcare personnel [8].

Although there are several definitions of bullying in the workplace, there are some similarities between all the definitions. In general, 'workplace bullying' can be defined as a type of violence involving recurrent practices through aggressive behaviours that occur over a period of time, which are undesirable by the victim [9,10]. Bullying in the workplace is a reality in many countries [11–14], particularly affecting professionals in the health sector [15–18].

Bullying in the workplace can lead to the emergence of physical and psychological problems, such as anxiety, depression, stress, and risk of death [19]. For some healthcare professionals, such changes may interfere with their ability to perform their work, such as providing care and referrals to health care. These experiences can be a factor of great stress in the lives of healthcare professionals, leading to serious consequences not only for professionals, but also for users and organizations [20]. To this end, there are some strategies that are studied as mediating variables (e.g., intention to quit, job engagement, job satisfaction) or moderators (e.g., social support, constructive leadership, attribution style) to face situations of harm, threat, and challenge to which are confronted [21].

The coping process is perceived as a set of efforts made by individuals when faced with some situations that may cause threat or discomfort to the person [22]. Coping strategies can be divided into two types, emotion-focused and problem-focused [23]. In emotion-focused coping strategies, energy is directed at somatic and/or feeling levels and aims to reduce the uncomfortable physical sensation caused by the state of stress. On the other hand, in problem-focused coping strategies, the victim tries to understand and know which problem is causing stress and acts directly to resolve the problem to try to change or avoid it in the future [23]. Authors like Rodriguez et al. [24] studied the differences in coping strategies between genders, concluding that men tend to use problem-focused strategies more, while women prefer to use emotion-focused strategies more.

Coping strategies are related to contextual factors. The individual may choose to adjust their strategy based on the specific situation that is causing the stress. It is important to note that there are no adaptive or maladaptive coping strategies [25]. The decision on which strategy to adopt is a personal choice, the individual chooses the strategy that they consider positive and that helps to alleviate discomfort and reduce negative feelings associated with stress. In contrast, coping strategies are considered negative and ineffective if they are applied, but the stressful situation continues to persist and maintains an imbalance in several aspects [25,26].

Folkman and Lazarus [27] created a transactional model of coping where they argue that stress is contextual, representing a process of interaction in constant evolution between the individual and the environment. In this context, stress is defined as a situation that the individual evaluates as significant and that imposes needs that exceed the resources available to deal with the moment. This model comprises four essential elements: (1) the conception of coping as a process that occurs between the individual and the environment; (2) its main purpose being to deal with stressful situations; (3) the involvement of assessment, that is, how the person perceives stress; (4) the implication of the mobilization of resources, in which individuals use cognitive and behavioural resources to deal with claims that arise both from within and outside the interaction with the environment [22,27].

According to Angst [28], the term resilience is directly related to coping strategies, as it can be considered as a procedural form between the individual and the environment that surrounds them, and the latter must evaluate and interpret the phenomena they perceive. Thus, people who use coping strategies can be considered resilient people.

Therefore, this scoping review aimed to explore the phenomenon of bullying suffered by healthcare professionals and the coping strategies used to combat it. A review would be important to explore the phenomenon of bullying suffered by healthcare professionals and the coping strategies used, as this is a significant and harmful problem that affects

the mental health and well-being of healthcare professionals. Bullying can have profound impacts on the quality of work, team morale, and patient safety. This scoping review can contribute to raising awareness about this issue, promoting changes in organizational practices, and providing support to healthcare professionals facing this form of violence in the workplace. Understanding the coping strategies used by healthcare professionals can help identify which ones are most effective and develop interventions to support those experiencing bullying. This scoping review provides a comprehensive overview of existing research on this topic, allowing for the delineation of studies in this area.

Thus, this scoping review is presented in an operationalizable and replicable manner. Its goal is to encompass a specific body of literature on the phenomenon of violence against healthcare professionals and the relationship between the bullying suffered and the coping strategies used to face these most stressful moments, examine its research trends, and potentially pave the way for a systematic review to pinpoint research gaps and provide recommendations for future studies. Therefore, we sought to identify the types of bullying behaviours that affect healthcare professionals and examine the possible consequences of these behaviours in terms of physical and mental health. Such as investigating the coping strategies that healthcare professionals adopt to deal with bullying in the workplace. To this end, the following questions arise:

1. What are the main bullying behaviours identified by healthcare professionals and what are their consequences?
2. What coping strategies are used by healthcare professionals who are victims of bullying?

2. Methodology

2.1. Research Procedures

For this scoping review, a search was carried out in the following databases: EBSCO, Web of Science, and PubMed. To this end, the following combinations of keywords were used: (Profissionais de saúde OR healthcare professionals OR médicos OR doctors OR physicians OR nurses OR enfermeiros) AND (Bullying OR mobbing OR *civility) AND (Estratégia* de coping OR coping strategie* OR cope OR coping OR coping skill*) OR (NAQ-R OR Negative Acts Questionnaire-Revised). To obtain the most relevant results from all databases, some restrictions were used. In the EBSCO database, the following restrictions were used: "Full Text", "Peer Reviewed", "Available to library collection". In Web of Science and PubMed, they were restricted to "Open Access" and "Full Text", respectively. On all platforms, the language was restricted to Portuguese, English, and Spanish, and the search was restricted to article dates greater than the year 2010 (Supplementary Materials). The research was carried out in May 2023.

2.2. Inclusion and Exclusion Criteria

In order to guide the selection of studies, some criteria were defined:

Inclusion criteria: (a) studies that addressed violence against healthcare professionals and coping strategies; (b) studies in which the population was doctors and/or nurses; (c) studies in Portuguese, English, and Spanish; (d) publications dated after 2010.

Exclusion criteria: (a) studies with a student population; (b) scoping reviews, systematic reviews, or meta-analyses; (c) studies carried out with professionals other than doctors and/or nurses; (d) studies that covered only one of the variables under study; (e) publications written in a language other than Portuguese, English, and Spanish; (f) publications dated earlier than 2010 (a report on the Assessment of Episodes of Violence Against Health Professionals was released by the General Directorate of Health [29]). By focusing on a period after 2010, we can ensure that the data and findings discussed in the report are still accurate and reflective of the current situation regarding violence against health professionals. Additionally, as the review was carried out in May 2023, it is important to consider more recent information to provide the most current and reliable analysis and recommendations.

2.3. Article Selection

The study followed the guidelines for scoping review [30] and was conducted in multiple stages involving article selection based on predefined criteria [31]. The project was registered [DOI 10.17605/OSF.IO/H7TAS]. The process ultimately yielded a final set of articles for analysis (cf. Figure 1) [32].

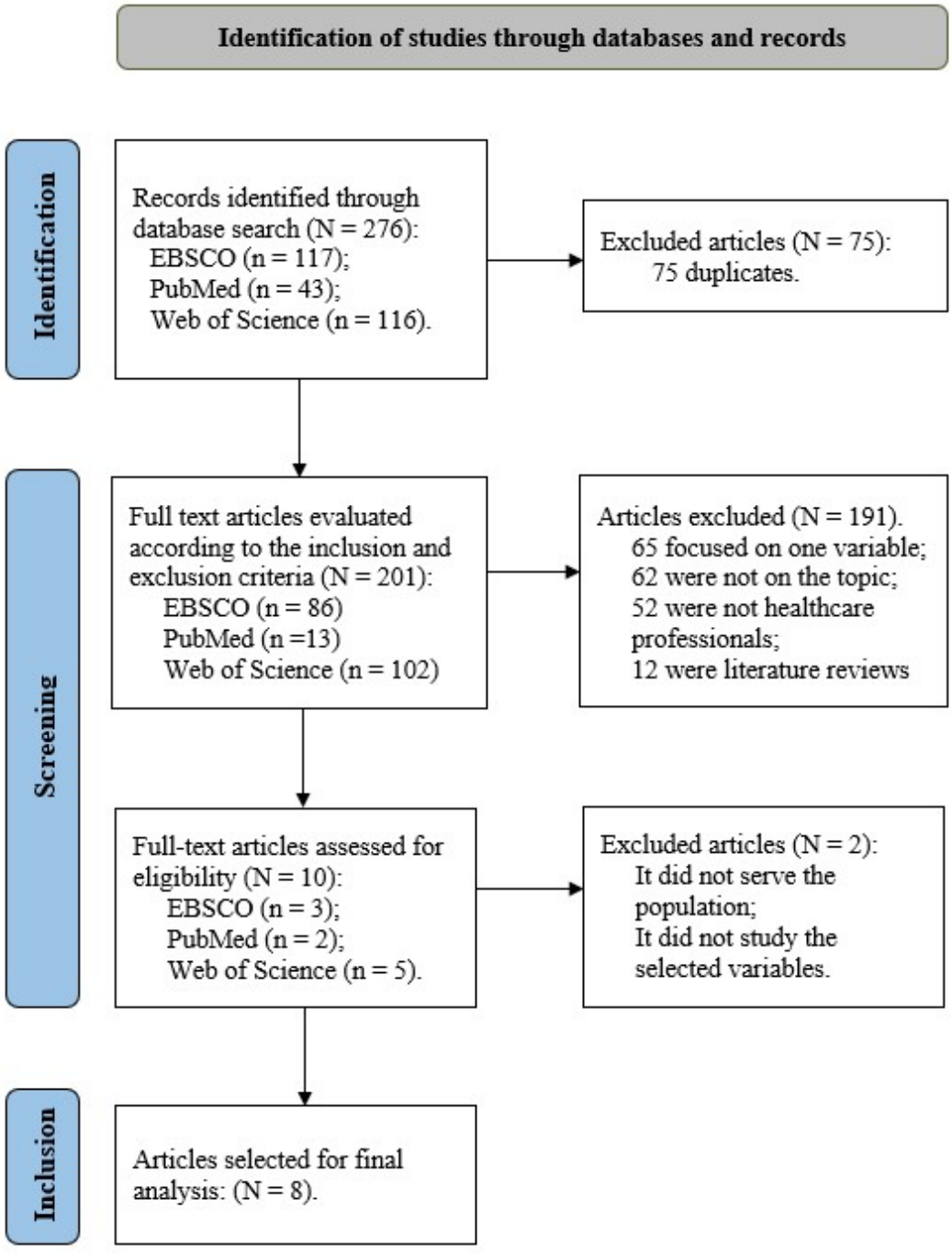

Figure 1. Article selection flowchart (retrieved from http://www.prisma-statement.org/, accessed on 20 march 2024).

Initially, a search across three electronic databases yielded a total of 276 articles (117 from EBSCO, 43 from PubMed, and 116 from Web of Science). After excluding 75 duplicate articles, the remaining 201 articles underwent further screening.

During the second stage, articles were reviewed based on title and abstract to exclude those not relevant to the dissertation topic. This step resulted in the exclusion of 191 articles (86 from EBSCO, 13 from PubMed, and 102 from Web of Science): 65 articles focused on only one variable, 62 were unrelated to the intended topic, 52 did not study the intended sample, and 12 were literature reviews.

In the final stage, the ten selected articles were thoroughly reviewed to identify their relevance to the study objectives. As a result, eight articles were deemed suitable for inclusion, while two were excluded for not meeting the defined criteria—one did not study the intended sample, and the other focused on only one of the variables of interest in this study.

2.4. Article Quality Analysis

To carry out the analysis of the quality of the articles, a checklist [32] was used in which 13 evidence-based items (Table 1) were evaluated to assess the solidity of the articles. In this checklist, six important points are evaluated: (I) the clarity of the title; (II) the structure of the summary; (III) the state of the art and the objectives of the study; (IV) the study protocol, eligibility criteria, sources of information, inclusion/exclusion criteria, information collection and study design; (V) summary of the main results; (VI) limitations found in the study.

Table 1. Quality table of articles under analysis.

Articles/Topics	1	2	3	4	5	6	7	8	9	10	11	12	13	Total
Berry et al. [33]	1	1	1	1	2	2	2	1	2	2	2	1	1	19 Average
Hawkins et al. [34]	2	2	2	2	2	2	2	2	2	2	2	1	2	25 High
Hong et al. [35]	2	2	2	2	2	2	2	2	2	2	2	2	2	26 High
Mills et al. [36]	1	2	2	2	2	1	2	2	2	2	2	2	0	22 High
Peng et al. [37]	1	2	2	2	2	2	2	2	2	2	2	2	1	24 High
Reknes et al. [38]	1	1	2	2	2	2	2	1	2	2	2	2	2	23 High
Tabakakis et al. [39]	1	2	2	1	2	2	2	1	2	2	2	2	1	22 High
Yoo & Ahn [40]	1	1	1	1	2	2	2	2	2	2	2	2	0	20 Average

Topics analysed: 1—title; 2—abstract; 3—rationale; 4—objectives; 5—protocol; 6—eligibility criteria; 7—information sources; 8—inclusion/exclusion criteria; 9—data collection process; 10—study design; 11—main measures; 12—summary of main results; 13—conclusion and study limitations. Grades: 0—not reported/not specified; 1—unclear/reported to a certain extent; 2—adequately done.

In the checklist, articles are classified using a Likert scale in which the score varies between 0 and 2. A score of 0 indicates that the study lacks information on the topic at hand, whilst a score of 1 indicates that the researchers briefly acknowledged the problem without offering thorough explanations. A score of 2 indicates that the researchers extensively examined the issue and presented their technique in a clear and understandable way. Two researchers independently examined each article using the same grid. Items with different scores were assessed together to achieve the final values shown in Table 1. The researchers agreed by 95%. Table 1 shows the eight articles selected for this scoping review.

3. Results

The articles analysed all highlighted the negative impact of workplace violence on healthcare professionals in both their professional and personal lives. To conduct a more focused analysis, key data were extracted from each article, considering the fact that they were all based on empirical studies. Table 2 includes information on the authors and publication year, goals, countries where the studies were conducted, sample size, research instruments, design, and main findings related to the research questions. The full reading of the screened articles facilitated an exhaustive comparative analysis (horizontal and vertical) of the aspects studied, leading to an integrated cross-sectional analysis and extraction of the main results to answer the initial research questions.

Table 2. Summary of selected articles.

Authors (Year)	Goals	Local/ Participants	Instruments	Design	Main Results [Bullying, Symptoms, and Coping Strategies]
Berry et al. [33]	Determine differences in the perception of stress, state anxiety, and post-traumatic stress symptoms based on levels of exposure to bullying, as well as determine the strategies used	USA 1st phase = 84 nurses 2nd phase = 11 nurses	Negative Acts Questionnaire; 10-Item Perceived Stress Scale; 20-Item Subscale of the State Trait Anxiety Inventory; Post-traumatic Stress Disorder Checklist Civilian Version; Individual Questionnaire	Quantitative and qualitative study	The study identified significant differences in the perception of stress, anxiety, and post-traumatic symptoms that have been reported by people with frequent or daily exposure to workplace bullying behaviour.
Hawkins et al. [34]	Understand the type and frequency of negative behaviours in the workplace and the strategies used when exposed to these behaviours	Australia 74 nurses	Negative Acts Questionnaire—Revised; Purpose-designed questions; Ways of Coping questionnaire	Quantitative study	The most common type of negative workplace behaviour reported was "work-related bullying", and they reported using a variety of coping strategies, including problem-focused strategies and seeking social support.
Hong et al. [35]	Investigate the effects of workplace bullying and different symptoms of post-traumatic stress and coping among hospital nurses	Korea 233 nurses	Workplace Bullying in Nursing—Type Inventory; Impact of Event Scale—Revised; Ways of Coping Checklist	Quantitative study	The study explores bullying in the workplace of nurses, detecting high-risk subgroups, and suggesting the development of coping interventions to reduce workplace bullying and symptoms of post-traumatic stress.
Mills et al. [36]	Determine whether nurses' humour orientation styles and leadership styles can influence perceptions of workplace bullying	USA 459 participants	Multidimensional Sense of Humour Scale; Bass's Multifactor Leadership Questionnaire; Negative Acts Questionnaire—Revised	Quantitative study	One of the four humour subscales, Humour Appreciation, affected perceptions of workplace bullying. The other three, Humour Recognition, Humour Production and Humour for Coping, had no effect. However, managers' leadership styles affected reports of negative acts.
Peng et al. [37]	Determine the relationship between workplace bullying and nurses' quality of life and also the mediating role of resilience between workplace bullying and quality of life	China 493 nurses	Negative Acts Questionnaire—Revised; 10-item Connor–Davidson Resilience; the Chinese Version of Professional Quality-of-Life Scale	Quantitative study	Bullying in the workplace had negative and direct effects on nurses' quality of professional life. Resilience mediated the relationship between workplace bullying and quality of professional life.
Reknes et al. [38]	To investigate whether bullied nurses have a more negative coping style when faced with stressful events than nurses who are not bullied and to determine whether coping style moderates the relationship between bullying and anxiety	Norway 1st phase = 2059 participants 2nd phase = 1582 participants	Negative Acts Questionnaire—Revised; Hospital Anxiety and Depression Scale; Utrecht Coping List	Quantitative study	Bullied nurses use a goal-oriented active coping style less frequently than non-bullied nurses. Furthermore, active goal-oriented coping appears to be beneficial only when exposure to bullying behaviours is very low. Victims of bullying appear to deal more negatively with stressful events than others.
Tabakakis et al. [39]	Investigate the impact of workplace factors on nurses' psychological resilience, including bullying	Australia 480 nurses	The Connor–Davidson Resilience 10 scale; The Practice Environment Scale of the Nursing Work Index; Negative Acts Questionnaire—Revised	Quantitative study	The work environment and perception of exposure to workplace bullying play a significant role in shaping nurses' psychological resilience.
Yoo & Ahn [40]	Analyse the relationship between workplace bullying experiences, responses, and coping strategies	Korea 113 nurses	Workplace Bullying in Nursing-Type Inventory; Workplace Bullying in Nursing—Consequence Inventory; Way of Coping	Quantitative study	Nurses complained of helplessness, depression, stress, insomnia, and physical discomfort, and complained that they made more mistakes in their work and wanted to change jobs.

3.1. Multiple Approaches to Workplace Bullying Research

Except for the study by Berry et al. [33], which is mixed in nature (i.e., both qualitative and quantitative), all of the other investigations were quantitative in nature. Some studies had more specific goals, like examining the effects of bullying in the workplace and various symptoms of post-traumatic stress disorder caused by bullying, as well as anxiety states and the coping strategies used by nurses [33,35]. These selected empirical

articles were based on objectives as diverse as determining the type and frequency of negative behaviours in the workplace as well as the coping strategies used when exposed to such behaviours [34,40]. In a different study that was examined, the authors aimed to determine whether bullying victims' coping mechanisms were less adaptive to stressful situations than those of nurses who were not bullied and whether bullying and anxiety are mediated by coping mechanisms [38]. A few of the chosen studies sought to understand the mediating function of resilience in a study on workplace bullying and professionals' quality of life, or they sought to ascertain the relationship between workplace bullying and nurses' quality of life [37,39]. Another study that was chosen examined the possibility that nurses' leadership and humour orientation styles could affect how they perceive bullying in the workplace [36].

Overall, the studies emphasize the multifaceted nature of workplace bullying research and the importance of considering various perspectives and factors in addressing this prevalent issue. The inclusion of both qualitative and quantitative approaches, as seen in the study by Berry et al. [33] allows for a more holistic understanding of the issue.

3.2. Methodological Aspects of International Research on Workplace Bullying

The studies provide a glimpse into various aspects of nursing practice and research from different countries, including Australia [34,39], Korea [35,40], the United States of America [33,36], Norway [38], and China [37]. Each study had specific inclusion criteria for participants, ranging from newly licensed nurses to experienced ones, working in different healthcare settings (e.g., clinicals, hospitals). The methods used for data collection also varied, from disseminating questionnaires in contexts to utilizing online platforms like Survey Monkey [36,39] and Google Forms [35]. Some studies [33,38] stood out for involving two phases of investigation, showcasing a longitudinal approach to understanding nursing practices. The recruitment methods also differed, from contacting nurses through professional organizations to utilizing social media platforms like WeChat [37].

In this review and for the development of empirical studies on the topic, it was particularly important to know the diversity of assessment instruments used and their scope.

Hawkins et al. [34] used two quantitative instruments and a group of questions with specific objectives. One of the instruments was the Negative Acts Questionnaire—Revised (NAQ-R) [41], which aims to measure exposure to bullying in the workplace, consisting of 22 items that are divided into three subscales. The other instrument was the Ways of Coping Questionnaire [23], designed to examine an individual's coping strategies in stressful situations, consisting of 66 items from eight domains of three types. The group of questions was developed from the literature and consisted of nine items.

In the study by Yoo and Ahn [40], three quantitative instruments were used: the Workplace Bullying in Nursing—Type Inventory (WPBN-TI) [42], developed to measure experiences of bullying in the workplace and consisting of 16 items; the Workplace Bullying in Nursing—Consequence Inventory (WPBN-CI) [43], built to measure responses to bullying in the workplace and consisting of 13 items; and finally, the Way of Coping by Lazarus and Folkman [23], revised and translated into Korean by [44], used to measure coping strategies and consisting of 33 items.

Mills et al. [36] used three quantitative instruments to achieve the objective of the study: the Multidimensional Sense of Humour Scale (MSHS) [45], consisting of 24 items and used to assess the sense of humour; Bass's Multifactor Leadership Questionnaire (MLQ) [46], a measuring instrument consisting of five factors to identify three leadership styles; and finally, the Negative Acts Questionnaire—Revised (NAQ-R) [41].

In the study by Hong et al. [35], the authors used three quantitative instruments: the Workplace Bullying in Nursing—Type Inventory (WPBN-TI) [42]; the Korean version of the Impact of Event Scale—Revised by Lim et al. [47], consisting of 22 scales divided into three subscales, used to assess nurses' post-traumatic stress; the Korean version of the Ways of Coping Checklist (WCCL) by Park and Lee [48], modified from the original version by

Folkman and Lazarus [23], consisting of 39 items divided into two subscales that aim to evaluate the coping strategies used by nurses.

Reknes et al. [38] used three quantitative instruments: the Negative Acts Questionnaire—Revised (NAQ-R) [41]; the Hospital Anxiety and Depression Scale (HADS-A) [49], used to measure the anxiety symptoms and consisting of seven items; and the reduced version of the Utrecht Coping List (UCL) [50], consisting of 22 items divided into two subscales, which measure the frequency with which respondents act in a specific way when faced with problems or unpleasant situations, defining seven coping styles.

The study by Peng et al. [37] used a total of three quantitative instruments: the Negative Acts Questionnaire—Revised (NAQ-R) [41]; the Chinese version of the 10-item Connor–Davidson Resilience (CD-RISC-10) [51], consisting of 10 items and used to assess psychological resilience; and the Chinese version of Professional Quality-of-Life Scale (ProQOL-CN) by Shen et al. [52], consisting of 25 items divided into three subscales.

Tabakakis et al. [39] used three quantitative instruments: the 10-item Conner–Davidson Resilience (CD-RISC-10) [51]; the Negative Acts Questionnaire—Revised (NAQ-R) [53]; and finally, the Practice Environment Scale of the Nursing Work Index (PES-NWI) [54], consisting of 31 items divided into five subscales and used to evaluate the work environment.

Regarding the study by Berry et al. [33], four quantitative instruments and interviews were used. The four instruments used were the Negative Acts Questionnaire—Revised (NAQ-R) [41], the 10-item Perceived Stress Scale [55], which aims to assess perceived stress in the last month, the 20-item subscale of the State Trait Anxiety Inventory [56] that assesses how participants feel at the time of the survey, and finally, the Post-traumatic Stress Disorder Checklist—Civilian Version (PCL-C) [57], which tracks post-traumatic stress symptoms and contains seventeen assessment items. In relation to the second part of the study, telephone interviews were carried out with a semi-structured script which addressed the behaviours suffered from bullying, what they did to deal with or prevent these behaviours, and other actions taken to continue working in the same hospital unit.

Overall, the diversity in research environments, participant criteria, data collection methods, and recruitment strategies in the studies reviewed highlights the broad scope and depth of healthcare professionals practice and research around the world.

3.3. Bullying Behaviours, Consequences, and Coping Strategies

Some articles in this review mentioned the main workplace bullying behaviours that their participants were exposed to. In studies by Hawkins et al. [34] and Berry et al. [33], nurses who were victims of bullying expressed that the most common type of behaviour was work-related bullying, that is, exposure to excessive workloads, being humiliated or ridiculed in relation to their work, and receiving tasks with delivery of impossible deadlines, among others. The healthcare professionals in the study by Hong et al. [35] also mentioned that they received verbal attacks and inadequate work instructions.

Some authors also mentioned the negative impacts that healthcare professionals had after being exposed to various acts of bullying in the workplace. For example, in the study by Yoo and Ahn [40], nurses complained of helplessness, depression, stress, insomnia, and physical discomfort, and even complained that they made more mistakes in their work and that they wanted to change jobs. They also reported that long-term exposure to bullying behaviours significantly reduces nurses' coping resources [37].

More than 50% of the participants in three of the articles studied reported that they already had the intention of leaving their current job, changing units, or even giving up the nursing profession, since the bullying behaviours to which they were exposed were a very important factor for dissatisfaction with current employment, which is a major consequence of workplace violence [34,39,40].

These results demonstrate that the bullying suffered by these healthcare professionals can have negative effects in physical and mental terms and also interfere with the quality of the service they provide and the quality of personal life.

Studies have shown that nurses used different coping strategies, both active and passive, to deal with the most stressful moments of bullying in the workplace. Some of the strategies used were, for example, turning to a family member or friend for advice, focusing on what you had to do next, finding a "friend to work with", avoiding anyone who exposes you to these behaviours, and using music and prayer as a form of distraction, among others [33,34].

Studies that identify which strategies are used by healthcare professionals indicate that, according to the answers given in surveys, problem-focused coping strategies are the most used in this profession, such as focusing on what had to be done next, trying to analyse the problem to better understand it, and focusing on work to distract your mind [33,34].

4. Discussion

The main bullying behaviours identified by healthcare professionals in the workplace include personal attacks, such as insults, humiliation, and ridicule, as well as work-related behaviours like excessive workloads and tasks with impossible deadlines. Understanding workplace bullying behaviours typically involves retrospective self-report questionnaires, where participants recall and report acts, they may have experienced. The choice of assessment instruments depends on the specific goals of each study and the cultural context in which it is conducted. Researchers utilize various instruments to measure exposure to bullying, coping mechanisms, psychological effects, and organizational factors. This diversity in assessment tools contributes to a comprehensive understanding of the incidence, consequences, and associations of workplace bullying in healthcare settings. To explore the temporal relationships between exposure to workplace bullying, coping strategies, and outcomes such as psychological well-being among healthcare workers, mixed-method studies with a longitudinal design are important [33,38]. Such studies can provide insights into how experiences of bullying evolve over time and their impact on individuals' well-being.

Upon reviewing the various themes and investigations within the scope of this review, it becomes evident that bullying constitutes a detrimental act with far-reaching consequences for healthcare professionals, spanning physical, mental, professional, and quality-of-life domains [19,20,58]. Individuals subjected to frequent or daily bullying at work often experience heightened levels of stress, anxiety, helplessness, depression, and post-traumatic symptoms [33–35]. Furthermore, healthcare professionals may lose their motivation to work in such environments, leading to the desire to change jobs or even leave the profession altogether [37]. Notably, workplace violence detrimentally impacts job satisfaction, ultimately affecting clinical decision making and performance [34,39,40], particularly among nurses who often bear the brunt of workplace bullying [7].

Identifying high-risk subgroups among healthcare professionals susceptible to workplace bullying underscores the need for targeted interventions aimed at mitigating violence and its repercussions [35]. The findings hold crucial implications for specific professional groups, such as nurses, necessitating a comprehensive understanding of prevalent bullying behaviours, including excessive workloads and verbal attacks, to enable effective recognition and resolution [7]. Given the adverse effects of bullying, such as helplessness, stress, and attrition from the profession, urgent interventions are warranted to support and safeguard healthcare workers [19].

Resilience emerges as a critical mediator in the association between workplace bullying and professional quality of life [37,39], highlighting the significance of resilience-focused programs for healthcare professionals, particularly early in their careers. These initiatives should address structural empowerment's impact on professional satisfaction and burnout, while also enhancing interpersonal interactions and addressing vulnerabilities (primary prevention). Additionally, interventions aimed at mitigating the adverse effects of workplace violence (secondary or tertiary prevention) must be implemented promptly and continuously to curb the phenomenon [19]. Proposed interventions may include skills training,

cognitive-based problem-solving programs, and education on workplace violence [59–61]. Providing support for victims and implementing beneficial activities to alleviate perceived negative repercussions are equally essential components of intervention efforts.

Moreover, the role of leadership styles and organizational culture is pivotal in preventing bullying within the healthcare context. Cultivating supportive and respectful work environments, where leaders engage with staff, employ positive interaction methods, and establish long-term goals, serves as a deterrent to workplace bullying [36]. For healthcare organizations and management teams, these findings underscore the imperative of fostering a conducive workplace environment to prevent bullying and safeguard the well-being of healthcare professionals. By understanding the coping strategies employed by healthcare professionals, organizations can furnish appropriate resources and support to help employees effectively manage workplace bullying [7]. Employers should assess the type and frequency of bullying incidents using empirical measures (see Section 3.2) and develop strategies to manage and reduce stress, combat employee fatigue, and bolster coping mechanisms associated with exhaustion, should workplace bullying be identified.

Despite the prevalence of bullying experienced by healthcare professionals, many employ coping strategies such as problem-focused mechanisms and seeking social support to mitigate its impact on their lives and professions [34]. However, studies indicate that bullied healthcare professionals exhibit lower frequencies of goal-oriented active coping strategies, which are effective only under minimal exposure to bullying behaviours [38].

Nevertheless, this scoping review has its limitations. Despite thorough searches, some relevant studies may have been missed due to unavailability or inaccessibility. Additionally, studies with nonsignificant findings might not have been included, potentially biasing the review. Nonetheless, this review contributes to understanding bullying against healthcare professionals and their coping strategies.

Future research should concentrate on developing and evaluating interventions to prevent and address workplace bullying in healthcare settings. Longitudinal studies can offer insights into intervention effectiveness over time and identify best practices for supporting healthcare professionals. Moreover, investigating the long-term effects of workplace bullying on the physical and mental health of healthcare professionals, as well as patient care quality, is essential. Exploring the effectiveness of training programs, support systems, and organizational policies can foster a positive work environment, enhance satisfaction and retention, and reduce instances of bullying. Addressing these issues will create safer, more supportive environments for healthcare professionals and ultimately improve patient care.

5. Conclusions

In conclusion, workplace bullying in healthcare settings poses a significant threat to the well-being and professional quality of life of healthcare professionals. The detrimental effects of bullying, such as stress, anxiety, depression, and attrition from the profession, highlight the urgent need for targeted interventions to support and safeguard healthcare workers. Resilience-focused programs, interventions to mitigate workplace violence, and support for victims are crucial components of efforts to address workplace bullying. Leadership styles and organizational culture play pivotal roles in preventing bullying, emphasizing the importance of cultivating supportive work environments. By understanding coping strategies and providing appropriate resources and support, healthcare organizations can effectively manage and reduce the impact of workplace bullying on healthcare professionals. Further investigation into workplace violence, particularly in sensitive sectors like healthcare, public safety, and education, is imperative due to its personal and societal ramifications. Collaboration among researchers, policymakers, and healthcare organizations is essential for translating research findings into actionable interventions that benefit healthcare professionals and enhance patient care.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/ijerph21040459/s1, File S1: Bullying against Healthcare Professionals and Coping Strategies: Scoping Review Protocol.

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SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 51 - Volume 3

Sir Robert Francis' Response to Direction 5 Questions & Associated Documentation

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