What do you do if your bosses are bullies?

PERSONAL VIEW Anonymous

Until recently I had a senior job in health that I was proud of. I shouldn’t have been surprised when they bullied me out of it, because they’d been gunning for me for a couple of years. Also, after seeing several others before me blink off the scene and even out of the organisation, I should have read the omens more intelligence—particularly the dangers of saying “No” or (even worse) “Why?” to those at the top of the organisation when the only permitted response was “Yes.” I wasn’t that good in the job latterly, but you’re never at your best when you’re haemorrhaging from multiple stab wounds in the back and looking constantly over your shoulder to try to dodge the next one. It’s been an eye opening and hide toughening experience, and it is worth passing on some valuable learning points.

You probably think it can’t happen to you. So did I. As a BMJ reader you may find yourself in the firing line, because by all accounts bullying is rife in the health service. Naturally your employer will claim to be totally committed to stamping out bullying throughout the organisation. So did mine. Regrettably its policy on bullying and harassment is a masterpiece of cynicism and hypocrisy, and you may find that yours is too.

How do you know it’s happening? This isn’t a daft question. My employer helpfully explains that bullying takes many forms, some of them subtle, and provides a useful checklist (all of which I’ve been able to tick). It may begin with covert undermining of your authority, so all you notice is that things seem harder than they need to be. Like me, you may take a long time to realise that the gradient of the playing field is steadily steepening against you and finally that it has been generously sown with mines as well. Brighter bullies tend to avoid situations that could come back to bite them, but in-your-face thuggery may still slip through. For me, this included threatening phone calls with more “fucks” per minute than even the BBC would tolerate, then being told that my contract wasn’t worth the paper it was printed on and, finally, that I didn’t “have any rights to anything.” Hard to ignore, because it all came from the top of the organisation.

How does it feel? Absolutely horrible, especially when it has gone on for months and you realise that it’s not going to stop. As well as having the pleasure torn out of your work—together with your motivation, self esteem, dignity, and reputation—you will feel isolated and alone. Many of your friends and colleagues will rally round, though not, unfortunately, around you. Indeed they may disappear over the horizon. Perhaps they can’t think what to say or are afraid that it might be catching. This isolation plays right into the bullies’ hands, by doing some of their work for them and helping to erode your credibility and desire to fight back. At my workplace they beefed up the cordon sanitaire around me by barring me from the premises and from contacting colleagues for two months.

What should you do? Above all, don’t keep it to yourself, and get help as soon as you’ve made the diagnosis. Trying to fight it on your own is debilitating and demoralising, especially when the bullies are powerful in the organisation. I tackled mine a couple of times, as recommended in the organisation’s own carefully bland advice; all this did was to make them shout louder, and to my shame I backed down. It’s difficult and painful and not the sort of stuff you want to take home, but tell your family what’s going on; mine has been superb throughout.

You may well need further assistance. Your personnel department will have guidelines on how to react and especially on being a better victim. But beware: if the bullies are big shots, those nice people in personnel won’t lift a finger against them. Also, some senior personnel managers are right at the heart of institutional bullying; they are wheeled in as required to give fake legitimacy to proceedings and sometimes to put the frighteners on. Presumably their jobs are on the line if they don’t dance to their masters’ tune, but it is disturbing to see how comfortable some of them are in this hybrid role of lapdog and Rottweiler.

Luckily, you’ve got a thick skin that can take all this stuff. Unfortunately, like mine, yours may not be thick enough. I survived thanks to my family and other help that I never thought I’d resort to: counselling (this—provided, ironically, by my employer—was excellent), a psychiatrist (interesting), escitalopram (grim), and the BMA’s employment advice service (worth every penny of three decades’ subscription). I owe them a lot.

Bullying has got to be stopped. It can wreck individuals and their careers, and when it becomes institutional it will eventually cripple the organisation. Individuals can fight back, but bigger guns are needed to force institutions like mine to confront their bullies and get rid of them. Naming and shaming would be a good start. An independent body, the Andrea Adams Trust (www.andreamadams.org), is happy to be called in to investigate allegations of workplace bullying, and the BMA has the necessary clout to impose sanctions on proven offenders.

I hope it doesn’t happen to you. But if it does, I hope this article will help. And if you see it happening to someone else, don’t just look away. Bullying should be a thing of the past, but until that happy and long overdue day comes, you could be next.

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Regrets, I have a few

Looking back, you’ll wonder why we did it. Friendship wrist bands? Strictly Come Dancing? Long hair on men? Similarly, looking back through the annals of medicine you flinch: tonsillectomy, danazol, all foot surgery, diazepam, and bisphosphonates. The difference between the two groups (Strictly Come Dancing excepted) is that in medicine such mistakes can do enormous harm that is often only revealed in time. I wonder how the use of opiate-containing painkillers might be seen in the future?

Pharmacists are now fretting about dependence on the counter painkillers that contain low doses of codeine, and some argue that these preparations should become prescription only. But doctors have the option to prescribe much stronger opiates and in much larger quantities—and increasingly we do, stung by jibes that doctors have managed pain poorly in the past and supported by research evidence that the therapeutic use of opiates does not cause dependence. Also, drug company representatives have long wired and dined with branded painkillers. So, strong opiates are now used freely and widely in many non-malignant pain syndromes.

But is dependence on prescribed opiates a problem? Yes, and not only with dihydrocodeine and tramadol but also with compound products such as co-codamol 30/500 and co-dydramol that contain large quantities of opiates. We are increasingly aware of the problems of these compound analgesics: early requests for repeat prescriptions, persistent overuse, indications often long forgotten, and overuse for poorly defined pain syndromes such as headache and back pain. Trying to withdraw the drugs or even reduce the dosage leads to confrontation, aggression, defensiveness, and anxiety—the stigmata of dependence. Treating pain is difficult, because the perception of pain is subjective, and treatment is inconsistent across populations and open to manipulation.

We need to be aware of possible dependence on all opiates. The compound analgesics have potential for widespread harm. We should not place compound analgesics on repeat prescription computer systems, should prescribe small quantities only, and should routinely use the lowest strength or even consider withdrawing compound preparations altogether, so that opiate doses are laid bare. As to whether we’ve been too quick to climb the opiate analgesic pain ladder, only our children will know.

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Snow

Belgrade, 8 January, the day after Orthodox Christmas. It is snowing hard, and it’s 10 degrees below zero. Serbia has no gas, the overloaded electricity grid is creaking, and many homes and some hospitals have no heating. My family bundle up around a small electric heater in the kitchen, children doing homework, husband and I working on international health consultancy work, thanks to the internet. Like high tech camping, it is not so bad, unless this goes on for longer. We huddle companionably under piled duvets to watch the news. Then we know we are fortunate indeed.

We watch as Gaza, one of the most crowded urban areas on the planet, is bombarded. It is not possible to shell such a place without killing civilians. Families there are clearly desperate, trying to find food and clean water and to keep terror stricken children sane. The hospitals are running out of supplies, services are failing, the rather one sided football score of casualties mounts.

Some readers will have plausible yet opposing explanations for why it has come to this.

War makes the simplest things harder. No quick trip to buy forgotten milk—there is no milk. No deliberating which size suture to use—just desperation to sew up with something. No moaning about delays in cross matched blood arriving—just watching someone bleed to death, as no blood is available. And the rampant bureaucracy: when I ran UN medical evacuation from Sarajevo during the siege it took 28 varyingly stupid signatures to get each patient on the plane. Ever since, any boring, benign committee meeting seems like a party.

Amid this my daughter passes on a message from her history teacher suggesting that she stops arguing with him. Her punishment is to write a short biography of Gandhi. We explore Youtube and watch Ben Kingsley deliver Gandhi’s famous words, “I am prepared to die for my opinions but not to kill for them.” We imagine Gandhi’s views on the ethics of rich countries sending multiple billions of dollars in military “aid” for various armies to kill for their opinions. Gandhi would not accept any argument justifying the bombardment of Gaza, Israel, or anywhere else. I send back a note congratulating the teacher on his choice of inspirational role model and point out that Gandhi would probably expect her to have her own opinions.

The snow outside my window looks so pretty, but only because I do not have to sleep in it, tramp through it without shelter at the end of the journey, or dodge bullets to tunnel down and get some filthy water to drink. I raise a glass of chilly red Vranac wine, opportunistically advertised “Pro Corde” (“For the heart”), with its own ECG tag. Happy New Year.

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A fully rational life

Theodor Gomperz (1832-1912) was a great Austrian classicist who impressed and was perceived as profound by Freud: indeed it was he who commissioned Freud to translate a volume of John Stuart Mill’s work into German. Gomperz’s son, a philosopher, was a patient of Freud’s for a time.

Gomperz devoted a chapter in his great four volume history of classical philosophy to the Greek doctors, especially to Hippocrates and the school of Cos. He was extremely complimentary about them, seeing them as forerunners not only of rational medicine but of a properly empirical and scientific approach to the phenomena of nature as a whole.

To Gomperz primitive medicine was merely absurd: “As well as magic spells, amulets, and various ceremonies, medicinal plants and ointments were used, and it was not rare that a single, unique remedy was used against the most diverse diseases.” There was certainly nothing rational about it.

The fantastic element was so great that the choice of medicines was determined as much by an association of ideas as by actual experience. The red colour of haematite seemed to have destined it for haemostasis. In Egypt, it was believed that the blood of black animals would prevent haemorrhage. In Egypt, it was believed that the blood of black animals would prevent haemostasis. In Egypt, it was believed that the blood of black animals would prevent haemorrhage.

For Gomperz this was a great advance in rationality, because if everything was equally divine it followed that everything could be investigated with equal empirical rigour.

Not having lived to see the first world war, Gomperz believed that empirical knowledge inevitably led to “a fully rational life,” a better existence, which perhaps explains why the question of whether the Greeks actually benefited from Hippocratic rationality at the time of Hippocrates never so much as crossed his mind. It seemed sufficient to him that Hippocrates was an intellectual forerunner, albeit a distant one, of the current state of enlightenment: but when we read the medical texts of Gomperz’s day, with their floating kidneys leading to nephropathy, and their autoinjections leading to hemicolectomies, we realise how far rationality had to go before it reached its apogee—in us, of course.

Theodore Dalrymple is a writer and retired doctor

BETWEEN THE LINES

Theodore Dalrymple

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of detail into a single pattern. But his precious observations, and his numerous but premature conjectures on the relation between climate and health, between the succession of seasons and the course of illnesses, were as nothing compared with the immortal honour of having been the first to try to establish a causative relation between the character of peoples and the physical conditions in which they live.”

He likewise praises the author of On the Sacred Malady (epilepsy), who denied the divine nature of the falling sickness and who wrote: “The nature and cause of this illness derives from precisely the same divine principle that gives rise to all the rest. None is more divine, none is more human, than any other.”

A young Tom Selleck appears briefly as one of the people in a coma. The real star, however, is the heroine, Dr Susan Wheeler (played by Genevieve Bujold, who didn’t become quite so famous). She is a bright young intern who becomes suspicious at her prestigious New England teaching hospital when some patients don’t wake up from their anaesthesia and remain in a vegetative state. She tracks the victims to a facility where they are kept alive and nourished while suspended by wires through their long bones. When she realises that their organs are being harvested to order, her efforts are discovered, and soon it looks as though her organs could be next.

The equipment and decor of the film’s hospital could easily still be in use in any first world country today, although nurses with hats have disappeared, and young doctors are nowadays usually without ties or in scrubs, unlike Dr Wheeler and her colleagues, who wear white suits.

Like the public, doctors are subject to errors of judgment and may transgress. In Coma the whistleblower has an uphill struggle but ultimately triumphs to prevent further suffering, putting the interests of the patients above her career.

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MEDICAL CLASSICS

Coma By Robin Cook


When debate raged recently about presumed consent for organ donation, you might have been forgiven for thinking that the public interest in organ retention and the issue of consent was new. However, body snatchers such as Burke and Hare were in the news more than 100 years ago, transplant surgery is half a century old, and in 1978 a suspense thriller called Coma hit the cinema screens. It is a tale of organ theft on a grand and somewhat implausible scale, but it does reflect the medical technology and knowledge of the day quite well. The plot is supported by accurate medical detail because the writer of the novel on which the film was based was a doctor.

Robin Cook is an American ophthalmic surgeon. Coma was his first book, and his other 27 novels follow a formula, with predictable titles such as Fever, Outbreak, Vital Signs, Seizure, and Foreign Body. He has a knack of tapping into topical fears and interests among the public; for example, his novel about stem cell technology, Shock, appeared just as the stem cell debate took off in the US media, when the public knew little about the issue.

The film Coma, directed by Michael Crichton, more famous now for his work on ER and Jurassic Park and who died last year (BMJ 2008;337:a2517), was an early vehicle for Michael Douglas, who plays the main character’s love interest.

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By Robin Cook

Fever

Shock

Seizure

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The fantastic element was so great that the choice of medicines was determined as much by an association of ideas as by actual experience. The red colour of haematite seemed to have destined it for haemostasis. In Egypt, it was believed that the blood of black animals would prevent hair from turning white; while today in Styria, as once in India, Greece and Italy, the bodies of yellow birds were thought to expel jaundice.

Gomperz compares this farrago of nonsense with the rationality of the Hippocratic corpus. Praising the author of Airs, Waters, Places, he says: “The author is a man whose foot had trodden the soil of southern Russia as well as that of the Nile Valley, whose scrutinising eye had surveyed an infinite and inexhaustible variety of scenes and whose powerful mind tried to combine this immense mass
A giddy dance

The history of Europe's oldest psychiatric institution is a familiar tale of recurring neglect and reform, finds Wendy Moore

Rambling through the centuries of Bethlem Hospital's long history can have a dizzying effect. Rather than a steady, sedate march towards progress, the story of Europe's oldest psychiatric institution is a giddy dance of scandals, investigations, and promised reforms in an ever-repeating pattern, reminiscent of the history of mental healthcare as a whole.

Founded in a fit of philanthropic fervour in London in 1247, Bethlem began treating mental illness in the 14th century. The first allegations of mistreatment were swift to follow. Stories of neglect, abuse, and corruption prompted a first royal commission in 1403, which led to parliamentary proposals for reform in 1411—setting in motion a cycle that would become wearily familiar down the years.

As the horror stories continued, it was little wonder that by the 16th century the hospital's nickname of “Bedlam” had become synonymous with chaos or that, from the 17th century, the hospital's reputation brought flocks of gawping sightseers. When William Hogarth set the final hellish scene of the Rake's Progress inside Bedlam in the mid-18th century, showing his deranged antithesis shaven, almost naked, and manacled by the ankles, he had no need to use artistic licence.

The history of Bedlam makes for gloomy reading. But against the bleak backdrop, Catharine Arnold's slender but sprightly book brings to life the individual human stories of patients who faced their torment with stoicism and humour, relatives who confronted the authorities with indignation and—less often—doctors who swam against the tide to treat their charges with humanity and respect. For as much as it is a story of London’s “mad,” the history of Bedlam is the tale of the capital’s “mad doctors.”

Although the first of Bedlam's keepers boasted no medical qualifications, conditions improved little even once the professional bar was raised. Helkiah Crooke, physician to James I, took over as medical superintendent in 1619, and a year later one patient's father complained that his daughter's foot had almost rotted away from lack of medical care.

Yet Crooke was a ministering angel by comparison with the four generations of Monros who held sway over Bedlam from 1728 to 1855. Mostly preoccupied with their lucrative private patients, the Monros managed to induce a reign of brutality at Bedlam while also absolving themselves of any therapeutic responsibility. Indeed James Monro, son of the first Monro, blithely maintained that insanity had no knowable cause nor any cure.

In turn his son, Thomas Monro, defending at yet another official inquiry the scandal of a patient kept in chains for 12 years, declared that although leg irons were not appropriate for wealthy gentlemen they were entirely in order for Bedlam's paupers. To their credit Bethlem's governors disagreed, refusing to reappoint him, but they then sanctioned a fourth generation, Edward Monro, as a new physician.

In the face of such arrogance, not to mention physical restraints, patients were powerless to protest. Whether they exhibited signs of severe psychosis, such as those who attempted to assassinate various monarchs, or simply mild eccentricity, they were shackled, flogged, starved, doused with cold water, purged, and bled indiscriminately.

Most submitted with the resignation voiced by George III when tortured by Francis Willis, who favoured “breaking” his patients in the manner of horses. Told that Willis had entered medicine after leaving the church the king said: “You have quitted a profession I have always loved, and you have embraced one I most heartily detest.” Reminded that Jesus himself had healed the sick, the king lucidly retorted: “Yes, but he had not £700 a year for it.”

Accustomed to violence and squalor, patients must have wondered whether they were truly delusional and envisioning paradise in the rare interludes when compassion reigned. The farsighted William Hood, who took over as medical superintendent in 1853, removed the iron bars, manacles, and straw beds and introduced carpets, books, singing birds, and even wine with dinner, along with dances and outings to galleries.

For all its depressing content Arnold's history is a light and breezy read, although the details are sometimes sketchy and conclusions overgeneralised. To describe 18th century Britain as a “mad country” governed by “mad politicians and a mad monarch,” and the anti-Catholic Gordon riots of 1780 as “collective madness,” is silly sensationalism. The Georgians may have been no more prone to mental illness than anyone today—even if they were more tolerant of eccentricity. And although she provides a passable potted history of the development of psychotherapy in the 20th century, events at Bethlem are barely mentioned.

More seriously, and inexcusably, Arnold's book relies almost entirely on secondary sources—especially the 1997 scholarly history edited by Jonathan Andrews—and virtually ignores Bethlem's unique and bountiful archives, which stretch back to 1559. Ultimately, therefore, the book offers an enticing introduction but no illuminating insights to the full story of Bedlam.

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